

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2026
NAME OF PROVIDER OR SUPPLIER  Fountain View Subacute and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5310 Fountain Ave Los Angeles, CA 90029	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) were free from abuse by failing to ensure alleged abuse reported by Resident 1 on 1/26/2026 was immediately reported, investigated, and addressed by facility staff. This failure resulted in delayed intervention by the facility, placing Resident 1 and other residents at risk for continued abuse. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of heart failure (the heart muscle isn't pumping blood as well as it should, failing to meet the body's needs for oxygen and nutrients, leading to fluid buildup (swelling) and symptoms like shortness of breath and fatigue) and need for assistance with personal care. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/21/2025, indicated Resident 1 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for showering, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral and personal hygiene, and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for lower body dressing, toileting, and putting on taking off footwear. The MDS indicated Resident 1 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eat. During an interview on 1/27/2026 at 11:42 AM with Resident 1, Resident 1 stated that about five days ago, Certified Nursing Assistant 1 (CNA1) cleaned her perineal area and touched her inappropriately in her vagina and has not seen him since. Resident 1 stated she reported to the social worker but they don't do anything about the matter. During an interview on 1/27/2026 at 12:53 PM with the Social Services Worker (SSW), the SSW reported that Resident 1 reported an allegation of abuse directly to her on 1/26/2026 around 6:30 PM. The SSW acknowledged awareness of the facility's abuse prevention and reporting policy and stated she knew the allegation should have been immediately reported to facility administration. However, the SSW failed to report the allegation to the Administrator, Director of Nursing (DON), or other facility leadership. The SSW acknowledged she did not file an SOC 341 form (the official California Department of Social Services document used to report suspected abuse or neglect of elders (65+) or dependent adults (18-64). It is mandatory for reporters-such as caregivers, health practitioners, and staff-to use this form for documenting physical, mental, financial, or neglect-related abuse), did not call the police, nor call the Ombudsman as per facility protocol. During an interview on 1/27/2026 at 1:07 PM with the Administrator, the Administrator stated she had not been informed of Resident 1's report that</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 055111	If continuation sheet Page 1 of 6

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>staff had touched her inappropriately in her vagina. The Administrator stated this was considered a type of abuse if it did occur, and should have been reported to her the day it happened. The Administrator stated the SSW has been provided training and in service on reporting abuse, and she knows what to do as a mandated reporter. During an interview on 1/27/2026 at 1:16 PM with the Director of Staff Development (DSD), the DSD stated that on 1/22/2026, the Ombudsman visited the facility and Resident 1 reported to the Ombudsman that she had been touched inappropriately by a staff member. The DSD stated she failed to ask details about the allegation and assumed Resident 1 was referring to staff giving her back rubs as Resident 1 usually requests. The DSD stated that CNA1 had not been suspended from the facility and an investigation regarding the alleged abuse had not been started. During an interview on 1/27/2026 at 2:36 PM with the Director of Nursing (DON), the DON stated he was not made aware of the allegation at the time it was reported by Resident 1. The DON stated that failure to report the allegation prevented the facility from implementing immediate protective interventions and placed Resident 1 at risk for continued abuse. During a review of the facility's policy and procedures (P&amp;P) titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 9/2022, the P&amp;P indicated all reports of resident abuse are immediately reported to the administrator, local, state and federal agencies and thoroughly investigated by facility management. Immediately is defined as within two hours of an allegation involving abuse. The administrator immediately reports to local state Ombudsman, state licensing/recertification agency, Adult protective services, law enforcement, facility medical doctor, and resident's attending physician. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was safe through the implementation of its abuse prevention and reporting policies, resulting in failure to identify, report, and investigate alleged abuse on 1/26/2026. This failure resulted in the alleged perpetrator Certified Nursing Assistant 1 (CNA1) to continue to work at the facility and come in contact with Resident 1, placing Resident 1 and other residents at risk for continued abuse. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of heart failure (the heart muscle isn't pumping blood as well as it should, failing to meet the body's needs for oxygen and nutrients, leading to fluid buildup (swelling) and symptoms like shortness of breath and fatigue) and need for assistance with personal care. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/21/2025, indicated Resident 1 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for showering, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral and personal hygiene, and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for lower body dressing, toileting, and putting on taking off footwear. The MDS indicated Resident 1 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eat. During an interview on 1/27/2026 at 11:42 AM with Resident 1, Resident 1 stated that about five days ago on 1/22/2026, Certified Nursing Assistant 1 (CNA1) cleaned her perineal area and touched her inappropriately in her vagina and has not seen him since. Resident 1 stated she reported to the social worker but the facility didn't do anything about the matter. During an interview on 1/27/2026 at 12:53 PM with the Social Services Worker (SSW), the SSW reported that Resident 1 reported an allegation of abuse directly to her on 1/26/2026 around 6:30 PM. The SSW acknowledged awareness of the facility's abuse prevention and reporting policy and stated she knew the allegation should have been immediately reported to facility administration. However, the SSW failed to report the allegation to the Administrator, Director of Nursing (DON), or other facility leadership. The SSW acknowledged she did not file an SOC 341 form (the official California Department of Social Services document used to report suspected abuse or neglect of elders (65+) or dependent adults (18-64). It is mandatory for reporters-such as caregivers, health practitioners, and staff-to use this form for documenting physical, mental, financial, or neglect-related abuse), did not call the police, nor call the Ombudsman as per facility protocol. During an interview on 1/27/2026 at 1:07 PM with the Administrator, the Administrator stated she had not been informed of Resident 1's report that staff had touched her inappropriately in her vagina. The Administrator stated this was considered a type of abuse if it did occur, and should have been reported to her the day it happened. The Administrator stated the SSW has been provided training and in service on reporting abuse, and she knows what to do as a mandated reporter. During an interview on 1/27/2026 at 1:16 PM with the Director of Staff Development (DSD), the DSD stated that on 1/22/2026, the Ombudsman visited the facility and Resident 1 reported to the Ombudsman that she had been touched inappropriately by a staff member. The DSD stated she failed to ask details about the allegation and assumed Resident 1 was referring to staff giving her back rubs as</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1 usually requests. The DSD stated that CNA1 had not been suspended from the facility and an investigation regarding the alleged abuse had not been started. During an interview on 1/27/2026 at 2:36 PM with the Director of Nursing (DON), the DON stated he was not made aware of the allegation at the time it was reported by Resident 1. The DON stated that failure to report the allegation prevented the facility from implementing immediate protective interventions and placed Resident 1 at risk for continued abuse. During a review of the facility's policy and procedure (P&amp;P) titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 9/2022, indicated all reports of resident abuse are immediately reported to the administrator, local, state and federal agencies and thoroughly investigated by facility management. Immediately is defined as within two hours of an allegation involving abuse. The administrator immediately reports to local state Ombudsman, state licensing/recertification agency, Adult protective services, law enforcement, facility medical doctor, and resident's attending physician. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents' (Resident 1) allegations of abuse, were immediately reported to facility administration on 1/26/2026 in the required time frame of two hours and appropriate authorities in accordance with federal requirements. This failure resulted in placing Resident 1 and other residents at risk for continued abuse by allowing alleged perpetrator to continue coming in contact with residents. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of heart failure (the heart muscle isn't pumping blood as well as it should, failing to meet the body's needs for oxygen and nutrients, leading to fluid buildup (swelling) and symptoms like shortness of breath and fatigue) and need for assistance with personal care. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/21/2025, indicated Resident 1 had intact cognition (ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for showering, upper body dressing, roll left and right, sit to lying, lying to sitting on side of bed, partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for oral and personal hygiene, and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for lower body dressing, toileting, and putting on taking off footwear. The MDS indicated Resident 1 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eat. During an interview on 1/27/2026 at 11:42 AM with Resident 1, Resident 1 stated that about five days ago, Certified Nursing Assistant 1 (CNA1) cleaned her perineal area and touched her inappropriately in her vagina and has not seen him since. Resident 1 stated she reported to the social worker but they don't do anything about the matter. During an interview on 1/27/2026 at 12:53 PM with the Social Services Worker (SSW), the SSW reported that Resident 1 reported an allegation of abuse directly to her on 1/26/2026 around 6:30 PM. The SSW acknowledged awareness of the facility's abuse prevention and reporting policy and stated she knew the allegation should have been immediately reported to facility administration. However, the SSW failed to report the allegation to the Administrator, Director of Nursing (DON), or other facility leadership. The SSW acknowledged she did not file an SOC 341 form (the official California Department of Social Services document used to report suspected abuse or neglect of elders (65+) or dependent adults (18-64). It is mandatory for reporters-such as caregivers, health practitioners, and staff-to use this form for documenting physical, mental, financial, or neglect-related abuse), did not call the police, nor call the Ombudsman as per facility protocol. During an interview on 1/27/2026 at 1:07 PM with the Administrator, the Administrator stated she had not been informed of Resident 1's report that staff had touched her inappropriately in her vagina. The Administrator stated this was considered a type of abuse if it did occur, and should have been reported to her the day it happened. The Administrator stated the SSW has been provided training and in service on reporting abuse, and she knows what to do as a mandated reporter. During an interview on 1/27/2026 at 1:16 PM with the Director of Staff Development (DSD), the DSD stated that on 1/22/2026, the Ombudsman visited the facility and Resident 1 reported to the Ombudsman that she had been touched inappropriately by a staff member. The DSD stated she failed to ask details about the allegation and assumed Resident 1 was referring to staff giving her back rubs as Resident 1 usually</p> <p>(continued on next page)</p>		

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