

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Fountain Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 11680 Warner Avenue Fountain Valley, CA 92708	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52238</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to implement their abuse P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report in a timely manner an allegation of staff-to-resident abuse to the local State and Federal agencies for one of three sampled residents (Resident 1). This failure had the potential for the abuse allegation going unreported and uninvestigated.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 2001 showed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to the local State, and Federal agencies (as required by current regulations) and thoroughly investigated by the facility management. The suspicion of abuse must be reported immediately to the administrator and to other officials according to state law. The abuse must be reported within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>Closed medical record review for Resident 1 was initiated on 2/11/25. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's H&P examination dated 1/4/25, showed Resident 1 could make needs known but could not make medical decisions.</p> <p>Review of Resident 1's Nurses Note on 11/17/24 at 0800 hours, showed Resident 1 had an unwitnessed fall resulting in an injury. The note showed Resident 1 reported to the staff three different allegations as to how she fell and got injured. Resident 1's allegations included a male CNA who went into her room and attacked her.</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
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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>Review of Resident 1's SSD Note dated 11/19/24 at 1741 hours, showed Resident 1 was evaluated by the PET Team on 11/18/24. Resident 1 was accepted to the acute care hospital for the psychiatric evaluation related to delusion that Resident 1 was beaten up by a staff which was the reason for her broken nose and refusing to allow the staff to care for her.</p> <p>Further review of the closed medical record showed no documented evidence the abuse allegation was reported to the local State and Federal agencies as per the facility's P&P.</p> <p>On 2/12/24 at 0908hours, an interview and concurrent closed medical record review was conducted with the SSD who verified they were a mandated reporter of an allegation of abuse. The SSD verified and acknowledged the incident with abuse allegation occurred on 11/17/24, should have been reported as an allegation of abuse.</p> <p>On 2/12/25 at 1005 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON was made aware of Resident 1's allegation of abuse on 11/17/24. The DON acknowledged all allegation of abuse should be reported.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46128</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to implement their abuse P&P related to investigation of the physical abuse for one of three sampled residents (Resident 1). This failure posed the risk for the potential abuse to remain unidentified and for the residents to go unprotected.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation dated 2001 showed any incident or allegation of abuse, neglect, exploitation, or theft/misappropriation of resident property are initiated and thoroughly investigated by the administrator. The staff member assigned to gather the facts will at a minimum reviews the documentation and evidence, reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, interview the person(s) reporting the incident, interview any witnesses to the incident, interview staff members (on all shifts) who have had contact with the resident, review all events leading up to the alleged incident. The Administrator will review the investigation report and submit the completed report to other officials in accordance with the State law, including to the State Survey Agency, within 5 working days of the incident.</p> <p>Closed medical record review for Resident 1 was initiated on 2/11/25. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's H&P examination dated 1/4/25, showed Resident 1 could make needs known but could not make medical decisions.</p> <p>Review of Resident 1's Nurses Note on 11/17/24 at 0800 hours, showed Resident 1 had an unwitnessed fall resulting in an injury. The note showed Resident 1 reported to the staff three different allegations as to how she fell and got injured. Resident 1's allegations included a male CNA came into her room and attacked her.</p> <p>On 2/12/25 at 1005 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON was made aware of Resident 1's allegation of abuse on 11/17/24. The DON stated the investigation was not worth it due to Resident 1's fixation on a male CNA who no longer worked at the facility. However, the DON verified and acknowledged the facility's protocol of abuse was to investigate all allegations of abuse.</p> <p>Cross reference to F609.</p>		