

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  04/10/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50003</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of three sampled residents' (Resident 3) medical record was accurate and complete.</p> <p>* The facility failed to ensure the documentation for monitoring Resident 3's condition for 72 hours each shift was completed after the resident's fall incident. This failure posed the risk for changes in Resident 3's health condition to go undetected and possibly delay necessary care and treatment.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Change of Condition Notification dated 2001 showed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>Medical record review for Resident 3 was initiated on 4/10/25. Resident 3 was admitted to the facility on [DATE].</p> <p>Review of Resident 3's H&amp;P examination dated 8/24/24, showed Resident 3 had no capacity to understand and make decisions.</p> <p>Review of Resident 3's eINTERACT Change in Condition Evaluation - V 5.1 dated 2/21/25, showed Resident 3 had an unwitnessed fall on 3/24/25 at 2015 hours, with no evidence of an injury.</p> <p>Review of Resident 3's progress notes failed to show documented evidence the licensed nurses had monitored the resident's condition post fall on the following dates and shifts:</p> <ul style="list-style-type: none"> <li>- on 3/24/25, for the NOC shift (2300 - 0700 hours);</li> <li>- on 3/25/25, for the day shift (0700 - 1500 hours);</li> <li>- on 3/25/25, for the NOC shift;</li> <li>- on 3/26/25, for the day shift;</li> <li>- on 3/26/25, for the NOC shift</li> </ul> <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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 3/27/25, for the day shift; and</p> <p>- on 3/27/25, for the evening shift (1500 -2300 hours).</p> <p>On 4/10/25 at 1000 hours, an interview was conducted with RN 3. When asked about the facility's process when a resident had a change in condition, RN 3 stated the licensed nurses were expected to assess the resident's condition and document their findings. RN 3 stated after the initial change of condition documentation, the licensed nurses were expected to continue the monitoring of the resident's condition every shift for 72 hours and to document the assessment in the resident's medical record.</p> <p>On 4/10/25 at 1120 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 stated Resident 3 had an unwitnessed fall on 3/24/25, and the licensed nurses were expected to monitor Resident 3's condition every shift for 72 hours after the fall to ensure the changes in the resident's condition were closely monitored. RN 4 verified there were missing documentation from the licensed nurses to show the resident's condition was monitored every shift for 72 hours after the fall incident.</p> <p>On 4/10/25 at 1345 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>