STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055111	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Subacute and Nursing Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the development and implementation of personˆcentered care plan for three of three sampled residents (Residents 1, 2, and 3) when:For Resident 1, the facility failed to create a personˆcentered care plan that reflected the resident's assessed needs.For Residents 1, 2, and 3 the facility failed to implement careˆplan interventions by not administering medications as ordered, as required under professional standards and careˆplan directives.For Resident 3, the facility failed to implement the prescribed treatment as outlined in the resident's care plan.These deficient practices had result in unmet medical needs, increased risk of avoidable decline, and compromised quality of care for all affected Resident.1.During a review of Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions. During a review of Resident 1's care plan titled The resident noted with lethargy, episodes of seizure. dated 2/21/2026, the care plan indicated intervention as following: administer medication as order, evaluate for side effects and effectiveness. During a review of Resident 1's care plan titled The Resident had an actual unwitnessed fall w. dated 3/29/2026, the care plan indicated intervention as following: check range of motion and continue interventions on the at risk-plan. During a review of Resident 1's care plan titled The Resident was observed with episode of 30 sec seizure, dated 4/14/2026, the care plan indicated intervention as following: vital signs taken with normal limits. During a review of Resident 1's care plan titled the Resident has significant of 5 lb (3.68%) loss. dated 6/4/2026, the care plan indicated intervention as monitor vital sign and reported to MD if indicated. During an interview with Licensed Vocational Nurse (LVN) 1 on 6/30/2026 at 1:51 pm, LVN 1 stated, care plan lists current conditions, interventions and goals for the residents, care plan should be specific and individualized. During an interview with Assistant Director of Nursing (ADON) on 7/1/2026 at 2:40 pm, the ADON stated Resident 1's care plan was not specific enough. ADON further stated the following:Resident 1 experienced lethargy, it did not specify which medication to give and how often,Resident 1 had actual unwitnessed fall, it did not specify how often to check range of motion and what intervention to continue,Resident 1 observed with seizure, it did not specify on how often vital sign should be monitored.Resident 1 had significant 5 lb. loss, it did not specify what vital sign indicated to notify the physician. ADON continued stated that Resident's care plan should be specific, so facility know what intervention to follow. Failed to do so, making Resident 1's care plan was not specific and individualized, it affects the care and treatment for Resident 1. 2a.During a review of (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions.During a review of Resident 1's physician order dated 4/1/2026, the physician order indicated:Keppra (a medicine that helps prevent seizures) oral Tablet 750 mg (milligram, a very small unit that measures how much medicine is in a pill or dose) give 1 tablet by month every 12 hours for seizure disorder.Lacosamide (a medicine that helps prevent seizures) oral tablet 100 mg (Lacosamide) give 1 table by mouth every 12 hours for seizure disorder.During a review of Resident 1's physician order dated 4/16/2026, the physician order indicated:Depakote (a medicine that helps prevent seizure) oral tablet delayed release 250 mg (divalproex sodium) give 750 mg by mouth two times a day for anticonvulsant (a type of medicine that helps prevent seizure).During a review of Resident 1's care plan titled The Resident is at risk for seizure activity related to history of seizure disorder. Dated 4/19/2025, the care plan stated administer medication as ordered- Divalproex Sodium Oral Tablet Delayed Release- Lacosamide Oral Tablet- levetiracetam Oral TabletDuring a review of Resident 1's medication administration record (MAR) dated 5/2026, the MAR indicated the following:Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 750 mg by mouth two times a day for anticonvulsant, was not administered on the following dates and times:at 9:00 am, on 5/27.at 21:00 pm on 5/2, 5/4, 5/5, 5/9, 5/17, 5/20Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth every 12 hours for Seizure disorder, was not administered on the following dates and times:at 21:00 pm on 5/1, 5/2, 5/4, 5/5, 5/9, 5/17, 5/20Keppra Oral Tablet 750 MG (Levetiracetam) Give 1 tablet by mouth every 12 hours forSeizure disorder, was not administered on the following dates and times:at 21:00 pm on 5/1, 5/2, 5/4, 5/5, 5/9, 5/17, 5/202b. During a review of Resident 2's admission record dated 7/2/2026, the admission record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses that included muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypertension (high blood pressure), Diabetes (condition where the body has trouble using sugar the right way), and history of fall.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 2's cognition (ability to think, remember and reason for daily decision making) was intact.During a review of Resident 2's physician order dated 4/2/2026, the physician order indicated:Lamotrigine (a medicine that helps prevent seizures) oral tablet 100 mg (milligram, a very small unit that measures how much medicine is in a pill or dose) give 1 table by month two times a day for anti-convulsantLevetiracetam (Keppra, a medicine that helps prevent seizures) ER oral tablet extended release 24-hour 1500 mg (Levetiracetam) give 1500 mg by mouth two times a day for anti-seizure.Pregabalin (a medicine that helps calm overactive nerves, can be used for nerve pain or seizure) oral capsule 200mg neuropathic pain hold if respiratory rate < 12 and/or excessive sedation.During a review of Resident 2's care plan titled The Resident is newly admitted to the facility, dated 4/2/2026, the care plan included interventions administer medication, treatments, and other services in accordance with physician orders.During a review of Resident 2's MAR dated 5/2026 and 6/2026, the MAR indicated the following:Lamotrigine oral tablet 100mg (Lamotrigine) give 1 table by month two times a day for anti-convulsant, was not administered on the following dates and times:at 17:00 pm: 5/1, 5/9, 6/13Levetiracetam ER oral tablet extended release 24-hour 1500 mg (Levetiracetam) give 1500 mg by mouth two times a day for anti-seizure. was not (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administered on the following dates and times:at 17:00 pm: 5/1, 5/9, 6/13Pregabalin oral capsule 200mg neuropathic pain hold if RR < 12 and/or excessive sedation. Was not administered on the following dates and times:at 9:00 am: 5/3, 5/4at 17:00 pm: 5/1, 5/2, 5/3, 5/4, 5/92c. During a review of Resident 3's admission record dated 7/2/2026, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cellulitis (an infection of the skin. It happens when germs (usually bacteria) get into the body through a cut, scratch, or any break in the skin) of right lower limb, cellulitis of left lower limb, diabetes (condition where the body has trouble using sugar the right way) and hypertension (high blood pressure).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 6/15/2026, the MDS indicated Resident 3's cognition (ability to think, remember and reason for daily decision making) was intact.During a review of Resident 3's physician order dated 5/13/2026, the order indicated:insulin aspart (a fast-acting insulin [a medicine helps move sugar from your blood into your cells]) injection solution 100 unit/ml per sliding scale (a way for nurses to decide how much insulin to give based on a person's blood sugar level).During a review of Resident 3's care plan titled Resident has type 2 diabetes. dated 5/26/2026, the care plan indicated to monitor Resident 2 blood glucose as ordered and administered antidiabetic medication as ordered.During a review of Resident 3's MAR dated 5/2026 and 6/2026, the MAR indicated the following:insulin aspart injection solution 100 unit/ml, inject as per sliding scale:if 0 - 150 = 0 unit,if 151 - 200 = 2 unitsif 201 - 250 = 3 unitsif 251 - 300 =5 unitsif 301 - 350 = 7 unitsif 351+ = 10 units call MD immediately for further instruction if blood glucose is greater than 400, subcutaneously before meals and at bedtime for diabetes. inject insulin 15 - 20 mins minutes before each meal, the blood sugar level was not monitor and medication order was not administered on the following dates and times:at 6:30 am: 6/6at 4:30 pm: 6/13at 9:00 pm: 6/13During an interview with Licensed Vocational Nurse (LVN) 1 on 6/30/2026 at 1:50 pm, LVN 1 stated resident's care plan should be followed and intervention should be implemented. LVN 1 also stated resident's medication should be administered as order.During an interview with Assistant Director of Nursing (ADON) on 7/1/2026 at 2:40 pm, the ADON stated resident's care plan should be followed and implemented. ADON continued stated, failed to implement the care plan by not administered seizure medications and insulin as order affected all residents care, increased the risk for injury, harm and re-hospitalization. 3.During a review of Resident 3's admission record dated 7/2/2026, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cellulitis (an infection of the skin. It happens when germs (usually bacteria) get into the body through a cut, scratch, or any break in the skin) of right lower limb, cellulitis of left lower limb, diabetes (condition where the body has trouble using sugar the right way) and hypertension (high blood pressure).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 6/15/2026, the MDS indicated Resident 3's cognition (ability to think, remember and reason for daily decision making) was intact.During a review of Resident's physician order on 5/14/2026, the physician order indicated the following:polysporin (a type of antibiotic ointment you put on the skin to help stop infections) external ointment [PHONE NUMBER]0 unit/gm (bacitracin-polymyxin B) Apply to BLE topically every shift for cellulitis for 14 days.During a review of Resident's physician order on 5/14/2026, the physician order indicated the following:left lower leg venous ulcer-clean with normal saline (NS), pat dry, apply polysporin, apply non-adherent dressing, apply abd pad (a thick, absorbent bandage used to cover big wounds or wounds that leak a lot of fluid), wrap with kerlix (a soft, stretchy bandage used to wrap wounds), secure with tape every day shift for 30 daysright lower leg front scattered fluid filled blister-clean with NS, pat dry, apply non-adhesive dressing, wrap with kerlix, secure with tape every day shift for 14 days.During a review of Resident 3's care plan titled Resident is newly admitted to facility dated 5/13/2026, the care plan included intervention as administered medication, treatment, and other services in accordance with physician's order.During a review of Resident 3's care plan titled Resident has actual skin breakdown. dated 5/13/2026, the care plan included intervention as provide wound treatment as ordered.During a review of Resident 3's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	treatment administration record (TAR) dated 5/2026, the TAR indicated the following:polysporin external ointment [PHONE NUMBER]0 unit/gm (bacitracin-polymyxin B) Apply to BLE topically every shift for cellulitis for 14 days, was not administered on the following date and time:day shift: 5/15, 5/16, 5/21, 5/28evening shift: 5/14, 5/15, 5/16, 5/17, 5/19, 5/20, 5/21night shift: 5/14, 5/15, 5/16, 5/22left lower leg venous ulcer-clean with NS, pat dry, apply polysporin, apply non-adherent dressing, apply abd pad, wrap with kerlix, secure with tape every day shift for 30 days, was not administered on the following date and time:Day shift: 5/15, 5/21, 5/26right lower leg front scattered fluid filled blister-clean with NS, pat dry, apply non-adhesive dressing, wrap with kerlix, secure with tape every day shift for 14 days, was not administered on the following date and time:Day shift: 5/15, 5/21, 5/26 During an interview with LVN 1 on 6/30/2026 at 1:51 pm, LVN 1 stated, resident's care plan and treatment orders should be followed and implemented. Failing to provide treatment as order would affect Resident 3's care and delay Resident 3's recovery. During an interview with ADON on 7/1/2026 at 2:40 pm, the ADON stated Resident 3's treatment did not administer as physician ordered, Resident 3's care plan was not implemented. Failing to follow the physician's order and implement resident's care plan would compromise resident 3's recovery and prolong her healing process. During a review of the facility's policy and procedures (P&P) titled administering medication, dated 11/20/2025, the P&P indicated Medication are administered in a safe and timely manner, and as prescribed.During a review of the facility's P&P titled, care plan comprehensive, dated 11/20/2025, the P&P indicated that facility must develop and implement a comprehensive person-centered care plan for each resident.

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Fountain View Subacute and Nursing Center	5310 Fountain Ave Los Angeles, CA 90029

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, facility failed to ensure three of three sampled residents (Resident 1, Resident 2 and Resident 3) were adequately monitored for changes in condition and adverse effects of medications, when:Resident 1 was not monitored for vital signs, pain level, seizure activity, hours of sleep and adverse effects of multiple medications,Resident 2 was not monitored for vital signs, pain level, seizure activity, opioid overdoes symptoms and adverse effects of multiple medications.Resident 3 was not monitored for vital signs, pain level, blood sugar level, oxygen level, opioid overdose, and anticoagulant (a medicine that helps prevent blood from clotting too easily) side effect.These deficient practices had potential to result in significant harm due to missed signs of deterioration or adverse medication consequences. 1.During a review of Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions. During a review of Resident 1's physician order dated 4/1/2026, the order indicated the following: Pain monitor.During a review of Resident 1's physician order dated 4/2/2026, the order indicated the following: Monitor for seizure activity. Monitor for signs and symptoms of .During a review of Resident 1's physician order dated 4/6/2026, the order indicated the following: Anti-depressant Monitoring. Monitor hours of sleep.During a review of Resident 1's physician order dated 4/28/2026, the order indicated the following: Anti-Convulsant monitor.During a review Resident 1's MAR dated 5/2026 and 6/2026, the MAR indicated the following: Pain monitor. was not done on the following dates and times:Day shift:5/27Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20 Monitor for seizure activity. was not done on the following dates and times:Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20 Monitor for signs and symptoms of . vital signs were not done on the following dates and times:Day shift:5/27Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20 Anti-depressant monitoring. was not done on the following dates and times:Day shift:5/27Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20Monitor hours of sleep. was not done on the following dates and times:Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20 Anti-Convulsant monitor. was not done on the following dates and times:Day shift:5/27Evening shift:5/2, 5/4, 5/5, 5/9, 5/17, 5/20 2. During a review of Resident 2's admission record dated 7/2/2026, the admission record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses that included muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypertension (high blood pressure), Diabetes (condition where the body has trouble using sugar the right way), and history of fall.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 2's cognition (ability to think, remember and reason for daily decision making) was intact.During a review of Resident 2's physician order dated 4/2/2026, the order indicated the following: Anti-anxiety medication (a medicine that helps a person feel less worried, nervous, or scared) monitor side effect. Anti-convulsant medication (a medicine that helps prevent seizures) monitor side effect. Anti-depressant (a medicine that helps a person feel less sad, hopeless, or tired all the time.) monitor side effect. Monitoring for opioid overdoes (when a person takes too much of an opioid [a type of drug used for pain]) symptoms. Observe for episode of seizure. Pain monitor .During a review of Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2's physician order dated 4/12/2026, the order indicated the following: Monitor abnormal signs/symptoms every shift.blood pressure, temperature, pulse, Respiratory rate.During a review Resident 2's MAR dated 5/2026 and 6/2026, the MAR indicated the following: Anti-anxiety monitor side effect . was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9, 6/13Night shift: 5/14 Anti-convulsant monitor side effect. was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9,6/13Night shift: 5/14 Anti-depressant monitor side effect. was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9,6/13Night shift: 5/14 Monitoring for opioid overdoes symptoms. was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9, 6/13Night shift: 5/14 Observe for episode of seizure. was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9, 6/13Night shift: 5/14 Pain Monitor. was not done on the following dates and times:Day shift: 5/27, 6/28Evening shift: 5/1, 5/4, 5/9, 6/13Night shift: 5/14Vital signs were not monitored on the following dates and times:Day shift: 5/12, 5/27, 6/28Evening shift: 5/1, 5/4, 5/9, 6/13Night shift: 5/14 3.During a review of Resident 3's admission record dated 7/2/2026, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cellulitis (an infection of the skin. It happens when germs (usually bacteria) get into the body through a cut, scratch, or any break in the skin) of right lower limb, cellulitis of left lower limb, diabetes (condition where the body has trouble using sugar the right way) and hypertension (high blood pressure). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 6/15/2026, the MDS indicated Resident 3's cognition (ability to think, remember and reason for daily decision making) was intact. During a review of Resident 3's physician order dated 5/13/2026, the order indicated the following: Insulin aspart injection solution 100 unit/ml, inject as per sliding scale:if 0 - 150 = 0 unit,if 151 - 200 = 2 unitsif 201 - 250 = 3 unitsif 251 - 300 =5 unitsif 301 - 350 = 7 unitsif 351+ = 10 units call MD immediately for further instruction if blood glucose is greater than 400, subcutaneously before meals and at bedtime for diabetes, must take finger stick blood glucose prior to administration. inject insulin 15 - 20 mins minutes before each meal. Pulse oxygen (measured with a small device called a pulse oximeter, usually clipped onto a finger, tells you how much oxygen is in a person's blood) level every shift to keep oxygen saturation greater than or equal to 90% Pain monitor every shift.During a review of Resident 3's physician order dated 5/14/2026, the order indicated the following: Monitoring for opioid overdose symptoms: side effect: 1. Anticoagulant medication monitoring.During a review of Resident 3's physician order dated 5/24/2026, the order indicated the following: Monitor abnormal signs/symptoms every shift.Blood pressure, temperature, pulse, Respiratory rate.During a review Resident 3's MAR dated 5/2026 and 6/2026, the MAR indicated the following:Finger stick blood glucose was not monitored on the following dates and time:at 6:30 am: 6/6/at 4:30 pm: 6/13at 9:00 pm: 6/13Pulse oxygen was not monitored on the following dates and times:Day shift: 5/27Evening shift 5/14, 5/16, 6/13Night shift: 5/14Pain level was not monitored on the following dates and times:Day shift: 5/27Evening shift: 5/16, 6/13.Opioid overdose symptoms were not monitored on the following dates and times:Day shift: 5/27,Evening shift: 5/16, 6/13.Anticoagulant monitoring was not done on the following dates and times:Day shift: 5/27Evening shift: 5/16, 6/13.Vital signs were not monitored on the following dates and times:Day shift: 5/27Evening shift: 6/13. During an interview with Licensed Vocational Nurse (LVN) 1 on 6/30/2026 at 1:51 pm, LVN 1 stated resident assessment and documentation should be specific, accurate and completed. If assessment and documentation were not accurate and completed, it could harm the residents and affect their care. During a phone interview with Director of Nursing (DON) on 7/2/2026 at 12:34 pm, the DON acknowledged that multiple assessments of multiple sampled residents were not completed. Residents were not monitored on vital signs, pain level, medication side effects. [NAME] stated no documentation or progress notes were done for those missing dates and times. It is not safe practice; it affected all the sampled residents' care. During a review of the facility's policy and procedures (P&P) titled charting and documentation, dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/20/2025, the P&P indicated documentation in the medical record will be objective, complete and accurate.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safe medication management by not identifying and reporting multiple significant medication irregularities for one of three sampled residents (Resident 1) as required by accepted standards of practice, when:nurses failed to report medication dosages given outside of recommended guidelinesnurses failed to report repeated drugˆtoˆdrug interaction alerts,These deficient practices increase the risk of ineffective therapy, medication toxicity, uncontrolled symptoms, and preventable adverse drug events for Resident 1.During a review of Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions. 1.During a review of Resident 1's nursing progress notes dated 5/27/2026, the progress notes indicated the following: Depakote (a medicine for seizure, that helps keep the brain calm and steady.) oral tablet delayed Release 250 mg (milligram, a tiny unit used to measure how much medicine is in a pill or liquid) give 250 mg by mouth in the afternoon for anticonvulsant (medicine that helps prevent seizures)-The dosing regimen of 250 mg daily is below the usual dosing regimen of 310 mg 2 times per day to 3 times per day-the frequency of daily is below the usual frequency of 2 to 3 times per day. 2.During a review of Resident 1's nursing progress notes dated 4/14/2026, the progress notes indicated, order of Ativan (seizure medication) tablet 1 mg, has triggered the drug to drug interaction with following medication:Depakote with severe severity.During a review of Resident 1's nursing progress notes dated 4/16/2026, the progress notes indicated, order of depakote (seizure medication) oral tablet delayed release 250mg, has triggered the drug to drug interaction with the following medication:Phenytoin sodium extened capsule 100mg with moderate severity.Ativan tablet 1mg with severe severity.During a review of Resident 1's nursing progress notes dated 6/13/2026, the progress notes indicated, order of lorazepam tablet 0.5mg, has triggered the drug to drug interaction with the following medication:Depakoe with severe severityDuring an interview with Licensed Vocational Nurse (LVN) 3 on 7/1/2026 at 1;28 pm, LVN 3 stated for any time drug to drug interactions triggered, nurses would notify the physician, get instruction from physician, and then acknowledge it and documented that they did it. For any medication dosing outside of recommendation, physicians should also be notified as well. LVN 3 continued stated, she cannot find any progress notes on 4/14/2026, 4/16/2026, 5/27/2026 and 6/13/2026, that physician was notified. LVN 3 further stated drug to drug interaction and order medication dosage out of recommendation are both considered as change of condition, physician need to be notified, otherwise it could harm the residents. During an interview with Assistant Director of Nursing (ADON) on 7/1/2026 at 2:50 pm, ADON stated, on 4/14/2026, 4/16/2026 and 6/13/2026, drug to drug interaction was triggered for Resident 1, the nurse only acknowledged but did not notify the physician, as well as 5/27/2026 medication was outside of recommendation. ADON continue stated failed to report those will affect Resident 1's care and could even cause harm to Resident 1. During a phone interview with Pharmacy Consultant, (PC) on 7/2/2026 at 2:28 pm, PC stated facility had not reported any drug to drug interaction or medication order outside of recommendation guideline to him. PC further explained that if there is a drug to drug interaction or medication dosing was outside of recommendation, the DON and Physician should be (continued on next page)

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	055111	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View Subacute and Nursing Center	5310 Fountain Ave Los Angeles, CA 90029

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified, if any facility needs guidance from pharmacist, they could also reach out to call any pharmacist or to PC. During a review of the facility's policy and procedures (P&P) titled change of condition: notification of, dated 11/20/2025, and P&P indicated facility should immediately inform Resident's physician a need to alter treatment significantly.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that medications were administered as ordered for three of three sampled residents (Residents 1, Resident 2 and Resident 3), whenfor Resident 1, the facility failed to administer multiple doses of prescribed seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse) medications, blood pressure medications and antibiotic (a medicine that kills bacteria), resulting in repeated missed doses.for Resident 2, the facility failed to administer multiple doses of prescribed seizure medications, resulting in repeated missed doses.for Resident 3, the facility failed to administer multiple doses of prescribed insulin (a medicine helps move sugar from your blood into your cells) injections, also resulting in repeated missed doses.These deficient practices had potential to cause serious adverse outcomes, including increased seizure activity, worsening infection, avoidable decline, compromised all sampled residents safety and could even result re-hospitalization.Findings:1.During a review of Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions.During a review of Resident 1's physician order dated 4/1/2026, the physician order indicated:Keppra (a medicine that helps prevent seizures) oral Tablet 750 mg (levetiracetam) give 1 tablet by month every 12 hours for seizure disorder.Lacosamide (a medicine that helps prevent seizures) oral tablet 100 mg (lacosamide) give 1 table by mouth every 12 hours for seizure disorder.Midodrine HCl (a medicine that helps raise low blood pressure) tablet 5mg give 2 table by mouth three times a day for hypotension (low blood pressure), hold if systolic blood pressure (the top number you see when someone gets their blood pressure checked) > 130During a review of Resident 1's physician order dated 4/16/2026, the physician order indicated:Depakote (a medicine that helps prevent seizure) oral tablet delayed release 250 mg (divalproex sodium) give 750 mg by mouth two times a day for anticonvulsant (a type of medicine that helps prevent seizure).During a review of Resident 1's physician order dated 5/5/2026, the physician order indicated:Metronidazole (an antibiotic that helps the body fight bacterial infections) oral tablet 600 mg (metronidazole) give 1 tablet orally every 8 hours for bacterial infection for 5 days.During a review of Resident 1's medication administration record (MAR) dated 5/2026, the MAR indicated the following:Keppra Oral Tablet 750 MG (Levetiracetam) Give 1 tablet by mouth every 12 hours forSeizure disorder, was not administered on the following dates and times:at 21:00 pm on 5/1, 5/2, 5/4, 5/5, 5/9, 5/17, 5/20Lacosamide Oral Tablet 100 MG (Lacosamide) Give 1 tablet by mouth every 12 hours for Seizure disorder, was not administered on the following dates and times:at 21:00 pm on 5/1, 5/2, 5/4, 5/5, 5/9, 5/17, 5/20Midodrine HCl tablet 5mg give 2 table by mouth three times a day for hypotension, hold if systolic blood pressure > 130, was not administered on the following dates and times:at 13:00 pm on 5/27at 1700 pm on 5/2, 5/4, 5/5, 5/9, 5/17, 5/20In addition to midodrine, Resident's blood pressure was also not monitored and recorded during midodrine missing dates and times.Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 750 mg by mouth two times a day for anticonvulsant, was not administered on the following dates and times:at 9:00 am, on 5/27.at 21:00 pm on 5/2, 5/4, 5/5, 5/9, 5/17, 5/20Metronidazole oral tablet 600 mg (metronidazole) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	give 1 tablet orally every 8 hours for bacterial infection for 5 days, was not administered on the following dates and times:22:00 pm on 5/5, 5/9 2. During a review of Resident 2's admission record dated 7/2/2026, the admission record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses that included muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixed^up electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypertension (high blood pressure), Diabetes (condition where the body has trouble using sugar the right way), and history of fall.During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was intact.During a review of Resident 2's physician order dated 4/2/2026, the physician order indicated:Lamotrigine (a medicine that helps prevent seizures) oral tablet 100mg (Lamotrigine) give 1 table by month two times a day for anti-convulsantLevetiracetam (Keppra, a medicine that helps prevent seizures) ER oral tablet extended release 24-hour 1500 mg (Levetiracetam) give 1500 mg by mouth two times a day for anti-seizure.Pregabalin (a medicine that helps calm overactive nerves, can be used for nerve pain or seizure) oral capsule 200mg neuropathic pain hold if respiratory rate < 12 and/or excessive sedation.During a review of Resident 2's MAR dated 5/2026 and 6/2026, the MAR indicated the following:Lamotrigine oral tablet 100mg (Lamotrigine) give 1 table by month two times a day for anti-convulsant, was not administered on the following dates and times:at 17:00 pm: 5/1, 5/9, 6/13Levetiracetam ER oral tablet extended release 24-hour 1500 mg (Levetiracetam) give 1500 mg by mouth two times a day for anti-seizure. was not administered on the following dates and times:at 17:00 pm: 5/1, 5/9, 6/13Pregabalin oral capsule 200mg neuropathic pain hold if RR < 12 and/or excessive sedation. Was not administered on the following dates and times:at 9:00 am: 5/3, 5/4at 17:00 pm: 5/1, 5/2, 5/3, 5/4, 5/93. During a review of Resident 3's admission record dated 7/2/2026, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included cellulitis (an infection of the skin. It happens when germs (usually bacteria) get into the body through a cut, scratch, or any break in the skin) of right lower limb, cellulitis of left lower limb, diabetes (condition where the body has trouble using sugar the right way) and hypertension (high blood pressure).During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition (ability to think, remember and reason for daily decision making) was intact.During a review of Resident 3's physician order dated 5/13/2026, the order indicated:insulin aspart (a fast-acting insulin [a medicine helps move sugar from your blood into your cells]) injection solution 100 unit/ml per sliding scale (a way for nurses to decide how much insulin to give based on a person's blood sugar level).During a review of Resident 3's MAR dated 5/2026 and 6/2026, the MAR indicated the following:insulin aspart injection solution 100 unit/ml, inject as per sliding scale:if 0 - 150 = 0 unit,if 151 - 200 = 2 unitsif 201 - 250 = 3 unitsif 251 - 300 =5 unitsif 301 - 350 = 7 unitsif 351+ = 10 units call MD immediately for further instruction if blood glucose is greater than 400, subcutaneously before meals and at bedtime for diabetes. inject insulin 15 - 20 mins minutes before each meal, the blood sugar level was not monitor and medication order was not administered on the following dates and times:at 6:30 am: 6/6/at 4:30 pm: 6/13at 9:00 pm: 6/13 During an interview with Licensed Vocational Nurse (LVN) 1 on 6/30/2026 at 1:50 pm, LVN 1 stated resident's medications should be administered as physician's order.During an interview with Assistant Director of Nursing (ADON) on 7/1/2026 at 2:40 pm, ADON acknowledged that all Resident 1, Resident 2 and Resident 3 had multiple medications not administered as order. ADON further explained failed to administered medications as physician's ordered will affect resident' care, prolong their illness, and could even cause re-hospitalization.During a phone interview with Pharmacy Consultant (PC) on 7/2/2026 at 2:28 pm, the PC stated, antibiotics should be given as scheduled and completed, missing doses won't give the 100% effect of the medicine, and the infection could prolong. PC also stated missing seizure medications will increase the chance resident having seizure episodes. Facility should have follow physician's order for any medication administration.During a review of the facility's policy and procedures (P&P) titled administering medication, dated 11/20/2025, the P&P indicated Medication are administered in a safe and timely manner, and as prescribed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that accuracy of medical record documentation for one of three sampled residents (Resident 1) when Resident 1 was admitted to the hospital on [DATE] and not physically present at the facility on 6/18/2026, the Nurse Practitioner (NP) 1 documented in her 30 days follow up notes dated 6/18/2026 that resident was seen and evaluated at the facility.This deficient practice had potential to result in mislead clinical staff, and affect Resident 1 care planning, and compromise the integrity of Resident 1's medical record.During a review of Resident 1's admission record dated 7/2/2026, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses that included colon cancer (a disease that starts in the colon [a long tube in your belly that helps turn food into poop.] cells in colon start to grow in an uncontrolled way), muscle weakness, seizure (a condition when the brain suddenly sends out a burst of fast, mixedˆup electrical signals. During a seizure, a person might shake or jerk uncontrollably, stare blankly and stop responding and collapse), and hypotension (low blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was not intact, unable to make decisions. During a review of Resident 1's Change of Condition (COC) report dated 6/16/2026, the COC report indicated resident 1 was transferred to hospital on 6/16/2026. During a review of Resident 1's Progress notes dated from 6/17/2026 to 6/20/2026, the Progress notes indicated resident was still in the hospital and had not return to facility during any of those dates. During a review of Resident 1's 30-day follow-up progress notes dated 6/30/2026, Resident 1's 30-day follow-up progress notes indicated on 6/18/2026, Resident was seen and evaluated by the Nurse Practitioner (NP) 1 with the following statement: Pt seen for routine follow up, currently in bed, appears to be comfortable. Not in any distress with no nonverbal signs or symptoms of pain or discomfort. During an telephone interview with NP 1, on 7/1/2026 at 10:19 am, NP 1 stated the following, the 30-days follow up progress note was made by me. On 6/18/2026 Resident 1 was on the bed, non-verbal, I saw him. but I do not remind exact room number for this resident. Asked NP 1 if she aware Resident 1 was transferred to the hospital on 6/16/2026 and did not return to facility on 6/18/2026, NP then stated the following: Oh, No, I didn't see him on 6/18/2026, the last time I saw him was 5/26/2026, the 30-days follow up was an error documentation. NP 1 further explained she should not have documented she saw the resident, error documentation affect Resident 1's care. During an interview on 7/1/2026 at 2:40 pm with Assistant Director of Nursing (ADON), the ADON stated NP 1's action was not acceptable. If the physician or nurse practitioner did not see the resident, they should not document that they did. Facility administrations were responsible for making sure that all residents are seen by their physician or nurse practitioner. ADON further stated that NP 1's action should count as false documentation, and it would cause miscommunication between staff members, affect Resident 1's care planning and compromised the integrity of Resident 1's medical record.During a review of the facility's policy and procedures (P&P) titled, Charting and Documentation, dated the P&P indicated Documentation in the medical record will be objective, complete, and accurate.