



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055111 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/27/2011 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>FOUNTAIN VIEW SUBACUTE AND NURSING CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5310 FOUNTAIN AVE, LOS ANGELES, CA 90029 LOS ANGELES COUNTY</b> |
|--|---|

|                    |  |               |   |                    |
|--------------------|--|---------------|---|--------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|

Continued From page 1

Based on observation, interview, and record review, the facility failed to ensure Resident 1, who had a history of falls and was assessed as being a high risk for falls, received adequate supervision and necessary care to prevent severe fatal brain injury from a fall for one out of one sample residents (1).

A review of the Skilled Nursing Facility's admission record dated [REDACTED] 2010, at 11 p.m. indicated Resident 1 was an [REDACTED] year-old admitted from the acute care hospital after being hospitalized for a fall and for hematuria (blood in the urine) from [REDACTED] to [REDACTED], 2010. The resident had the first fall at an Assisting Living Facility and had sustained a laceration to his left forehead that was repaired with sutures at the hospital. The cranial computerized tomography (CT) scan dated [REDACTED], 2010, done after the first fall indicated there was no evidence of acute hemorrhage (profuse bleeding) from the first fall. However, the resident did not return to the Assisting Living Facility because he required Skilled Nursing Care.

The resident's admission diagnoses to the skilled nursing facility (SNF) included status post fall, history of falls, hematuria, open wound of the scalp, urine retention, hypertension, and benign prostate hypertrophy (enlargement of the prostate that leads to symptoms of urinary hesitancy and

**F323- 483.25(h) Free of Accident/ Hazards/ Supervision/ Devices**

- The facility will make every reasonable effort that each resident environment remains as free of accident/ hazards as possible; and that each resident receives adequate supervision and assistive devices to prevent accidents.

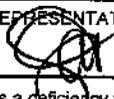
Resident #1 is no longer at the facility.

Event ID:FI4Z11

12/21/2011

9:40:50AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

ADMINISTRATOR

(X6) DATE

12/21/11

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. Except for nursing homes, the findings 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.







CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055111 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/27/2011 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>FOUNTAIN VIEW SUBACUTE AND NURSING CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5310 FOUNTAIN AVE, LOS ANGELES, CA 90029 LOS ANGELES COUNTY</b> |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

Continued From page 5

A review of the Daily and Q (every) Shift Charting dated [REDACTED] 2010, at 7:55 a.m. indicated the resident was not responding to touch, verbal stimuli, and his eyes were closed. The resident's vital signs were: blood pressure was 130/64, pulse was 100, respirations were 20, temperature was 97.8 degrees Fahrenheit, and his oxygen saturation was 96 percent (%) on room air. The physician was notified and the paramedics transferred the resident to the acute care hospital emergency room.

On October 29, 2010, at 1:45 p.m., during interviews with the DON and the Administrator (AS 1), the DON explained the "Restraint Alternative Program" included the use of a "low bed" (specially ordered bed that is lower than a normal bed), to remind the resident not to get up unassisted, and side rails up for positioning. AS 1 stated the facility uses low beds and wheelchair alarms (for residents assessed as a high risk for falls). He stated he thought the facility had 24 hours after admission to obtain equipment, including Resident 1's special "high/low" bed. According to AS 1, the facility's regular bed, which can be lowered to a height of two feet above the floor, differs from the "high/low bed" which can be lowered to 12 inches above the floor (from the bottom of the frame, not the top of the mattress). According to AS 1, if a resident attempts to get out of bed unassisted, he/she would roll out of bed onto

DON/designee will also monitor compliance by randomly observing Nursing staff during provision of care to assure that assistive devices are applied to prevent accidents according to physician's orders. Trends regarding the delivery of service/care, as well as Plan of Correction and compliance will be shared at the Quality Assurance Committee meeting for further recommendation and follow up.

- Corrective action completion date: December 21, 2011.

Event ID:FI4Z11

12/21/2011

9:40:50AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Arm.

(X6) DATE

12/21/11

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. Except for nursing homes, the findings 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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>055111</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>01/27/2011</b> |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>FOUNTAIN VIEW SUBACUTE AND NURSING CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5310 FOUNTAIN AVE, LOS ANGELES, CA 90029 LOS ANGELES COUNTY</b> |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

Continued From page 7

normal heart rhythm for people who have certain types of abnormal heartbeats (arrhythmias)] performed and normal sinus rhythm was established. The CT scan revealed a large subdural hematoma (SDH) that measured 3 centimeters with midline shift and radiographic evidence of brainstem herniation (deadly side effect of very high pressure inside the skull that occurs when the brain shifts across structures within the skull).

The resident was diagnosed as having a large left subdural hematoma (a collection of blood on the surface of the brain usually caused by a serious head injury and often requires surgical intervention). There was no surgical procedure performed. The neurological evaluation from the General Acute Care Hospital deemed the resident a poor surgical candidate and no intervention was offered. He was made "comfort measures only". The resident's neurological status worsened and he was pronounced dead on [REDACTED] 2010, at 11.20 a.m.

A review of the Certificate of Death dated [REDACTED] 2010, obtained from the acute care hospital revealed the cause of death was "Blunt Head Trauma" from a ground level fall at the nursing home.

On November 1, 2010, at 3:48 p.m., during an interview CNA 1 stated that Registered Nurse 2 (RN 2) found the resident on the floor and called her to the resident's room to help put the

**THIS PAGE LEFT BLANK  
INTENTIONALLY**

Event ID:FI4Z11

12/21/2011

9:40:50AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Adm.

(X8) DATE

12/20/11

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. Except for nursing homes, the findings 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.



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055111 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>01/27/2011 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>FOUNTAIN VIEW SUBACUTE AND NURSING CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5310 FOUNTAIN AVE, LOS ANGELES, CA 90029 LOS ANGELES COUNTY</b> |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

Continued From page 9

The facility failed to ensure Resident 1 who had a history of falls and assessed as being at a high risk for falls received adequate supervision and necessary care to prevent severe fatal brain injury from a fall for one out of one sample residents (1).

The above violation presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result and was a direct proximate cause of death of Resident 1.

**THIS PAGE LEFT BLANK INTENTIONALLY**

Event ID:FI4Z11

12/21/2011

9:40:50AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Adm.

(X6) DATE

12/21/11

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. Except for nursing homes, the findings 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.