STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055316	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Healthcare Center	2530 Solace Place Mountain View, CA 94040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow standards of practice when medications were not given as prescribed for two of three residents (Residents 1 and 2):Resident 1's lamotrigine (a medication used to prevent seizures [uncontrolled jerking, blank stares, and loss of consciousness]) order and administration time was adjusted in the electronic health record (EHR) and lamotrigine was not given to Resident 1 on 10/7/25 and 10/8/25;Resident 2's lacosamide (a medication used to prevent seizures) order was incorrectly duplicated in the EHR and nurses did not administer the correct daily dose to Resident 2 on 10/21/25, 10/22/25, and 10/23/25.These failures resulted in missed medication doses, overmedication, and had the potential to result in health complications. Findings: 1. Review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including epilepsy (uncontrolled electrical disturbance in the brain which can cause seizures). Review of Resident 1's SNF (Skilled Nursing Facility) Orders from the hospital, dated 10/6/25 indicated a list of medications the resident should be taking, which included lamotrigine (a medication used to prevent seizures) 25 milligrams (mg, unit of measurement) Take 2 tablets (50 mg total) by mouth daily at bedtime for 5 days. The orders also indicated Resident 1 was Currently on Week 2 of an up-titration (gradual increase of a medication dose from a low dose to a higher dose) schedule for lamotrigine and indicated the increases to the dosage of lamotrigine over the course of 8 weeks. Review of Resident 1's Clinical Physician Orders indicated an order, dated 10/6/25 Lamotrigine 25 mg Give 2 tablet by mouth at bedtime for seizure for 5 days. The lamotrigine order was discontinued on 10/7/25. Review of Resident 1's Clinical Physician Orders indicated an order, dated 10/7/25 Lamotrigine 25 mg Give 2 tablet by mouth in the morning for seizure for 1 week, with a start date of 10/8/25 at 9 a.m. Review of Resident 1's Progress notes, dated 10/7/25 at 3:01 p.m. indicated Registered Nurse A (RN A) wrote, IFT [Interfacility Transfer] order [admission orders/orders from the hospital] and diagnosis were reviewed with the NP [Nurse Practitioner] and updated and placed as accurate. Review of Resident 1's Encounter Progress Notes written by the NP, dated 10/7/25 indicated, Continue Lamictal [lamotrigine] titrating up recommended by Neurologist . Continue all home medications as reviewed and prescribed by primary care physician and/or Discharging hospital physician as noted in Discharge or Transfer Summary. Review of Resident 1's Medication Administration Record for 10/2025 indicated Resident 1 received lamotrigine 25 mg 2 tablets (50 mg) on 10/6/25 at 9 p.m. There was no documentation that indicated Resident 1 received lamotrigine 25 mg 2 tablets (50 mg) on 10/7/25 and 10/8/25. Review of Resident 1's Physical Therapy (PT) Treatment Encounter Note(s), dated 10/8/25 indicated, The skilled therapeutic activities commenced with the patient consenting between 10:15am-10:30am to engage in therapy while lying in bed . Once in the therapy gym, the patient attempted the Omnicycle [motorized machine used in rehabilitation therapy to increase strength and mobility to arms and/or legs]; however, jerky/dystonic movements [involuntary muscle contractions] were observed getting worse, prompting the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immediate cessation of the activity, and nursing staff was notified. The patient was subsequently wheeled back to the room, transferred back to bed, and placed in a side-lying position with the bed flat after a seizure was identified . Review of Resident 1's Change in Condition Evaluation, dated 10/8/25 indicated, At approximately 1000 [10 a.m.], writer went to administer [Resident 1's] morning medications; however, the [Resident 1] was not in the room. And was attending therapy in the rehab department . At approximately 1050 [10:50 a.m.] the therapist reported that [Resident 1] was experiencing a seizure during the therapy session . 911 was called and [Resident 1] was transferred to [the hospital] . Review of Resident 1's Neurology Consult Note from the hospital , dated 10/8/25 indicated recommendations included, . Facility education re: [regarding] importance of not missing anti-seizure meds and giving ALL as prescribed . During an interview on 10/21/25 at 4:25 p.m., RN A explained how Resident 1's lamotrigine administration time was changed to be given in the morning instead of at bedtime. RN A stated on 10/7/25 she went through the admission orders with the Nurse Practitioner (NP) and adjustments were made. RN A confirmed there was no lamotrigine dose given to Resident 1 on 10/7/25. RN A stated the lamotrigine order was changed on 10/7/25 and the start date was 10/8/25. RN A stated she did not know why the NP decided to change Resident 1's lamotrigine order. During an interview on 12/4/25 at 11:33 p.m., the NP stated usually the facility continues with the hospital medication and does not change it. She stated she was not sure why Resident 1's lamotrigine order was changed. The NP stated she did not put an order to change Resident 1's lamotrigine. During an interview on 12/31/25 at 12:03 p.m. the director of nursing (DON) explained why the lamotrigine dose was not given to Resident 1 on 10/7/25. The DON stated when orders are changed in the EHR, the next dose starts the next day. The DON stated Resident 1's lamotrigine order was scheduled to be given on 10/8/25 at 9 a.m., but it was not given because Resident 1 was taken to therapy. The DON stated nurses can give a medication dose one hour before to one hour after the dose is due. She stated Resident 1 should have received her morning medications on 10/8/25 between 8 a.m. and 10 a.m. During an interview 1/16/26 at 9:46 a.m., the Doctor of Medicine (MD) stated he was not sure why Resident 1's lamotrigine order was changed to be given in the morning. During an interview on 1/16/26 at 1:03 p.m., the consultant pharmacist (CP) stated she called the facility and stated they are unaware as to why the timing of Resident 1's lamotrigine order was changed. The CP stated changes in medication administration timing should be ordered by a provider. 2. Review of Resident 2's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including wedge compression fracture (a type of break in the vertebra [spine] where the broken bone collapses and forms a wedge shape) and epilepsy. Resident 2's record also indicated he was hospitalized from [DATE] to 10/20/25 and readmitted to the facility on [DATE]. Review of Resident 2's SNF Orders from the hospital, dated 10/20/25 indicated he had an order for lacosamide 150 mg tablet Take 1 tablet (150 mg total) by mouth 2 (two) times a day. The orders indicated the last time lacosamide 150 mg was given was 10/20/25 at 9:31 a.m. Review of Resident 2's physician orders indicated he had the following lacosamide orders:Lacosamide Oral Tablet 150 mg Give 1 tablet by mouth two times a day for seizure, start date on 10/21/25 at 8 a.m. Lacosamide Oral Tablet 150 mg Give 1 tablet by mouth every 12 hours for seizures, start date on 10/21/25 at 9 p.m. Review of Resident 2's MAR for October 2025 indicated one lacosamide order was scheduled for the medication to be given at 8 a.m. and 5 p.m. and another lacosmide order was scheduled for the medication to be given at 9 a.m. and 9 p.m. Review of Resident 2's Controlled Drug Record (CDR) for Lacosamide indicated the medication label Lacosamide 150 mg tablet Take 1 tablet (150 mg total) by mouth 2 times a day. Resident 2's CDR indicated Lacosamide 150 mg was given to Resident 2 twice a day from 10/11/25 to 10/16/25. The CDR also indicated Lacosamide 150 mg was given to Resident 2 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once on 10/21/25, three times on 10/22/25, and four times on 10/23/25:10/21/25 at 9:04 a.m.;10/22/25 at 8:40 a.m.;10/22/25 at 5 p.m.;10/22/25 at 9 p.m.; 10/23/25 at 8 a.m.;10/23/25 at 9 a.m.;10/23/25 at 5 p.m.; and 10/23/25 at 9 p.m. Review of Resident 2's Progress Notes, dated 10/23/25 indicated at 6 p.m., Resident 2 complained of dizziness. The notes also indicated at 8 p.m., Resident 2's evening medications were given and at 9 p.m., Resident 2 complained of dizziness and requested to go to the hospital. The notes indicated 911 was called and Resident 2 was transported to the hospital. During an interview and concurrent record review on 12/31/25 at 11:27 a.m., the DON confirmed Resident 2 received Lacosamide 150 mg on 10/21/25 at 9:04 a.m.; 10/22/25 at 8:40 a.m., 5 p.m. and 9 p.m.; 10/23/25 at 8 a.m., 9 a.m., 5 p.m., and 9 p.m. During an interview on 1/16/26 at 11:49 a.m., Licensed Vocational Nurse B (LVN B) stated he does not remember giving Resident 2's lacosamide twice on 10/23/25. LVN B stated Resident 2's lacosamide was supposed to be given once on his shift. He stated he just follows what is in the MAR. During an interview on 1/21/26 at 9:42 a.m., Licensed Vocational Nurse C (LVN C) stated she does not remember giving Resident 2's lacosamide twice on 10/23/25. LVN C stated she was usure of the date, but she remembered transferring Resident 2 to the hospital due to blurry vision and stroke-like symptoms. During an interview on 1/16/26 at 1:03 p.m., the CP stated the maximum daily dose of lacosamide is 400 mg. She stated on 10/23/25 Resident 2 received 600 mg, which is more than the maximum daily dose. The CP stated administering lacosamide over the maximum daily dose predisposes the resident to side effects, including headaches, dizziness, ataxia (poor muscle control), and altered mental status. The CP stated she spoke to the DON to find out why Resident 2 had two lacosamide orders. The CP stated the DON told her the nurse who input the lacosamide order forgot to discontinue the first one. The CP stated it was definitely an error. She stated it looks like nurses can input an order without any oversight and she will recommend providing an education session for nurses to prevent this from happening again. Review of the facility's policy, Administering Medications, revised 4/2019 indicated, Medications are administered in a safe and timely manner, and as prescribed . Ensure that the six rights of medication are followed: a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation .Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time . Administer within 60 minutes prior to or after schedule time unless otherwise ordered by physician.