| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055111 | A. Building<br>B. Wing | 06/11/2026 |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>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.

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 6/8/2026 when:-Eleven residents (unidentified) on pureed diet (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding) received pureed carrots instead of pureed mixed vegetables (corn, carrots, peas, and green beans) per the menu.This failure had the potential to result in meal dissatisfaction and decreased nutritional intake for the residents (unidentified) on the pureed diet.Findings:During a review of the facility lunch menu on 6/8/2026, the following items were to be served for the pureed diet:Pureed fried chicken 1/2 cup; pureed potato salad 1/2 cup; pureed mixed vegetables 1/2 cup; pureed bread; pureed mandarin oranges, and beverage of choice.During an observation of the tray line service (tray line- a system of food preparation, in which trays move along an assembly line) for lunch on 6/8/2026 at 12:30PM, the residents (unidentified) on pureed diet received pureed carrots instead of pureed mixed vegetables per the menu.During a review of the facility spreadsheet (food portion and serving guide) and an interview with Cook1 on 6/8/2026 at 1 PM, Cook1 stated Cook1 made a mistake and forgot to prepare the pureed mixed vegetables. Cook1 stated Cook1 did not follow the menu and served the pureed carrots to all the residents (unidentified) who were on pureed diet instead of mixed vegetables. Cook1 stated it was important to follow the menu because the residents (unidentified) could be upset when they were expecting vegetables and receive something else. During an interview with Dietary Supervisor (DS) on 6/8/2026 at 1 PM, the DS stated cooks (in general) needed to follow the menu, and it was important to serve what was on the menu and inform the DS when any ingredient needed to be replaced. During a review of the facility cooks spreadsheet titled New Gen Fountain View Spring 2026 for week 1 Tuesday (dated 6/8/26), the spreadsheet indicated to serve Pureed/Level4 diets: pureed fried chicken, pureed potato salad; pureed mixed vegetables; pureed bread; pureed mandarin oranges and beverage.During a review of facility's policy and procedure (P&P) titled Menus (revised 2/2026) the P&P indicated, Menus will be planned in advance to meet the nutritional needs of the resident in accordance with established national guidelines. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. |

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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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when:1. One large box of breaded chicken was thawing inside the Walk-in refrigerator with no thaw date.2. the ice machine was not maintained in a sanitary manner, the inner plastic board inside the ice storage bin had pink color stains and residue.3. One cook (Cook1) wearing layered gloves did not wash hands and replace gloves when moving between different tasks.4. Temperature of the potato salad held for cold holding during lunch service on 6/8/2026 was at 55.5 degrees Fahrenheit (F).These failures had the potential to result in harmful bacteria growth and cross contamination of food (transfer of harmful bacteria and chemicals form one place to another) that could lead to food borne illness in 66 out of 86 residents who received food and ice from the facility.Findings:1. During an observation in the walk-in refrigerator on 6/8/2026 at 9:15AM, there was one large box of breaded chicken that was stored on the bottom shelf with no date.During a concurrent observation and interview with the Dietary Supervisor (DS) on 6/8/2026 at 9:15AM, the DS stated the box of chicken was delivered on 6/4/2026. The DS stated the breaded chicken was delivered frozen, and it was stored in the freezer. The DS stated it was important to label with the thaw date or when it was removed from the freezer to know when to use or discard before it was expired. The DS stated food was thawed for three days in the refrigerator then cooked.During a review of facility's policy and procedure (P&P) titled Cold Foods (revised 2/2026) the P&P indicated, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.2.During an observation of the facility ice machine on 6/8/2026 at 10 AM, located in the kitchen, a clean paper towel swipe of the ice storage bin ceiling produced small amounts of pink residue. The residue was located under the plastic baffle (an ice machine baffle or [ice deflector] is an internal panel or partition that directs the flow of ice as it falls from the evaporator into the storage bin or dispenser. It prevents ice from jamming the machine, guides it evenly into the bin, and stops cubes from spilling out of the front panel)During a concurrent observation and interview with the DS on 6/8/2026 at 10 AM, the DS stated an outside vendor (unidentified) would clean the ice machine once a month. The DS stated there was pink residue produced on the paper towel when the under the plastic board was swiped. The DS stated it should be cleaned better. The DS stated the pink residue could contaminate the ice for the residents (in general).During an interview with the District Manager (DM) on 6/8/2026 at 10:10AM, the DM stated the facility should have the outside vendor (unidentified) go to the facility twice a month, to make sure the ice machine was clean.During a review of facility's policy and procedure (P&P) titled Ice (revised 10/2022) the P&P indicated, Ice will be prepared and distributed in a safe and sanitary manner. Ice bins will be cleaned monthly and as needed.During a review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces and Utensils code 4-602.11, the code indicated, (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.3.During an observation in the kitchen on 6/8/2026 at 11:45AM, [NAME] 1 was wearing disposable gloves, observed [NAME] 1 wearing two gloves on top of each other. Cook1 was transferring cooked food from the oven to the steam table (used to hold precooked food at safe temperatures >135 degrees F; it has multiple stainless-steel compartments (wells) that use heated water to produce steam and keep food warm), Cook1 left the area and grabbed serving utensils from<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the cabinets. Cook1 returned to the food preparation area, gathered ingredients in the blender to make minced chicken. When Cook1 finished making the minced chicken, observed Cook1 remove the top layer of the gloves and kept the gloves underneath and proceeded to remove the minced chicken from the blender into a pan. Cook1 then grabbed a thermometer and started checking the temperature of the food held on the steam table.During a concurrent observation and interview with Cook1 on 6/8/2026 at 12 PM, Cook1 stated that Cook1 removed the top layer gloves because they got dirty. Cook1 stated Cook1 had another layer of gloves under to work fast and quickly move from one task to another without stopping to wear another glove. Cook1 stated that the correct way was to wear one layer of gloves, wash hands and then replace gloves when they were dirty. Cook1 stated it was important to wash hands and change gloves because the gloves get dirty and it can contaminate food.During a review of the 2022 U.S. Food and Drug Administration Food Code, titled When to Wash Code 2-301.14, indicated, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and E) After handling soiled EQUIPMENT or UTENSILS. (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.(G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD.(H) Before donning gloves to initiate a task that involves working with FOOD.4.During an observation of the lunch service on 6/8/2026 at 12 PM, a temperature check of the potato salad a TCS food (Time/Temperature control for safety food, TCS foods are foods that can support bacterial growth that can result in food borne illness unless stored, prepared and served safely) using facility thermometer registered at 55.5 degrees F. During a concurrent observation and interview with DS on 6/8/2026 at 12 PM, the DS stated the potato salad was in the refrigerator. The DS stated it should be 41 degrees F or lower from the refrigerator and asked DA2 to return the salads to cool down. The DS said some residents may complain when salad is not very cold. DS stated if potato salad stays out of the refrigerator for long time it can go bad.During an interview with DA1 and Cook1 on 6/8/2026 at 12:05PM DA1 stated we finished scooping and portioning the potato salad in bowls around 11:30AM. Cook1 stated finished making the potato salad late and did not have enough time in the refrigerator to become cold.During an interview with RD1 and the DM on 6/8/2026 at 1:28PM, RD1 stated the holding temperature for cold food should be 41 degrees F and below and the potato salad was not. The DM stated the kitchen staff (in general) should prepare the potato salad the day before and store it in the refrigerator to get that cold temperature for lunch.During a review of facility policy and procedures (P&P) titled Food Storage: Cold Foods (revised 2/2026) the P&P indicated, All perishable foods will be maintained at a temperature of 41F or below, except during necessary periods of preparation and service.During a review of facility policy and procedures (P&P) titled Food: Preparation (revised 2/2026) the P&P indicated, All foods will be held at appropriate temperatures, greater than 135F for hot holding, and less than 41 degrees F for cold food holding.During a review of the 2022 U.S. Food and Drug Administration Food Code 3-501.16 titled Time/Temperature control for safety food, hot and cold holding indicated, except during preparation, cooking or cooling, time/temperature control for safety food shall be maintained at 135 degrees F or above, and at 41 degrees F or below. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the documentation was accurate and complete for three of seven sampled residents (Resident 7, Resident 85, and Resident 74) by failing to ensure:1. Licensed nurses (in general) documented the presence of new skin alterations (change to the skin's color, texture, or growth pattern) accurately on Resident 7's Medication Administration Record (MAR).2. Licensed nurses (in general) documented the Change in Condition Evaluation (a sudden clinically important deviation from a resident's baseline in physical, behavioral, or functional domains) form completely for Resident 85. 3. completed documentation in the MAR for Resident 74 as required. 4. Documenting a medication as administered when it was not given or delivered by the pharmacy for Resident 74.These failures had the potential for nurses (in general) to misinterpret (to understand or explain something incorrectly) the documented information and lead to a lack of care for Resident 7, Resident 85 and Resident 74's needs.<br><br>Findings:<br><br>1.During a review of Resident 7's admission Record, the admission Record indicated the facility admitted the resident on 11/19/2021 with diagnoses that included chronic respiratory failure (a long-term condition where the respiratory system cannot adequately supply oxygen to the blood or clear carbon dioxide from the body), cerebral infarction (a medical emergency that occurs when blood flow to a part of the brain is blocked), tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe (trachea) to insert a tube that allows air to reach the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dependence on respirator (ventilator, a mechanical device to help support or replace breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness on one side of the body).<br><br>During a review of Resident 7's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 2/27/2024 that indicated to apply hand mittens (a soft, padded covering that fits over a resident's hand, that resembles a small boxing glove) to the resident's left hand to prevent the resident from pulling out invasive tubing (any instrument, catheter, or implant that temporarily or permanently enters the body through an incision, a surgical puncture, or a natural body opening). The Order Summary Report indicated Resident 7's left - hand mitten was to be released every two hours. The Order Summary Report indicated Resident 7's left hand was to be checked for circulation (continuous flow of blood through the veins and arteries) and skin integrity (the overall health and completeness of the skin) every two hours. The Order Summary Report indicated to document + if Resident 7 had new skin alterations. The physician order indicated to document - if the resident had no new skin alterations. The physician order indicated to report any redness, swelling, and/or pain to Resident 7's physician.<br><br>During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 11/13/2025, the MDS indicated the resident had severely impaired cognition (a profound decline in thinking, memory, and reasoning that makes a person unable to live independently). The MDS indicated Resident 7 was dependent on help for oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 7 had a feeding tube (gastrostomy). The MDS indicated Resident 7 received tracheostomy care. The MDS indicated Resident 7 had a mechanical ventilator.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The MDS indicated Resident 7 used a limb restraint (a device that inhibits an individual's movement in their arms or legs) daily.<br><br>During a review of Resident 7's Medication Administration Record (MAR) dated 4/1/2026 to 4/30/2026, the MAR indicated to apply hand mittens to the resident's left hand to prevent the resident from pulling out invasive tubing. The MAR indicated to release Resident 7's left hand mitten every two hours. The MAR indicated to check Resident 7's left hand for circulation and skin integrity every two hours. The MAR indicated to document + if Resident 7 had new skin alterations. The MAR indicated to document - if the resident had no new skin alterations. The MAR indicated Registered Nurse 2 (RN 2) documented + on 4/21/2026 at 12 AM, 4/21/2026 at 2 AM, 4/21/2026 at 4 AM, 4/27/2026 at 8 PM, 4/27/2026 at 10 PM, 4/28/2026 at 12 AM, and on 4/28/2026 at 2 AM.<br><br>During a review of Resident 7's MAR dated 5/1/2026 to 5/31/2026, the MAR indicated to apply hand mittens to the resident's left hand to prevent the resident from pulling out invasive tubing. The MAR indicated to release Resident 7's left hand mitten every two hours. The MAR indicated to check Resident 7's left hand for circulation and skin integrity every two hours. The MAR indicated to document + if Resident 7 had new skin alterations. The MAR indicated to document - if the resident had no new skin alterations. The MAR indicated RN 2 documented + on 5/4/2026 at 8 PM, 5/4/2026 at 10 PM, 5/18/2026 at 8 PM, 5/18/2026 at 10 PM, 5/19/2026 at 12 AM, 5/19/2026 at 2 AM, and 5/19/2026 at 6 AM.<br><br>During a review of Resident 7's MAR dated 6/1/2026 to 6/11/2026, the MAR indicated to apply hand mittens to the resident's left hand to prevent the resident from pulling out invasive tubing. The MAR indicated to release Resident 7's left hand mitten every two hours. The MAR indicated to check Resident 7's left hand for circulation and skin integrity every two hours. The MAR indicated to document + if Resident 7 had new skin alterations. The MAR indicated to document - if the resident had no new skin alterations. The MAR indicated RN 2 documented + on 6/1/2026 at 8 PM, 6/1/2026 at 10 PM, 6/2/2026 at 12 AM, and 6/2/2026 at 2 AM<br><br>During a concurrent telephone interview and record review on 6/9/2026 at 3:59 PM with RN 2, Resident 7's Order Summary Report dated 2/27/2024 and MAR dated 4/1/2026 to 4/30/2026, 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/11/2026 were reviewed. RN 2 stated she (RN 2) was familiar with Resident 7. RN 2 stated Resident 7 had a left-hand mitten. RN 2 stated Resident 7 had a physician order to check the resident's skin on the left hand every two hours. RN 2 stated Resident 7 did not have any skin alterations to the left hand. RN 2 stated she (RN2) had mistakenly documented + on Resident 7's MARs dated 4/1/2026 to 4/30/2026, 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/11/2026. RN 2 stated she (RN 2) should have documented - because Resident 7 did not have any new skin alterations to the left hand. RN 2 stated that documentation should be accurate. RN 2 stated that the documentation on the MAR should reflect Resident 7's status. RN 2 stated that there was potential for Resident 7's documentation to be misinterpreted which could in turn affect the resident's care if the documentation was not accurate.<br><br>During a concurrent observation and interview on 6/11/2026 at 10:04 AM, in Resident 7's room, the resident's left hand was observed with Licensed Vocational Nurse 6 (LVN 6). Resident 7 was observed with a left-hand mitten. LVN 6 stated she (LVN 6) was assigned to care for Resident 7. LVN 6 stated Resident 7 had a left-hand mitten because the resident tried to pull his (Resident 7) gastrostomy and tracheostomy tubing. LVN 6 stated Resident 7's left hand circulation and skin was checked hourly. LVN 6 was observed removing Resident 7's left-hand mitten. Resident 7's left-hand skin and circulation was observed intact (undamaged, complete, and in its original state).<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 6/11/2026 at 11:16 PM with the Director of Nursing (DON), Resident 7's physician order dated 2/27/2024 and MAR dated 4/1/2026 to 4/30/2026, 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/11/2026 were reviewed. The DON stated Resident 7 had a left-hand mitten because the resident attempted to pull his (Resident 7) gastrostomy and tracheostomy tubing. The DON stated the skin and circulation to Resident 7's left hand was checked regularly. The DON stated Resident 7's physician order and MAR indicated to document + if the resident had a new skin alteration and - if the resident did not have a new skin alteration. The DON stated RN 2 documented + on Resident 2's MAR dated 4/1/2026 to 4/30/2026, 5/1/2026 to 5/31/2026, and 6/1/2026 to 6/11/2026. The DON stated RN 2's documentation of + on Resident 7's MAR was a mistake. The DON stated documentation should always be accurate. The DON stated documentation should always reflect Resident 7's status. The DON stated Resident 7's physician order should be read properly to ensure that documentation was correct. The DON stated there was potential for Resident 7 to receive care that was not aligned with the resident's needs because staff (in general) may have misinterpreted the documentation on the resident's MAR.<br><br>2.During a review of Resident 85's admission Record, the admission Record indicated the facility admitted the resident on 10/13/2025 with diagnoses that included type 2 diabetes, sepsis (a life-threatening blood infection), end stage renal disease (irreversible kidney failure), dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hemiplegia, and hemiparesis.<br><br>During a review of Resident 85's MDS dated [DATE], the MDS indicated the resident was cognitively intact (had ability to think, understand, and reason). The MDS indicated Resident 85 required set up or clean up assistance (helper sets up or cleans up; resident completes activity) for eating. The MDS indicated Resident 85 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 85 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing himself, lower body dressing, and putting on/taking off footwear.<br><br>During a review of Resident 85's Change in Condition Evaluation dated 3/21/2026 at 12:41 PM, the Change in Condition Evaluation indicated the resident had generalized weakness (a perceived decrease in physical or muscle strength that affects the entire body). The Change in Condition Evaluation indicated there was no documentation that Resident 85's physician was notified of the resident's generalized weakness. The Change in Condition Evaluation indicated there was no documentation that Resident 85's representative was notified of the resident's generalized weakness. The Change in Condition Evaluation indicated there was no documentation that the Change in Condition Evaluation was signed and dated.<br><br>During a review of Resident 85's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 3/21/2026 to transfer the resident to General Acute Care Hospital 1 (GACH 1) due to generalized weakness.<br><br>During a concurrent interview and record review on 6/10/2026 at 10:25 AM with RN 3, Resident 85's Change in Condition Evaluation dated 3/21/2026 at 12:41 PM was reviewed. RN 3 stated she (RN 3) was working as the RN supervisor on 3/21/2026. RN 3 stated Resident 85 was not feeling well and was feeling weak on 3/21/2026. RN 3 stated Resident 85's physician was notified and the resident was sent to the GACH (not specified). RN 3 stated Resident 85's change in condition documentation was started but not completed on 3/21/2026. RN 3 stated Resident 85's Change in Condition Evaluation should have been completed with all the details of what happened. RN 3 stated it was (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | important to document a change in condition completely so that the documentation could be referenced by the physician or other nurses (in general) at a later time. RN 3 stated it was important that Resident 85's change in condition be documented completely so that nurses (in general) could have used the information to monitor the resident and provide the resident with the necessary interventions. RN 3 stated that if Resident 85's change in condition was not completely documented there was potential for the resident to not receive the necessary care needed after having a change in condition.<br><br>During a concurrent interview and record review on 6/11/2026 at 11:22 AM with the DON, Resident 85's Change in Condition Evaluation dated 3/21/2026 at 12:41 PM was reviewed. The DON stated that Resident 85's Change in Condition Evaluation was started but not completed. The DON stated Resident 85's Change in Condition Evaluation should have been documented completely. The DON stated Resident 85's Change of Condition Evaluation should have contained information on what had occurred and information on the resident's assessment. The DON stated the information on the Change in Condition Evaluation would have contained information that was to be passed on to Resident 85's physician. The DON stated the Change in Condition Evaluation would have also indicated recommendations from Resident 85's physician. The DON stated that Resident 85's physician was notified of the resident's change in condition on 3/21/2026, but the Change in Condition Evaluation was not completed to indicate the physician was notified. The DON stated there was potential for the nursing staff (in general) to not have knowledge of Resident 85's change in condition if the change in condition was not documented. The DON stated there was a potential for the residents (in general) to not to be monitored after having a change in condition if the change of condition was not documented.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Charting and Documentation reviewed 11/20/2025, the P&P indicated Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.<br><br>2.During a review of Resident 74's admission record, the admission record indicated that Resident 74 was originally admitted on [DATE], and readmitted on [DATE] with a diagnosis including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements); Alzheimer's disease (a disease characterized by a progressive decline in mental abilities); schizophrenia (a mental illness that is characterized by disturbances in thought); anxiety disorder (a mental health condition characterized by persistent, excessive fear or worry in everyday situations); and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 74's Minimum Data Set (MDS- a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 74 has some cognitive impairment (any condition that affects a person's mental functioning, and capacity.) The MDS indicated that Resident 74 uses a walker to ambulate (walk) and requires maximal assistance for toileting, showering, and lower body dressing; moderate assistance for oral & personal hygiene; and supervision for upper body dressing.<br><br>During a review of the physician's orders dated 2/16/2026, the orders indicated the following:<br><br>Atorvastatin tablet 40mg at bedtime (a medication used to treat high cholesterol)<br><br>Buspirone tablet 5 mg two times a day (a medication used to treat anxiety)<br><br>Quetiapine 25mg tablet two times a day (a medication used to treat schizophrenia [a mental illness<br>(continued on next page) |

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| | 055111 | A. Building<br>B. Wing | 06/11/2026 |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>Los Angeles, CA 90029 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that is characterized by disturbances in thought])<br><br>Temazepam 7.5mg capsule at bedtime (a medication used to help with sleep)<br><br>During a review of Resident 74's MAR for 4/2026, the MAR did not indicate medication was administered for quetiapine, or temazepam on 4/25/2026. The MAR indicated Resident 74 was administered temazepam on 4/11/2026, 4/13/2026, 4/18/2026, 4/20/2026, and 4/21/2026.<br><br>During a review of Resident 74's MAR for 5/2026, the MAR did not document whether or not Resident 74 was administered atorvastatin, buspirone, temazepam, and quetiapine on 5/2/2026 and 5/9/2026. The MAR indicated that Resident 74 was administered temazepam on 5/6/2026, 5/7/2026, and 5/11/2026, when the medication was not delivered to the facility.<br><br>During an interview on 6/11/2026 at 9:58 a.m. with Registered Nurse Supervisor (RN1), RN 1 stated that if the MAR has blank entries, that means the LVN did not indicate that the medication was administered to Resident 74. RN 1 stated it is important to administer medications as ordered and to document because Resident 74's medications treat her behavioral diagnoses.<br><br>During a telephone interview on 6/11/2026 at 11:22 a.m. with the PharmD., the PharmD stated they have been delivering all the medications to the facility in a timely manner except for Temazepam, because they never received the order from the facility.<br><br>During a concurrent observation and interview on 6/11/2026 at 11:58 a.m. with DON in the hallway, the DON could not find Resident 74's temazepam in two of the medication carts. DON stated there was no Temazepam found in any of the medication carts for Resident 74.<br><br>During a telephone interview on 6/11/2026 at 12:10 p.m. with LVN 4, LVN 4 stated he accidentally marked the temazepam administration as completed, but he has never given temazepam to Resident 74. LVN 4 stated it is important to accurately document medication administration for safety, and to ensure the residents are receiving the therapeutic effects of the medication.<br><br>During a phone interview on 6/11/2026 at 1:07 p.m. with LVN 5, LVN 5 stated that she documented medication administration of temazepam by accident. LVN 5 stated she made an error and thought she was giving temazepam, but she did not. LVN 5 stated it is important to document accurately because medications need to be given per the doctor's orders and residents need to receive the therapeutic effects of the prescribed medications.<br><br>During a concurrent interview and record review on 6/11/2026 at 1:25 p.m. with the DON, the DON stated that the blank entries in the MAR indicated LVNs did not document the medication administration. The DON stated the documentation policy was not followed for Resident 74. DON stated LVNs did not follow up with the pharmacy to retrieve the temazepam, nor did they escalate it to the DON or RN Supervisor.<br><br>During a review of the facility's policy and procedure (P&P), titled, Charting and Documentation last revised 8/2017, the P&P indicated that all documentation for medication administration must be objective, complete and accurate. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain an informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to treatment with sertraline (a medication used to treat mental illness) for one of five sampled residents (Resident 62) reviewed for unnecessary medications. This failure had the potential to prevent Resident 62 from exercising his right to decline treatment for the use of sertraline, increasing the risk of Resident 62 experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to sertraline, leading to impairment or decline in his mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 62's admission Record, the admission Record indicated the facility admitted on [DATE], and readmitted the resident on 9/25/2025 with diagnoses including but not limited to depression (a mood disorder that causes persistent feelings of sadness and loss of interest) and dementia (a progressive state of decline in mental abilities). The face sheet also indicated Resident 62 has a designated responsible party. During a review of Resident 62's History and Physical (H&P) dated 4/3/2026, the H&P indicated Resident 62 had fluctuating capacity to understand and make decisions. During a review of Resident 62's Order Summary Report dated 4/6/2026, the Order Summary Report indicated an order for Resident 62 to take sertraline 25 milligrams (mg, a unit of measurement for mass) by mouth one time a day for depression manifested by difficulty falling asleep. During a review of Resident 62's Care Plan Report dated 4/7/2026, the Care Plan Report indicated Resident 62 was currently using sertraline for depression. The Care Plan Report indicated to provide informed consent to resident or healthcare decision maker. During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 62 had severe problems with thinking or memory. During an interview on 6/10/2026 at 11:08 AM with the Medical Records Director (MRD), the MRD stated there was no documentation of an informed consent for Resident 62 use of sertraline. During an interview on 6/10/2026 at 11:16 AM with the Director of Nursing (DON), the DON stated there was no documentation of an informed consent for Resident 62's sertraline. The DON stated an informed consent for psychotropic medications (medications that affect the mind, emotions, or behavior) was important to ensure the resident had the opportunity to make an informed decision about whether to receive treatment with psychotropic medications or not. The DON stated psychotropic medications, like sertraline, could cause adverse effects that could cause a decrease in quality of life. The DON stated that there was no documentation of Resident 62's informed consent for sertraline. The DON stated Resident 62 was at additional risk of an adverse effects related to the use of sertraline. During a review of the facility's policy and procedure (P&P) titled, Informed Consent for Psychotropic Drugs, undated, the P&P indicated the prescriber must obtain consent for the medication before administration. The prescriber must discuss and document material information such as the risks and benefits of the medication. |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>Los Angeles, CA 90029 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of needs by not having the call light within reach for one out of one sampled resident (Resident 12). This failure had the potential for Resident 12 to not be able to receive assistance in a timely manner.Findings:During a review of Resident 12's admission Record, the record indicated that Resident 12 was originally admitted on [DATE] and readmitted on [DATE] with a diagnoses of metabolic encephalopathy (an altered mental state usually caused by organ failure or chemical imbalances); Alzheimer's disease (a disease characterized by a progressive decline in mental abilities); history of falling; generalized muscle weakness, and difficulty in walking. During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2026, the MDS indicated that Resident 12 has significant cognitive impairment (any condition that affects a person's mental functioning, and capacity). The MDS indicated that Resident 12 uses a walker to ambulate (walk) and requires supervision for oral hygiene, moderate assistance for toileting and upper body dressing, and maximal assistance for showering and lower body dressing. During an observation on 6/8/2026 at 12:14 p.m. in Resident 12's room, Resident 12 was sitting in bed, and her call light was not visible. Resident 12 stated she was unable to find her call light. Licensed Vocational Nurse 1 (LVN 1) came to the bedside and located the call light hanging along the left side of Resident 12's bed, out of reach from Resident 12. During an interview on 6/8/2026 at 12:27 p.m. with LVN 1, LVN 1 stated Resident 12's call light was not in reach but should have been. LVN 1 stated Resident 12 can use the call light when needed and had used it earlier in the day. LVN 1 stated it is important for the residents to have their call bell in reach, because the resident could require emergency services, and/or need assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During an interview on 6/9/2026 at 11:54 a.m. with the Registered Nurse Supervisor (RN 1), RN 1 stated that part of her job duties includes rounding (a proactive process in which a licensed staff member visits the resident to promote safety and evaluate care) on all the residents to ensure the call light is in reach. RN 1 stated the call light is used for resident needs and should always be within easy reach of the resident to prevent potential falls, or unknown patient distress. RN 1 stated that CNAs, nurses, charge nurses, supervisors, and the Director of Staff Development are all responsible for making sure the call light is in reach. During an interview on 6/11/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated the facility's call light policy includes making sure the call light is within the resident's reach. The DON stated if the call light is not in reach there could be a delay in care, an accident, or accidental falls for the residents. The DON stated everyone in the facility is responsible for making sure the call light is in reach of the resident and that the staff did not follow the call light policy for Resident 12 but should have. During a review of the facility's policy and procedure (P&P), titled Answering the Call Light, last revised 10/24/2024, the P&P indicated that the call light should be accessible to the resident at all times. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on interview and record review, the facility failed to ensure to complete the Advance Directive (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) Acknowledgement Form (a written documentation of request or refused formulation of advanced directives) for one of eight sampled residents (Resident 73). This failure violated Resident 73's rights to be fully informed of the option to request or refuse medical care and treatment.Findings:During a review of Resident 73's admission Record, the admission Record indicated the facility admitted the resident originally on 3/2/2024 and readmitted the resident on 4/24/2026 with diagnoses that included muscle weakness, abnormalities of gait (a person's specific manner or pattern of walking or moving on foot), end stage renal disease (irreversible kidney failure), and essential hypertension (high blood pressure). During a review of Resident 73's untitled history and physical document dated 8/3/2025, the untitled history and physical document indicated Resident 73 had the capacity to understand and make decisions. During a review of Resident 73's Advance Directive Acknowledgement Form dated 4/24/2026, the Advanced Directive Acknowledgement form indicated Resident 73 had not executed an Advance Directive and was not offered options to execute or decline Advanced Directive. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 73 made herself understood and understood others. The MDS indicated Resident 73's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was intact. The MDS indicated Resident 43 required maximal assistance with mobility. During a concurrent interview and record review on 6/9/2026 at 11:05 AM with the Social Service Director (SSD), Resident 73's Advance Directive Acknowledgement Form was reviewed. The SSD stated that an advanced directive allowed a resident to designate an agent or family member to participate in medical decision making. The SSD stated that the Advanced Directive Acknowledgement Form was initiated upon admission and completed for all residents (in general). The SSD stated that Resident 73's Advanced Directive Acknowledgement Form indicated none of the available option boxes were checked. The SSD stated that the form should have contained a checked box response indicating the Resident 73's choices and options regarding advance directive information. The SSD stated that the incomplete form did not reflect whether Resident 73 was provided information regarding advanced directives or whether resident 73 had elected any available options. The SSD stated that the facility failed to document and communicate Resident 73's choices regarding advance directive options. During a concurrent interview and record review on 6/9/2026 at 11:52 AM with the Administrator (ADM), Resident 73's Advance Directive Acknowledgement Form was reviewed. The ADM stated that the Advance Directive Acknowledged Form was used to communicate how residents (in general) wanted their care to be provided. The ADM stated that Resident 73's Advance Directive Acknowledgement Form contained option boxes that were not checked. The ADM stated that without the boxes being checked there was no indication that advance directive information was offered to Resident 73. The ADM stated that the Advance Directive Acknowledged Form was incomplete. During a concurrent interview and record review on 6/9/2026 at 12:03 PM with the Director of Nursing (DON) Resident 73's Advance Directive Acknowledgement Form reviewed. The DON stated that an advanced directive was a legal document that outlined a resident's in general) preferences for medical care. The DON stated that an advance healthcare directive was important to ensure that a resident's (in general) personal wishes were expected and conflicts avoided regarding care and medical treatment decisions. The DON stated the Advance Healthcare Directive Acknowledgement Form was completed upon admission by the resident or responsible party. The DON stated that resident 73's Advanced Directive Acknowledgement Form was incomplete because of the option boxes. The DON stated that the boxes should have been checked to indicate<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 73 responded to choices on advance directive and ensured the form was complete. During a review of the facility's policy and procedure (P&P) titled, Advance Directive, dated 11/20/2025, the P&P indicated to provide residents with the opportunity to make decisions regarding their health care. The P&P indicated the admission staff or designee will inform the resident of their right to execute an Advance Directive Form, if one does not already exist. The P&P indicated each resident is informed that it is their choice to complete the Advance Directive. The P&P indicated the choice not to complete the Advance Directive Form is recorded in the resident's medical record. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on interview and record review, the facility failed to ensure one of three randomly selected residents (Resident 32) and/or resident representative received mandatory information on Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN: a Skilled Nursing Facility [SNF] must issue this notice to a resident when it believes that Medicare (Federal health insurance) may not cover their care or stay. The SNF must provide the notice to the resident before providing the non-covered care) appeal process. This failure resulted in the facility denying Resident 32's right to accept or declined non-covered specific skilled services or ability to file an appeal placing Resident 32 at risk for unexpected financial burden/crisis.Findings:During a review of Resident 32's admission Record, the admission Record indicated the facility originally admitted Resident 32 on 11/10/2021 and readmitted Resident 32 on 3/23/2026 with diagnoses that included heart failure (a chronic condition where the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, hemiplegia and hemiparesis following cerebral infarction of left non-dominant side (the person experienced a stroke that damaged the right side of the brain, resulting in weakness or inability to move the left side of the body if they are right handed or right side if they are left handed), dementia (a progressive state of decline in mental abilities), aphasia (a disorder that makes it difficult to speak), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of multiple sites (unspecified), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool) dated 11/5/2025, the MDS indicated Resident 32 had severe cognitive [ability to think, read, learn, remember, reason, express thoughts, and make decisions] impairment). The MDS indicated Resident 32 was dependent (helper does all of the effort) for eating, oral hygiene (ability to clean mouth/teeth), toileting, showering/bathing, and for upper/lower body dressing. During a review of Resident 32's SNF Beneficiary (someone receiving benefits) Protection Notification Review (a quality-control audit that checks whether a SNF properly followed Medicare rules that ensures the SNF gives patients written warnings before stopping or changing their Medicare-covered care, thereby protecting them from unexpected bills and preserving their right to appeal) indicated the facility did not give Resident 32's or Resident 32's representative, the Notice of Medicare Non-Coverage (NOMNC) because the resident was on custodial care (care provided by a SNF that is not covered by Medicare for non-medical help with everyday life like eating, bathing, or dressing). During an interview on 6/11/2026 at 10:28 AM with the Business Office Manager (BOM), the BOM stated Resident 32 did not receive a NOMNC and Resident 32's last Medicare Part A coverage was on 11/5/2025. The BOM stated the facility discontinued Resident 32's therapy and Resident 32 became custodial on 11/6/2025. The BOM stated she (BOM) was not sure if Resident 32 or Resident 32's representative should have received a NOMNC. The BOM called the facility's Accounts Receivable Consultant (ARC) and placed the ARC on speakerphone. The ARC stated Resident 32 did not exhaust (use up all) of her (Resident 32) Medicare Part A benefits. The ARC stated the BOM should have given Resident 32 a NOMNC. During an interview on 6/11/2026 with the BOM and Director of Nursing (DON), the BOM stated the facility should have given Resident 32 a NOMNC in the event Resident 32 or Resident 32's representative wanted to appeal. The DON stated the NOMNC should have been given to protect Resident 32 from potential surprise or hidden charges. The DON stated Resident 32 should have been given the NOMNC two days before the last covered day. During a review of the of the facility's policy and procedure (P&P) titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised on 9/2024, the P&P indicated the following: A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change in coverage is likely.1. Written notices of the likelihood of Medicare<br>(continued on next page) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | payment denial are provided to the resident/beneficiary:a. as soon as the facility makes the assessment that Medicare payment certainly or probably will not be made and before the item or service is furnished;b. far enough in advance of an event (e.g., receiving a medical service) so that the beneficiary can make a rational, informed decision (choice you make based on facts, research, and understanding) without undue (excessive or unreasonable) pressure; andc. before a procedure is initiated and before physical preparation of the resident (e.g., disrobing, placement in or attachment of diagnostic or treatment equipment [tool or machine used to discover what is wrong with a person]) begins. 4. Written notices are provided in person to the beneficiary when possible. A copy of the notice is provided to the beneficiary (or authorized representative) immediately after the notice is signed. During a review of the facility's NOMNC form, last approved on 12/31/2011, the NOMNC form indicated the resident (in general) would possibly need to pay for services after a date (in general) indicated by the facility when Medicare probably would no longer pay for services. The NOMNC form indicated the resident (in general) had a right to appeal the decision and provided instructions on how the resident (in general) could appeal through an reviewer independent of the facility (not associated with the facility). The NOMNC form indicated a Quality Improvement Organization (QIO - a group of health experts hired by the government to protect Medicare patients, ensure proper care, and advocate for patients) could be contacted for immediate appeal. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on interview and record review, the facility failed to ensure adequate monitoring for the symptoms of anxiety (nervousness) and manifestations of verbalizing feeling anxious and/or nervous for one of five sampled residents (Resident 101) who had physician orders for Alprazolam (a medication used to treat anxiety) 0.25 milligrams (mg, a unit of weight and mass). This failure had the potential for Resident 101 to experience anxiety that was not treated, affecting the resident's quality of life. Findings:During a review of Resident 101's admission Record, the admission Record indicated the facility admitted the resident on 6/7/2026 with diagnoses that included intervertebral disc degeneration (a condition in which the cushioning in the spine begins to wear away), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), need for assistance with personal care, difficulty in walking, and hypertension (high blood pressure).During a review of Resident 101's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 6/9/2026 for Alprazolam 0.25 mg by mouth every 6 hours as needed for anxiety manifested by verbalization of feeling nervous/anxious for 14 days.During a concurrent interview and record review on 6/11/2026 at 11:34 AM with Registered Nurse 1 (RN 1), Resident 101's Order Summary Report was reviewed. RN 1 stated Resident 101 had physician orders for Alprazolam 0.25 mg by mouth every 6 hours as needed for anxiety manifested by the verbalization of feeling nervous/anxious for 14 days. RN 1 stated there was no physician order to monitor Resident 101 for symptoms of anxiety. RN 1 stated there should be physician orders to monitor Resident 101 for symptoms of anxiety. RN 1 stated that if there was no physician order to monitor Resident 101 for symptoms of anxiety the nurses (in general) would not be prompted to monitor the resident for symptoms of anxiety. RN 1 stated there was potential for Resident 101 to have symptoms of anxiety that would not be treated. RN 1 stated there a was potential for Resident 101's physician to not know if the order for Alprazolam needed to be continued or updated if the resident was not monitored for symptoms of anxiety.During a concurrent interview and record review on 6/11/2026 at 12:24 PM with the Director of Nursing (DON), Resident 101's Order Summary Report was reviewed. The DON stated Resident 101 had physician orders for Alprazolam 0.25 mg every 6 hours as needed for anxiety manifested by the verbalization of nervous/anxious feelings for 14 days. The DON stated there was no physician order to monitor Resident 101 for the verbalization of nervous/anxious feelings. The DON stated Resident 101 needed to be monitored for the verbalization of feeling nervous/anxious. The DON stated there was potential for Resident 101 to experience symptoms of anxiety that were not addressed. The DON stated there was potential for Resident 101's physician to not know if Alprazolam was effective at treating the resident's symptoms of anxiety if the symptoms were not monitored. During an interview on 6/11/2026 at 3:09 PM with Resident 101, Resident 101 stated he (Resident 101) had feelings of anxiousness, especially when people (unidentified) would bother him (Resident 101) at night.During a review of the facility's Policy and Procedure (P&P) titled Psychotropic Medication Use reviewed 11/20/2025, the P&P indicated Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medication.anti-anxiety medications.Proper psychotropic medication selection and prescribing (including dose, duration, and type of medication(s) may help stabilize or improve a resident's outcome, quality of life, and functional capacity. Residents receiving psychotropic medication are monitored and the response to treatment is documented. Monitoring may include lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the drug regimen review from the consultant pharmacist |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>Los Angeles, CA 90029 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and accurate Minimum Data Set (MDS - a resident assessment tool) for one of five sampled residents (Resident 6) by failing to: -Document Resident 6's diagnosis of deep vein thrombosis (a serious condition that occurs when a blood clot forms in a deep vein usually in the leg or thigh). This failure had the potential to result in a delay in the necessary care and treatment for Resident 6.Findings:During a review of Resident 6's admission Record, the admission Record indicated the facility originally admitted Resident 6 on 2/10/2024, and readmitted Resident 6 on 5/9/2026 with diagnoses that included encephalopathy (damage or disease that affects the brain), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), reduced mobility, functional quadriplegia (a person is completely unable to move their arms and legs due to severe frailty or a non-spinal medical condition, not an injury), dementia (a progressive state of decline in mental abilities), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD (End Stage Renal Disease-irreversible kidney failure), and acute embolism and thrombosis of unspecified deep veins (a sudden blood clot in a deep vein that either blocks blood flow or has broken off to travel elsewhere in the body) of left lower extremity (leg). During a review of Resident 6's left lower extremity ultrasound (a safe, painless test that allows doctors to see inside your body using sound waves) dated 4/28/2026, the ultrasound indicated Resident 6 had a DVT of the left posterior tibial vein (a major vein that pumps used, oxygen-depleted blood from your left foot, ankle, and calf back up your leg and toward your heart). During a review of Resident 6's Change of Condition Evaluation dated 5/5/2026, the Change of Condition Evaluation indicated Resident 6 complained about pain in the left lower extremity and an ultrasound showed a new DVT and PAD (Peripheral Artery Disease - a slow progressive narrowing of the blood flow to the arms or legs). During a review of Resident 6's acute hospital record dated 5/6/2026, the acute hospital record indicated Resident 6 had a partially occlusive (partially blocked) DVT of the right leg. During a review of Resident 6's History and Physical (H&P) dated 5/11/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 usually could make himself (Resident 6) understood and usually had the ability to understand others. During a review of Resident 6's Attending Progress note dated 5/18/2026, the Attending Progress note indicated Resident 6 should continue Xarelto (blood thinner) for right lower extremity (RLE) DVT. During a review of Resident 6's Order Recap Report dated 6/10/2026, the Order Recap Report indicated Resident 6's physician prescribed Resident 6 Xarelto Oral Tablet (20 milligrams [mg- metric unit of measurement] used for medication dosage and/or amount) by mouth one time a day for DVT. During a concurrent interview and record review on 6/10/2026 at 10:28 AM with the MDS Nurse (MDSN), Resident 6's History and Physical (H&P) dated 5/11/2026 was reviewed. The H&P indicated Resident 6 had a right lower extremity (RLE/right leg) DVT. The MDSN verified the H&P indicated Resident 6 had a RLE DVT. During a concurrent interview and record review on 6/10/2026 at 10:28 AM with the MDS Nurse (MDSN), Resident 6's MDS dated [DATE] was reviewed. The MDS indicated Section I - Active Diagnoses in the last seven days indicated the box was not checked for question I0500 for deep Venous Thrombosis (DVT), Pulmonary Embolus (PE - a sudden blockage in a lung artery, usually caused by a blood clot that travels from elsewhere in the body), or Pulmonary Thrombo-Embolism (PTE - a life-threatening medical emergency where a blood clot gets stuck in an artery in your lungs, blocking blood flow). The MDSN stated she (MSDN) missed the diagnosis of DVT. The MDSN stated an inaccurate MDS assessment could affect Resident 6's care planning. During a concurrent interview and record review on 6/10/2026 at 10:38 AM with Registered Nurse 1 (RN 1) and the Director of Nursing (DON), Resident 6's History and Physical (H&P) dated 5/11/2026 was reviewed. The H&P indicated Resident 6 had a right lower extremity (RLE/right leg) DVT. RN 1 and<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the DON stated the H&P Resident 6 had a RLE DVT. During a concurrent interview and record review on 6/10/2026 at 10:38 AM with the DON, Resident 6's MDS dated [DATE] was reviewed. The MDS indicated Section I - Active Diagnoses in the last seven days indicated the box was not checked for question I0500 for DVT, PE, or PTE. The DON stated Resident 6's MDS was not accurate because the MDS nurse did not indicate on the MDS that Resident 6 had a DVT. During a review of the facility's policy and procedure (P&P), titled Certifying Accuracy of the Resident Assessment, reviewed 11/20/2025, the P&P indicated the following: 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an individualized care plan was in place for two of two sampled residents (Resident 12 and Resident 70): to monitor for side effects and effectiveness of mirtazapine (a tetracyclic antidepressant (TeCA) primarily prescribed to treat Major Depressive Disorder (MDD) for Resident 12.to monitor episodes of restlessness for Resident 70 every shift.These failures had the potential for Resident 12 and Resident 70's delaying of care and treatment to be unidentified. Findings: 1.During a review of Resident 12's admission Record, the record indicated that Resident 12 was originally admitted on [DATE] and readmitted on [DATE] with a diagnoses of metabolic encephalopathy (an altered mental state usually caused by organ failure or chemical imbalances); Alzheimer's disease (a disease characterized by a progressive decline in mental abilities); generalized muscle weakness, and depression (a mood disorder that causes persistent sadness, a loss of interest in activities, and affects how one thinks, feels, and behaves.)During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2026, the MDS indicated that Resident 12 has significant cognitive impairment (any condition that affects a person's mental functioning, and capacity). The MDS indicated that Resident 12 uses a walker to ambulate (walk) and requires supervision for oral hygiene, moderate assistance for toileting and upper body dressing, and maximal assistance for showering and lower body dressing.During a review of Resident 12's physician's orders, dated 6/11/2026, the orders indicated the following:a. The resident is to receive mirtazapine tablet 7.5 milligrams (mg) for depression manifested by verbalization of feeling sad and crying.b. Staff to monitor the resident every shift for the following side effects related to mirtazapine use (Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity (skin), Excess Weight Gain).c. Staff to monitor the effectiveness of mirtazapine every shift for episodes of verbalization of feeling sad. 2. During a review of Resident 70's admission Record, the record indicated that Resident 70 was originally admitted on [DATE], and readmitted on [DATE] with a diagnosis of type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), vascular dementia (a progressive state of decline in mental abilities), and altered mental status.During a review of Resident 70's MDS dated [DATE], the MDS indicated that Resident 70 has significant cognitive impairment. The MDS indicated that Resident 70 required maximal assistance for showering, and supervision for oral hygiene, toileting, lower body dressing, and upper body dressing.During a review of Resident 70's physician's orders, dated 1/27/2026, the orders indicated to monitor the resident for episodes of restlessness and document effectiveness of interventions every shift.During an interview on 6/10/2026 at 9:59 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the purpose of a care plan is to highlight the process in how the facility addresses situations, identifies problems with residents, and manages them. LVN 2 stated if there is no care plan, there can be a communication breakdown between the nurses and residents can experience inconsistency of care.During an interview on 6/10/2026 at 10:15 a.m. with Registered Nurse Supervisor 1 (RN 1), RN 1 stated the purpose of the care plan is to ensure that any concerns or needs of the residents are addressed adequately. RN 1 stated the Director of Nursing (DON), MDS Nurse (MDSN), and licensed nurses are responsible for creating the care plan, and everyone is responsible for implementing it. RN 1 stated if the care plan is not created and not implemented, the issues the residents have will not be addressed effectively.During a concurrent interview and record review on 6/11/2026 at 2:14 p.m. with the DON, the DON stated that the purpose of the care plan is to guide the nurses on the interventions necessary for the residents. The DON stated licensed nurses are responsible for ensuring the care plan is in place and should be implemented by the nurses and certified nursing assistants. The DON stated if there is no care plan in<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | place, it could cause a delay in care and possible harm if issues are not addressed timely. The DON stated there was no care plan in place for Resident 12 and Resident 70 but should have been and staff did not follow the care plan policy and procedure.During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated that a care plan should be developed for all residents within 7 days of completion of the resident's comprehensive assessment (MDS). |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise the care plan for one of eight sampled residents (Resident 73) for hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney) by failing to: -Ensure the licensed nurses (in general) updated Residents 73's Care Plan Report to include hemodialysis orders on 4/25/2026 and change of hemodialysis days. This failure had the potential to result in a delay in nursing care for Resident 73.Findings: During a review of Resident 73's admission Record, the admission Record indicated the facility admitted the resident originally on 3/2/2024 and readmitted on [DATE] with diagnoses that included but not limited to muscle weakness, abnormalities of gait (a person's specific manner or pattern of walking or moving on foot), end stage renal disease (irreversible kidney failure), and essential hypertension (high blood pressure). During a review of Resident 73's Care Plan Report dated 7/31/2025, the Care Plan Report indicated Resident 73's hemodialysis treatment was two to four hours bedside dialysis treatment days Monday, Tuesday, Wednesday, Thursday and Friday. During a review of Resident 73's Order Summary dated 7/31/2025, the Order Summary indicated physician's order to provide two to four hours bedside dialysis treatment days: Monday, Tuesday, Wednesday, Thursday and Friday. During a review of Resident 73's untitled history and physical document dated 8/3/2025, the untitled history and physical document indicated Resident 73 had the capacity to understand and make decisions. During a review of Resident 73's Order Summary dated 4/25/2026, the Order Summary indicated the following physician's orders: emergency care instructions after dialysis treatment day, hemodialysis access monitoring every shift, do not take blood pressure in the right arm, dialysis emergency kits at bedside as needed, and monitor AV (arteriovenous, connection refers to a direct link between an artery and a vein) fistula (an abnormal connection between an artery and a vein site ) for signs and symptoms of infection, edema (swelling), and bleeding. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool)) dated 4/28/2026, the MDS indicated Resident 73 made herself understood and understood others. The MDS indicated Resident 73's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) is intact. The MDS indicated Resident 43 required maximal assistance with mobility. During a concurrent interview and record review on 6/10/2026, at 12:12 PM with Licensed Vocational Nurse 1 (LVN1) Resident 73's Order Summary and Care Plan Report on hemodialysis were reviewed. LVN 1 stated the order dated 7/31/2025 indicated hemodialysis treatment days were Monday to Friday and no weekends. LVN 1 stated that resident 73's Care Plan Report dated 7/31/2025 indicated hemodialysis treatment days Monday to Friday without weekends treatment. During a concurrent interview and record review on 6/10/202 at6 12:20 PM with LVN 1, Resident 73's Home Hemodialysis Order dated 5/12/2026 was reviewed. LVN 1 stated that Resident 73's Home Hemodialysis Order indicated four (Monday, Tuesday, Wednesday and Friday) treatments per week with treatment notes to be off on Thursday. LVN 1 stated that the Care Plan Report on hemodialysis should have been updated with changed treatment dates. During a concurrent interview and record review on 6/10/2026, at 12:20 PM with LVN 1, Resident 73's Order Summary Report dated 4/25/2026 was reviewed. LVN 1 stated that Resident 763's hemodialysis care related order summary indicated emergency care instructions after dialysis treatment day, hemodialysis access monitoring every shift, do not take blood pressure in the right arm, dialysis emergency kits at bedside as needed, and monitor AV fistula for signs and symptoms of infection, edema, and bleeding. The LVN 1 stated that Resident 73's Care Plan Report on hemodialysis should have been updated including Resident 73's hemodialysis care orders dated 4/25/2026. During a concurrent interview and record review on 6/10/2026, at 1:34 PM with the Director of Nursing (DON), Resident 73's Care Plan Report for hemodialysis dated 7/31/2025 and Resident 73's Order Summary<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 4/25/2026 were reviewed. The DON stated that Resident 73's Care Plan Report for hemodialysis indicated that it was initiated on 7/31/2025 and was not updated with Resident 73's hemodialysis care ordered on 4/25/2026. The DON stated that Resident 73's Care Plan Report for hemodialysis dated 7/31/2025 should have been updated with Resident 73's hemodialysis care ordered on 4/25/2026. During a concurrent interview and record review on 6/11/2026, at 11:31 AM with Hemodialysis Nurse1 (HDN 1), Resident 73's Home Hemodialysis Order dated 5/12/2026 was reviewed. HDN 1stated that Resident 73's Home Hemodialysis Order dated 5/12/2026 indicated new dialysis treatment schedule. HDN 1 stated Resident 73'S dialysis procedure was scheduled five times a week (Monday to Friday) except weekends. HD 1 stated that Resident 73's Home Hemodialysis Order was changed on 5/12/2026 and indicated four (Monday, Tuesday, Wednesday and Friday) treatment per week and off on Thursday. HDN 1 stated Resident 73's Home Hemodialysis Order dated 5/12/2026 should have been updated at Resident 73's Care Plan Report. During review of the facility's policy and procedure titled, Care Plan Comprehensive, dated 11/20/2025, it indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, physical, mental and psychosocial needs shall be developed for each resident. The P&P indicated assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident 's condition change. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 2) received the necessary treatment and services to promote healing of a pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to:-Ensure the licensed nurses (in general) promptly identified Resident 2's Stage 2 pressure ulcer/injury (partial-thickness loss of skin, presenting as a shallow open sore or wound) to the right heel.-Ensure Treatment Nurse 1 (TN 1) was competent (having the necessary skill, knowledge, or ability to do something well enough to meet a specific standard or requirement) in identifying pressure ulcers/injuries.-Notify the wound specialist (a medical professional-such as a specialized physician or a nurse practitioner-with advanced training in managing and treating complex, non-healing wounds) of Resident 2's stage 2 pressure ulcer to the right heel.-Ensure the licensed nurses (in general) did not have no more than a bedsheet on Resident 2's Low Air Loss Mattress (LALM, a specialized medical support surface designed to prevent and treat skin breakdown and pressure ulcers). These failures had the potential for Resident 2's Stage 2 pressure ulcer/injury to the right heel to worsen, develop an infection, and had the potential for Resident 2 to develop new pressure ulcers/injuries.Cross reference F726FindingsDuring a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 12/24/2025 with diagnoses that included chronic respiratory failure (a long-term condition where the respiratory system cannot adequately supply oxygen to the blood or clear carbon dioxide from the body), chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), dependence on the respirator (ventilator, a mechanical device to help support or replace breathing), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), severe protein-calorie malnutrition (a life-threatening condition caused by a severe, prolonged deficiency of all macronutrients, particularly calories and protein), dysphagia (difficulty swallowing), stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (tailbone area), dementia (a progressive state of decline in mental abilities), tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe (trachea) to insert a tube that allows air to reach the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right hand. During a review of TN 1's Competency Skills: Skin Evaluation with Documentation dated 1/10/2026, the Competency Skills: Skin Evaluation with Documentation indicated TN 1 was competent in the identification of skin problems and/or facility acquired pressure ulcers. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/31/2026, the MDS indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS indicated Resident 2 was dependent on help for oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 was at risk of developing pressure ulcers. The MDS indicated Resident 2 had three stage 4 pressure ulcers, two of which were present on admission/entry or reentry to the facility. The MDS indicated Resident 2 utilized a pressure reducing device for bed and was receiving pressure ulcer care. During a review of Resident 2's Treatment Administration Record (TAR) dated 4/1/2026 to 4/30/2026, the TAR indicated the resident received treatment to his (Resident 2) right heel skin tear daily from 4/12/2026 to 4/17/2026 and 4/20/2026 to 4/26/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 4/12/2026, 4/14/2026, 4/15/20256, 4/16/2026, 4/17/2026, 4/20/2026, 4/21/2026, 4/22/2026, 4/23/2026, and 4/26/2026. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/8/2026 for a LALM for skin management. The physician order indicated Resident 2's<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LALM was to be at a setting between 100 -150. The physician order indicated Resident 2's LALM was to be monitored for proper functioning and placement every shift for wound management. During a review of Resident 2's Change in Condition Evaluation dated 4/10/2026, the Change in Condition Evaluation indicated a skin tear had occurred to the resident's right heel during wound care. The Change in Condition Evaluation indicated that the abdominal pad (an extra-thick, highly absorbent medical dressing used to manage wounds and surgical incisions with heavy fluid drainage) on Resident 2's right heel was soaked with normal saline to prevent the abdominal pad from sticking. The Change in Condition Evaluation indicated that skin on Resident 2's right heel had accidentally peeled after the abdominal pad on the resident's right heel had slowly been removed. The Change in Condition Evaluation indicated Resident 2's physician was notified and provided new orders to cleanse the resident's right heel with Normal Saline (NS, a saltwater solution), pat dry the right heel, apply a xeroform (a sterile, non-adhering wound dressing) dressing to the right heel, and then cover the right heel with a dry dressing. During a review of Resident 2's physician order dated 4/10/2026 at 2:45 PM, the physician order indicated the resident was to receive treatment to the resident's right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for seven days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 4/19/2026 at 2:45 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 7 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 4/27/2026 at 1:50 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for seven days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 5/5/2026 at 12:15 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for seven days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 5/17/2026 at 3:47 PM, the physician order indicated the resident was to have treatment for his (Resident 2) right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's TAR dated 5/1/2026 to 5/31/2026, the TAR indicated the resident received treatment to his right heel skin tear daily from 5/1/2026 to 5/4/2026, 5/6/2026 to 5/12/2026, and 5/18/2026 to 5/31/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 5/3/2026, 5/4/2026, 5/8/2026, 5/10/2026, 5/20/2026, 5/21/2026, 5/22/2026, 5/26/2026, 5/27/2026, and 5/29/2026. During a review of Resident 2's physician order dated 6/1/2026 at 3:19 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order<br>(continued on next page) |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>Los Angeles, CA 90029 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's TAR dated 6/1/2026 to 6/10/2026, the TAR indicated resident 2 received treatment to his right heel skin tear daily from 6/2/2026 to 6/9/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 6/2/2026, 6/3/2026, 6/4/2026, 6/7/2026, 6/8/2026, and 6/9/2026. During a review of Resident 2's Surgical Consult dated 6/9/2026, the Surgical Consult indicated that Medical Doctor 1 (MD 1) was consulted for the resident's wounds found at the sacrococcyx (tailbone area), left ischium (the left lower posterior bone of the pelvis), and right ischium (right lower posterior bone of the pelvis). The Surgical Consult indicated a comprehensive skin examination was performed of Resident 2's head, face, scalp, neck, back, buttocks, sacrum (tailbone area), coccyx (tailbone), left ischium, right ischium, left trochanter (left hipbone area), right trochanter (right hipbone area), left upper extremity, right upper extremity, left lower extremity, and right lower extremity to examine for any new or current lesions (any damaged, abnormal, or diseased area on the skin) on the resident's body. The Surgical Consult indicated Resident 2 had wounds located on the sacrococcyx, left ischium, and right ischium. During a review of Resident 2's physician order dated 6/10/2026 at 1:31 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it was discontinued on 6/10/2026 due to a clarification of wound classification. The physician order indicated it was confirmed by TN 1. During a concurrent observation and interview on 6/10/2026 at 11:56 AM, in Resident 2's room, TN 1 was observed performing treatment to Resident 2's right foot. The back of Resident 2's right foot was observed to have dry peeling and scaly skin above the heel and around the top of the right foot. Thickened dark brown skin with an open wound in the shape of a butterfly was observed directly below the heel of Resident 2's right foot. The open wound was observed with a red fleshy base approximately 2 inches (a unit of length) wide by 1.5 inches tall. Below the wound towards the base of the foot a moist lifting skin flap was observed covering the width of the heel and extending approximately 1 to 1.5 inches into the center of Resident 2's right foot. The corners of the lifting skin were noted with thickened darkened skin. TN 1 stated that the wound on Resident 2's right heel was a skin tear. TN 1 stated he (TN 1) was the one who noticed that a part of the skin to Resident 2's right heel had fallen off. TN 1 stated Resident 2's wound on the right heel had been observed there for a while. TN 1 stated he (TN 1) did not know or remember the date of when Resident 2's right heel wound opened. TN 1 stated Resident 2 used to have a pressure ulcer to the right heel. TN 1 stated he was not sure if the wound specialist was aware of the wound to Resident 2's right heel. During an interview on 6/10/2026 at 1:43 PM with TN 1, TN 1 stated Resident 2 was at risk for developing pressure ulcers. TN 1 stated Resident 2 previously had a pressure ulcer to the right heel. TN 1 stated Resident 2's right heel was dry but one day the resident's skin on the right heel had come off. TN 1 stated he (TN 1) thought the wound to Resident 2's right heel was a skin tear. TN 1 stated he (TN 1) had Nurse Practitioner 1 (NP 1) come and see the wound to Resident 2's right heel after he (TN 1) performed treatment on 6/10/2026 at 11:56 AM. TN 1 stated NP 1 assessed Resident 2's wound on the right heel to be a stage 2 pressure ulcer and not a skin tear. TN 1 stated Resident 2 was seen by the wound specialist on a weekly basis. TN 1 stated that when Resident 2's skin on the right heel had come off he (TN 1) notified the resident's attending physician but not the wound specialist. TN 1 stated that in hindsight he (TN 1) should have also notified the wound specialist that the skin on Resident 2's right heel had come off. TN 1 stated he (TN 1) was with Resident 2 when the wound specialist saw the resident on 6/9/2026. TN 1 stated the wound specialist did not assess Resident 2's right foot. TN 1 stated he (TN 1) performed treatment to Resident 2's right heel almost daily. TN 1 stated he (TN 1) did not know when Resident 2's right heel wound became a stage 2 pressure ulcer. (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | TN 1 stated a pressure ulcer was a wound that appeared in areas where there was pressure. TN 1 stated he (TN 1) did not really know how to describe the different stages of pressure ulcers. TN 1 stated it was important to be able to promptly identify changes to Resident 2's skin condition to ensure the resident received the appropriate treatment. TN 1 stated there was potential for Resident 2's pressure ulcer to worsen and for the resident to develop new pressure ulcers if he (TN 1) did not know the different stages of pressure ulcers or could not identify changes in the resident's skin. During an interview on 6/10/2026 at 2:05 PM with Nurse Practitioner 1 (NP 1), NP 1 stated she (NP1) was assigned to the care of Resident 2. NP 1 stated Resident 2 was at risk for developing pressure ulcers. NP 1 stated she evaluated Resident 2's right heel on 6/10/2026 after she was asked by TN 1 to examine the resident's right foot. NP 1 stated Resident 2 had been receiving treatment for a skin tear to the right heel. NP 1 stated the wound on Resident 2's right heel was not a skin tear. NP 1 stated she identified the wound to Resident 2's right heel as a stage 2 pressure ulcer. NP 1 stated this was the first time she (NP 1) was made aware of Resident 2's stage 2 pressure ulcer to the right heel. NP 1 stated she (NP1) informed TN 1 to have the wound specialist come and see Resident 2's right heel for treatment. NP 1 stated that it was important to ensure that any changes to Resident 2's skin were promptly identified to ensure treatment would be provided to the resident. NP 1 stated that if changes to Resident 2's skin condition were not identified promptly there was potential for the resident's wounds to worsen or for the resident to develop new pressure ulcers. During a review of Resident 2's Change in Condition Evaluation dated 6/10/2026 at 3:09 PM, the Change in Condition Evaluation indicated the resident had a change in skin color or condition that started the afternoon of 6/10/2026. The Change in Condition Evaluation indicated the wound classification of Resident 2's right heel skin tear was clarified. The Change in Condition Evaluation indicated Resident 2's wound was seen and examined by NP 1 for a reassessment. The Change in Condition Evaluation indicated Resident 2's wound to the right heel was reclassified to a 6 x 5.5 centimeters (cm) stage 2 pressure ulcer. The Change in Condition Evaluation indicated Resident 2's stage 2 pressure ulcer to the right heel had partial thickness tissue loss with no signs or symptoms of infection, drainage, or odor. The Change in Condition Evaluation indicated current treatment to Resident 2's right heel was continued as ordered to cleanse with NS, pat dry, apply xeroform and cover with a dry dressing. The Change in Condition Evaluation indicated it was signed by TN 1. During a concurrent observation and interview on 6/10/2026 at 2:45 PM with the Director of Nursing (DON), in Resident 2's room, the resident's right heel was observed. The DON stated that he (DON) would identify the wound on Resident 2's right heel as a stage 2 pressure ulcer. The DON stated the wound on Resident 2's right heel was not a skin tear. The DON stated he (DON) did not know when Resident 2 developed the stage 2 pressure ulcer to the right heel. The DON stated there was no documentation of when Resident 2's right heel stage 2 pressure ulcer was identified. The DON stated Resident 2 was being seen by the wound specialist. The DON stated Resident 2's most recent wound specialist note did not indicate the wound specialist was aware of the resident's right heel pressure ulcer. The DON stated the wound specialist did not see Resident 2's right heel wound because the documentation indicated the wound was a skin tear and not a pressure ulcer. Resident 2 was observed on a Med Aire LALM. The DON stated Resident 2 was on a LALM for skin management. The DON stated that Resident 2 was wearing an incontinent brief. The DON stated Resident 2 was also laying on a cloth pad and a bed sheet that was on top of the LALM. The DON stated that having more than one bedsheet on the LALM defeated the purpose of the LALM. The DON stated there should only be one bedsheet on the LALM to ensure the LALM was efficient as treatment for pressure ulcers. The DON stated that it was important that TN 1 be able to identify any changes in Resident 2's skin so the resident could be treated promptly. The DON stated that without prompt identification of changes in Resident 2's skin there was potential for the resident's pressure ulcers to worsen, potential for the resident to develop new pressure ulcers, or potential for the resident to develop an infection to the wound. During a concurrent interview and record review on 6/11/2026 at 12:30 PM with the DON, TN 1's Competency Skills: Skin Evaluation (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | with Documentation dated 1/10/2026 was reviewed. The DON stated he (DON) performed the Competency Skills: Skin Evaluation with Documentation dated 1/10/2026 with TN 1. The DON stated TN 1 did not identify when Resident 2's developed the stage 2 pressure ulcer to the right heel. The DON stated TN 1 did not inform the DON of the change in Resident 2's skin. The DON stated he (DON) was made aware of Resident 2's pressure ulcer to right heel on 6/10/2026. The DON stated TN 1 was supposed to be competent at identifying changes to Resident 2's skin. The DON stated TN 1 should have been able to identify when Resident 2 developed the stage 2 pressure ulcer to the right heel. The DON stated TN 1 should have notified the DON and wound specialist about Resident 2's right heel. The DON stated TN 1 needed to be competent in all aspects of wound care or there would be potential for the residents (in general) to develop changes in skin that were not identified and promptly treated. During a review of the Operator's Manual titled Med Aire Plus Alternating Pressure and Low Air Loss Mattress Replacement Manual dated 3/15/16, the Operator's Manual indicated Cover the mattress with a cotton sheet.Patient Use: When the normal pressure indicator lights up (green), the pressure in the mattress had reached the pre-defined level, and the patient can then be placed on the mattress. Cover the mattress with a cotton sheet to avoid direct skin contact and improve the patient's comfort level. During a review of the facility's Job Description (JD) titled Licensed Practical (Vocational) Nurse (LPN)/(LVN) dated 5/2022, the JD indicated Monitor the skin health of the resident; provide preventative skin care; administer wound treatments as ordered. During a review of the facility's JD titled Wound Care/Treatment Nurse dated 7/2022, the JD indicated The Primary Purpose of this position is to provide wound care and treatments to residents as ordered and/or within the scope of nursing practice for the state.Duties and Responsibilities: . Identify management, and treat primary and secondary wound, including pressure ulcers/injuries, ostomies, surgical wounds, traumatic wounds and burns.Help identify and mitigate specific resident risk factors for pressure ulcers/injuries.Complete regular skin assessments on residents and document the findings.Provide skin and wound care and treatments, as ordered.Experience: Must have, as a minimum, two (2) year(s) experience as a registered nurse.Must possess a current unencumbered active license to practice as a registered nurse in the state of practice. During a review of the facility's Policy and Procedure (P&P) titled Skin Integrity Management reviewed 11/20/2025, the P&P indicated To provide safe and effective care to prevent the occurrence of pressure ulcers, management treatment, and promote healing of all wounds. The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revision to the plan of care as needed.Perform wound observations and measurements upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. Perform daily monitoring of wounds or dressing for presence of complications or declines and document if needed.Nursing staff will observe for any sign of potential or active pressure injury daily while providing nursing care. During a review of the facility's P&P titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 4/2026, the P&P indicated In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width, and depth, and presence of exudates or necrotic tissue; pain assessment; resident's mobility status; current treatments and preventive strategies; and all active diagnoses. During a review of the P&P titled Support Surface Guidelines dated 4/2026, the P&P indicated Following manufacturer's recommendation for use, ensure the support surface accommodates the weight, heights, size, and body mass index (BMI) of the resident. Ensure bed linens and other resident-care devices do not interfere with the function of the support surface. Check linens are free of wrinkles. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure there was effective coordination and communication of hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care for one of nine sampled residents (Resident 73) reviewed for dialysis by failing to ensure to:-Obtain and maintain Resident 73's current hemodialysis orders in Resident 73's medical record following readmission on [DATE] and after changes to Resident 73's dialysis treatment schedule on 5/12/2026.-Place an identifiable dialysis emergency kit (a sudden, unexpected, and dangerous situation that poses an immediate threat to life and health) readily available.These failures had the potential to delay recognition of changes to Resident 73's hemodialysis treatment orders and emergency interventions. Findings:During a review of Resident 73's admission Record, the admission Record indicated the facility admitted the resident originally on 3/2/2024 and readmitted on the resident on 4/24/2026 with diagnoses that included but not limited to muscle weakness, abnormalities of gait (a person's specific manner or pattern of walking or moving on foot) , end stage renal disease (irreversible kidney failure), and essential hypertension (high blood pressure).During a review of Resident 73's Order Summary dated 4/25/2026, the Order Summary indicated dialysis emergency kits at bedside as needed.During a review of Resident 73's Order Summary dated 7/31/2025, the Order Summary indicated physician's order to provide two to four hours bedside dialysis treatment days: Monday, Tuesday, Wednesday, Thursday and Friday.During a review of Resident 73's untitled history and physical document dated 8/3/2025, the untitled history and physical document indicated Resident 73 had the capacity to understand and make decisions.During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 73 made herself understood and understood others. The MDS indicated Resident 73's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) is intact. The MDS indicated Resident 43 required maximal assistance with mobility.During a concurrent observation and interview on 6/10/2026, at 12:12 PM with Licensed Vocational Nurse 1 (LVN 1), in Resident 73's room, a clear plastic bag was observed. LVN 1 was observed grabbing a clear plastic bag on top of Resident 73's bedside table with other Resident 73's personal belongings. LVN 1 stated the clear bag did not have a label but was the dialysis emergency kit. LVN 1 stated it should have been clearly labeled with Resident's name and should have been identifiable as dialysis emergency kit. LVN 1 stated that the dialysis emergency kit should have been located with easy access and not mixed with Resident 73's belongings.During a concurrent interview and record review on 6/10/2026 at 12:20 PM with LVN 1, Resident 73's Home Hemodialysis Order dated 5/12/2026 was reviewed. LVN 1 stated that Resident 73's Home Hemodialysis Order indicated four (Monday, Tuesday, Wednesday and Friday) treatments per week with treatment notes off on Thursday. LVN 1 stated that the Home Hemodialysis Order dated 5/12/2026 from the dialysis provider was not on Resident 73's medical records.During a concurrent interview and record review on 6/10/2026, at 1:20 PM with the Medical Records Director Resident 73's hemodialysis orders were reviewed. The MRD stated that there was hemodialysis ordered on 7/31/2025 and 6/10/2025. The MRD stated there was no hemodialysis treatment ordered dated 4/25/206 readmission of Resident 73 and no hemodialysis treatment ordered 5/12/2026. The MRD stated the nurses (in general) were responsible for placing all orders on admission.During a concurrent interview and record review on 6/10/2026, at 1:34 PM with the Director of Nursing (DON) Resident 73's hemodialysis orders were reviewed. The DON stated hemodialysis services were done in the facility with a contracted provider (unidentified). The DON stated that the contracted hemodialysis provider nurse (unidentified) received the hemodialysis order from the doctor (unidentified) and communicated residents (general) on hemodialysis care to the facility's nurse (unidentified) to place the order. The DON stated that there was no hemodialysis ordered on Resident<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 73's readmission. The DON stated that nurses (in general) should have placed the hemodialysis orders when Resident 73 was readmitted on [DATE] and on 5/12/2026 when the hemodialysis treatment order was changed to four days treatment. The DON stated that there was a failure to communicate Resident 73's hemodialysis orders from both the contracted hemodialysis provider nurse (unidentified)and facility nurse (unidentified).During an interview on 6/10/2026, at 1:43PM with the DON, the DON Stated that that dialysis emerging sick was important to be located at the bedside for dialysis access emergencies. The DON stated it was prepared, put together, and labeled with resident's room number(general) and identified as dialysis emergency kit. Stated Resident 73's dialysis emergency kit should have been labeled.During a concurrent interview and record review on 6/11/2026, at 11:31 AM with the Hemodialysis Nurse (HDN) the Home Health Dialysis order dated 5/12/2026 reviewed. The HDN stated that the process was to communicate to the nurse supervisor (general). The HDN stated provider dialysis did not document verbal communication on Resident 73's admission hemodialysis orders on 4/24/2026 to the admitting nurse (unidentified). The HDN stated it was important to document the communication from provider dialysis nurse to the facility nurse to ensure hemodialysis orders were in Resident 73's medical record.During review of the facility's policy and procedure (P&P) titled, Dialysis Care, dated 11/20/2025, the P&P indicated the facility will arrange for dialysis care as ordered by the attending physician. The P&P indicated that the facility maintains a contract with the dialysis service provider which addresses communications between the facility and provider. The P&P indicated communication and collaboration with nursing staff, dialysis provider staff and the physician will be on a regular basis concerning the residents care as follows: nursing staff will communicate the information in writing to the dialysis staff the residents' changes of conditions specific to the resident with each treatment. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on observation, interview, and record review, the facility failed to ensure one of three Treatment Nurses (TN 1) was competent in wound care services by failing to ensure:- TN 1 identified a Stage 2 pressure ulcer/injury (partial-thickness loss of skin, presenting as a shallow open sore or wound) on Resident 2's right heel.This failure had the potential for Resident 2's pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) to worsen and develop an infection, and/or for the resident to develop new pressure ulcers.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 12/24/2025 with diagnoses that included chronic respiratory failure (a long-term condition where the respiratory system cannot adequately supply oxygen to the blood or clear carbon dioxide from the body), chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), dependence on the respirator (ventilator, a mechanical device to help support or replace breathing), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), severe protein-calorie malnutrition (a life-threatening condition caused by a severe, prolonged deficiency of all macronutrients, particularly calories and protein), dysphagia (difficulty swallowing), stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (tailbone area), dementia (a progressive state of decline in mental abilities), tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe (trachea) to insert a tube that allows air to reach the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right hand. During a review of TN 1's Competency Skills: Skin Evaluation with Documentation dated 1/10/2026, the Competency Skills: Skin Evaluation with Documentation indicated TN 1 was competent in the identification of skin problems and/or facility acquired pressure ulcers. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/31/2026, the MDS indicated the resident had severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS indicated Resident 2 was dependent on help for oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 was at risk of developing pressure ulcers. The MDS indicated Resident 2 had three stage 4 pressure ulcers, two of which were present on admission/entry or reentry to the facility. The MDS indicated Resident 2 utilized a pressure reducing device for bed and was receiving pressure ulcer care. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/8/2026 for a Low Air Loss (LAL, mattress that operates using a blower-based pump that was designed to circulate a constant flow of air) for skin management. The Order Summary Report indicated Resident 2's LALM was to be at a setting between 100 -150. The physician order indicated Resident 2's LALM was to be monitored for proper functioning and placement every shift for wound management. During a review of Resident 2's Change in Condition Evaluation dated 4/10/2026, the Change in Condition Evaluation indicated a skin tear had occurred to the resident's right heel during wound care. The Change in Condition Evaluation indicated that the abdominal pad (an extra-thick, highly absorbent medical dressing used to manage wounds and surgical incisions with heavy fluid drainage) on Resident 2's right heel was soaked with normal saline to prevent the abdominal pad from sticking. The Change in Condition Evaluation indicated that skin on Resident 2's right heel had accidentally peeled after the abdominal pad on the resident's right heel had slowly been removed. The Change in Condition Evaluation indicated Resident 2's physician was notified and provided new orders to cleanse the resident's right heel with Normal Saline (NS, a saltwater solution), pat dry the right heel, apply a xeroform (a sterile, non-adhering wound dressing) (continued on next page) |

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| | 055111 | A. Building<br>B. Wing | 06/11/2026 |

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| Fountain View Subacute and Nursing Center | 5310 Fountain Ave<br>Los Angeles, CA 90029 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dressing to the right heel, and then cover the right heel with a dry dressing. During a review of Resident 2's physician order dated 4/10/2026 at 2:45 PM, the physician order indicated the resident was to receive treatment to the resident's right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing everyday shift for 7 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 4/19/2026 at 2:45 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 7 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 4/27/2026 at 1:50 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 7 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's Treatment Administration Record (TAR) dated 4/1/2026 - 4/30/2026, the TAR indicated the resident received treatment to his (Resident 2) right heel skin tear daily from 4/12/2026 to 4/17/2026 and 4/20/2026 to 4/26/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 4/12/2026, 4/14/2026, 4/15/20256, 4/16/2026, 4/17/2026, 4/20/2026, 4/21/2026, 4/22/2026, 4/23/2026, and 4/26/2026. During a review of Resident 2's physician order dated 5/5/2026 at 12:15 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 7 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 5/17/2026 at 3:47 PM, the physician order indicated the resident was to have treatment for his (Resident 2) right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's TAR dated 5/1/2026 - 5/31/2026, the TAR indicated the resident received treatment to his right heel skin tear daily from 5/1/2026 -5/4/2026, 5/6/2026 - 5/12/2026, and 5/18/2026 - 5/31/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 5/3/2026, 5/4/2026, 5/8/2026, 5/10/2026, 5/20/2026, 5/21/2026, 5/22/2026, 5/26/2026, 5/27/2026, and 5/29/2026. During a review of Resident 2's physician order dated 6/1/2026 at 3:19 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's physician order dated 6/10/2026 at 1:31 PM, the physician order indicated the resident was to have treatment for his right heel skin tear. The physician order indicated Resident 2's right heel skin tear was to be cleansed with NS, and pat dried. The physician order indicated to have a xeroform dressing applied to Resident 2's right heel skin tear. The physician order indicated to then cover Resident 2's right heel skin tear with a dry dressing every day shift for 14 days. The physician order indicated it<br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was discontinued on 6/10/2026 due to a clarification of wound classification. The physician order indicated it was confirmed by TN 1. During a review of Resident 2's TAR dated 6/1/2026 to 6/10/2026, the TAR indicated resident 2 received treatment to his right heel skin tear daily from 6/2/2026 to 6/9/2026. The TAR indicated TN 1 provided treatment to Resident 2's right heel skin tear on 6/2/2026, 6/3/2026, 6/4/2026, 6/7/2026, 6/8/2026, and 6/9/2026. During a concurrent observation and interview on 6/10/2026 at 11:56 AM, in Resident 2's room, TN 1 was observed performing treatment to Resident 2's right foot. The back of Resident 2's right foot was observed to have dry peeling and scaly skin above the heel and around the top of the right foot. Thickened dark brown skin with an open wound in the shape of a butterfly was observed directly below the heel of Resident 2's right foot. The open wound was observed with a red fleshy base approximately 2 inches (a unit of length) wide by 1.5 inches tall. Below the wound towards the base of the foot a moist lifting skin flap was observed covering the width of the heel and extending approximately 1 to 1.5 inches into the center of Resident 2's right foot. The corners of the lifting skin were noted with thickened darkened skin. TN 1 stated that the wound on Resident 2's right heel was a skin tear. TN 1 stated he (TN 1) was the one who noticed that a part of the skin to Resident 2's right heel had fallen off. TN 1 stated Resident 2's wound on the right heel had been observed there for a while. TN 1 stated he (TN 1) did not know or remember the date of when Resident 2's right heel wound opened. During an interview on 6/10/2026 at 1:43 PM with TN 1, TN 1 stated Resident 2 was at risk for developing pressure ulcers. TN 1 stated Resident 2 previously had a pressure ulcer to the right heel. TN 1 stated Resident 2's right heel was dry but one day the resident's skin on the right heel had come off. TN 1 stated he (TN 1) thought the wound to Resident 2's right heel was a skin tear. TN 1 stated he (TN 1) had Nurse Practitioner 1 (NP 1) come and see the wound to Resident 2's right heel after he (TN 1) performed treatment on 6/10/2026 at 11:56 AM. TN 1 stated NP 1 assessed Resident 2's wound on the right heel to be a stage 2 pressure ulcer and not a skin tear. TN 1 stated he (TN 1) performed treatment to Resident 2's right heel almost daily. TN 1 stated he (TN 1) did not know when Resident 2's right heel wound became a stage 2 pressure ulcer. TN 1 stated a pressure ulcer was a wound that appeared in areas where there was pressure. TN 1 stated he (TN 1) did not really know how to describe the different stages of pressure ulcers. TN 1 stated it was important to be able to promptly identify changes to Resident 2's skin condition to ensure the resident received the appropriate treatment. TN 1 stated there was potential for Resident 2's pressure ulcer to worsen and for the resident to develop new pressure ulcers if he (TN 1) did not know the different stages of pressure ulcers or could not identify changes in the resident's skin. During an interview on 6/10/2026 at 2:05 PM with Nurse Practitioner 1 (NP 1), NP 1 stated she (NP1) was assigned to the care of Resident 2. NP 1 stated Resident 2 was at risk for developing pressure ulcers. NP 1 stated she (NP1) evaluated Resident 2's right heel on 6/10/2026 after she (NP1) was asked by TN 1 to examine Resident 2's right foot. NP 1 stated Resident 2 had been receiving treatment for a skin tear to the right heel. NP 1 stated the wound on Resident 2's right heel was not a skin tear. NP 1 stated she (NP1) identified the wound to Resident 2's right heel as a stage 2 pressure ulcer. NP 1 stated this was the first time she (NP 1) was made aware of Resident 2's stage 2 pressure ulcer to the right heel. NP 1 stated that it was important to ensure that any changes to Resident 2's skin were promptly identified to ensure treatment would be provided to the resident. NP 1 stated that if changes to Resident 2's skin condition were not identified promptly there was potential for the resident's wounds to worsen or for the resident to develop new pressure ulcers. During a review of Resident 2's Change in Condition Evaluation dated 6/10/2026 at 3:09 PM, the Change in Condition Evaluation indicated the resident had a change in skin color or condition that started the afternoon of 6/10/2026. The Change in Condition Evaluation indicated the wound classification of Resident 2's right heel skin tear was clarified. The Change in Condition Evaluation indicated Resident 2's wound was seen and examined by NP 1 for a reassessment. The Change in Condition Evaluation indicated Resident 2's wound to the right heel was reclassified to a 6 x 5.5 centimeters (cm) stage 2 pressure ulcer. The Change in Condition Evaluation (continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated Resident 2's stage 2 pressure ulcer to the right heel had partial thickness tissue loss with no signs or symptoms of infection, drainage, or odor. The Change in Condition Evaluation indicated current treatment to Resident 2's right heel was continued as ordered to cleanse with NS, pat dry, apply xeroform and cover with a dry dressing. The Change in Condition Evaluation indicated it was signed by TN 1. During a concurrent observation and interview on 6/10/2026 at 2:45 PM with the Director of Nursing (DON), in Resident 2's room, the resident's right heel was observed. The DON stated that he (DON) would identify the wound on Resident 2's right heel as a stage 2 pressure ulcer. The DON stated the wound on Resident 2's right heel was not a skin tear. The DON stated he (DON) did not know when Resident 2 developed the stage 2 pressure ulcer to the right heel. The DON stated there was no documentation of when Resident 2's right heel stage 2 pressure ulcer was identified. The DON stated that it was important that TN 1 be able to identify any changes in Resident 2's skin so the resident could be treated promptly. The DON stated that without prompt identification of changes in Resident 2's skin there was potential for the resident's pressure ulcers to worsen, potential for the resident to develop new pressure ulcers, or potential for the resident to develop an infection to the wound. During a concurrent interview and record review on 6/11/2026 at 12:30 PM with the DON, TN 1's Competency Skills: Skin Evaluation with Documentation dated 1/10/2026 was reviewed. The DON stated he (DON) performed the Competency Skills: Skin Evaluation with Documentation dated 1/10/2026 with TN 1. The DON stated TN 1 did not identify when Resident 2's developed the stage 2 pressure ulcer to the right heel. The DON stated TN 1 did not inform the DON of the change in Resident 2's skin. The DON stated he (DON) was made aware of Resident 2's pressure ulcer to right heel on 6/10/2026. The DON stated TN 1 was supposed to be competent at identifying changes to Resident 2's skin. The DON stated TN 1 should have been able to identify when Resident 2 developed the stage 2 pressure ulcer to the right heel. The DON stated TN 1 should have notified the DON and wound specialist about Resident 2's right heel. The DON stated TN 1 needed to be competent in all aspects of wound care or there would be potential for the residents (in general) to develop changes in skin that were not identified and promptly treated. During a review of the facility's Job Description (JD) titled Licensed Practical (Vocational) Nurse (LPN)/(LVN) dated 5/2022, the JD indicated Monitor the skin health of the resident; provide preventative skin care; administer wound treatments as ordered. During a review of the facility's JD titled Wound Care/Treatment Nurse dated 7/2022, the JD indicated The Primary Purpose of this position is to provide wound care and treatments to residents as ordered and/or within the scope of nursing practice for the state.Duties and Responsibilities: . Identify management, and treat primary and secondary wound, including pressure ulcers/injuries, ostomies, surgical wounds, traumatic wounds and burns.Help identify and mitigate specific resident risk factors for pressure ulcers/injuries.Complete regular skin assessments on residents and document the findings.Provide skin and wound care and treatments, as ordered.Experience: Must have, as a minimum, two (2) year(s) experience as a registered nurse.Must possess a current unencumbered active license to practice as a registered nurse in the state of practice. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label an open Trelegy Ellipta inhaler (a medication used to treat breathing problems) with a complete open date affecting Resident 19 in one of three inspected medication carts (SNF North Cart). This failure increased the risk for Resident 19 to receive medication that has become ineffective or toxic due to improper storage, potentially leading to health complications that could result in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 11:53 AM with Licensed Vocational Nurse 1 (LVN 1) in the hallway, SNF North Cart was inspected. The SNF North Cart contained Resident 19's opened Trelegy Ellipta inhaler with an incomplete open date of 5/2026. According to the product labeling, Trelegy Ellipta should be used or discarded within six weeks of opening. LVN 1 stated the Trelegy Ellipta inhaler for Resident 19 only contained the month and year when it was opened. LVN 1 stated the day must also be listed on the container as to when the inhaler was initially opened. LVN 1 stated that without the full open date, the expiration of the inhaler could not be determined. LVN 1 stated if the inhaler was given after it was expired, it may not be effective at treating Resident 19's breathing problems, which could lead to medical complications requiring hospitalization. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, last revised February 2023, the P&P indicated multi-dose medication containers that have been opened are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open container. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to maintain infection control practices (the set of everyday habits and rules used to stop germs such as viruses and bacteria from spreading) necessary to prevent the spread of infections for two of two sampled residents (Resident 60 and Resident 67) by failing to:-Ensure Certified Nursing Assistants (CNA 1 and CNA 2) performed hand hygiene (the act of cleaning your hands to remove germs, dirt, and viruses) when feeding the residents (Resident 60 and Resident 67). These failures had the potential to increase the risk of infection among the residents (Resident 60 and Resident 67).Findings:During review of Resident 60s's admission Record (a document containing demographic and diagnostic information), the admission Record indicated the facility admitted the resident on 4/14/2026, with the diagnoses that included cerebral infarction (a blood vessel carrying oxygen and nutrients to the brain is blocked by a clot or fatty buildup.), dementia (decline in mental abilities), gastroenteritis (an irritation of the stomach and intestines), and colitis (inner lining of your colon [the large intestine] is swollen and inflamed), lack of coordination, and dysphagia (difficulty swallowing).During review of Resident 60's Minimum Data Set (MDS- a resident assessment tool) dated 4/19/2026, the MDS indicated Resident 60 had severe cognitive (ability to think and process information) impairment and required partial to moderate assistance to eat.During review of Resident 67s's admission Record, the admission Record indicated the facility admitted the resident on 4/25/2026 with the diagnoses that included muscle weakness, dysphagia (difficulty swallowing), atrial fibrillation (quivering heartbeat in the upper chambers of the heart), and dementia.During review of Resident 67s's MDS dated [DATE], the MDS indicated Resident 67 had severe cognitive impairment and required supervision or touching assistance when eating.During a concurrent observation and interview on 6/9/2026 at12:28 PM with CNA 1 in the dining room, CNA 1 did not perform hand hygiene after assisting Resident 60 with feeding and before cutting Resident 67's food. CNA 1 stated she (CNA1) forgot to perform hand hygiene between resident care tasks in the dining room. CNA 1 stated staff (in general) were required to perform hand hygiene between resident contacts to prevent cross contamination (is the process by which a harmful or dirty substance spreads from one area to another) of bacteria and viruses.During a concurrent observation and interview on 6/9/2026 at12:39 PM with CNA 2 in the dining room, CNA 2 did not perform hand hygiene after handling a dirty lunch tray and before assisting Resident 67 with eating. CNA 2 stated she (CNA2) forgot to perform hand hygiene after touching the dirty food tray. CNA 2 stated that staff (in general) were required to perform hand hygiene to prevent the transfer of bacteria and viruses between residents.During an interview on 6/9/2026 at 1:28 PM with the Infection Preventionist (IP), the IP stated staff (in general) were required to perform hand hygiene between all resident care tasks to prevent the transmission of bacteria and viruses, such as the flu, among the residents.During an interview on 6/9/2026 at 2:16 PM with Registered Nurse 1 (RN1), RN 1 stated staff (in general) were expected to wash their hands before and after providing resident care to prevent the spread of infection.During an interview on 6/9/2026 at 3:25 PM with the Director of Nursing (DON), the DON stated the facility's expectation was for the staff (in general) performed hand hygiene between all resident care tasks, as failing to do so could lead to infection control issues and the spread of infections and viruses.During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 9/18/2023, the P&P indicated all personnel shall follow handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol. Before and after contact with the resident. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure one of two residents' rooms (Resident 31's room) were free of insects.This failure had the potential to increase the risk of a bacterial and/or respiratory infection in the residents.Findings:During an observation on 6/9/2026 at 10:57 AM, in Resident 31's room, a brown insect resembling a cockroach was on the floor adjacent to a wall that had cracks and a missing section of the baseboard.During a concurrent observation and interview on 6/9/2026 at 11:19 AM with Maintenance Director (MND) in Resident 31's room, a brown insect was on the floor. The MND stated that routine monthly pest control services had been completed within the past three months and was not aware of any current insect issue.During a concurrent observation and interview on 6/9/2026 at11:22 AM with Infection Preventionist (IP) in Resident 31's room, the insect was on the floor. The IP stated they had never seen any insects in the facility before and acknowledged that such insects pose infectionˆcontrol risks. During a review of the facility's Pest Control Customer Service Reports (PCCSR) dated 3/11/2026, 4/14/2026 and 5/13/2026 the PCCSR indicated that the targeted pests for the pest control services included cockroaches and rats. During an interview on 6/11/26 at 2:04 PM with the Administrator (ADM), the Administrator stated it is important to control the critters and pests in the facility mainly for infection control and for the comfort of the resident. ADM stated a resident can become anxious if there are pests in the facility. The ADM stated that part of the facility's pest control program is to deep clean residents' rooms as needed to ensure a clean environment. The ADM stated that if there are residents who come into the facility with potential bugs, the pest control program ensures that those insects do not spread to the rest of the facility. During a review of the facility's policy and procedure (P&P) titled, Pest Control, the P&P indicated that the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.During a review of the facility's P&P titled, Infection Prevention and Control Program dated 9/18/24, the P&P indicated that an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment. |