STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555328	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Valley Post Acute	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)
F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was provided appropriate respiratory care. * The facility failed to ensure Resident 1's oxygen orders were administered by a license nurse and carried out as ordered by the physician. In addition, the facility failed to ensure Resident 1's MDS was accurately coded when the resident was on oxygen. These failures had the potential to affect the respiratory health and well-being of the resident in the facility. Findings: Review of the facility's P&P titled Oxygen Administration (undated) showed the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P further showed to verify there was a physician's order for this procedure and review the physician's orders or facility protocol for oxygen administration. 1. Medical record review for Resident 1 was initiated on 11/25/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10/18/25, showed the resident's decision-making capabilities as need assistance. Review of Resident 1's Order Summary Report dated 10/27/25, showed an order for oxygen via nasal cannula at 2 LPM every shift, notify the MD if the oxygen saturation drops below 88%. Review of Resident 1's Significant Change/Medicare-5 Day MDS dated [DATE], showed under Section O, Resident 1 was not on oxygen. Review of Resident 1's Oxygen Saturation Summary showed the resident's oxygen saturation was obtained via room air on the following dates and times:- 11/21/15 at 1616 hours, O2 saturation of 97%- 11/21/25 at 2331 hours, O2 saturation of 97%- 11/22/25 at 1836 hours, O2 saturation of 96%- 11/23/25 at 0054 hours, O2 saturation of 96%- 11/23/25 at 0055 hours, O2 saturation of 96%- 11/23/25 at 1827 hours, O2 saturation of 95%; and- 11/24/25 at 0815 hours, O2 saturation of 96% On 11/25/25 at 1407 hours, an observation and concurrent interview was conducted with CNA 1 in Resident 1's room. Resident 1's oxygen concentrator was on with the nasal cannula hanging on the oxygen concentrator. The nasal cannula was not stored in an oxygen storage bag. The oxygen concentrator showed the setting at 2.5 LPM. CNA 1 took the nasal cannula and placed it on Resident 1. CNA 1 verified the nasal cannula was not stored in the oxygen storage bag prior to use. CNA 1 further verified they should not have put the nasal cannula on the resident. CNA 1 stated the license nurses were supposed to put the nasal cannulas on the residents to ensure the oxygen was on the right setting. On 11/25/25 at 1430 hours, an observation, interview and concurrent medical record review was conducted with LVN 1 in Resident 1's room. LVN 1 verified Resident 1's oxygen concentrator was set at 2.5 LPM and the orders were for 2 LPM. LVN 1 verified the oxygen administered should match the physician's order. LVN 1 also verified the CNAs were not to apply the nasal cannula on the residents to ensure the oxygen therapy was applied correctly and stated the oxygen should be applied by the licensed nurses. On 11/25/25 at 1620 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated the nasal cannulas should be stored properly in the oxygen storage bags to maintain infection control and should be applied on the resident by the charge nurses and not by the CNAs. The DON further stated Resident 1's MDS should have coded Resident 1 on oxygen since the resident was on a continuous oxygen administration. The DON also verified the multiple dates the O2 saturation were noted as room air. The DON verified Resident 1 should be on continuous oxygen as ordered. The DON verified the above findings.