STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555328	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Valley Post Acute	11680 Warner Avenue Fountain Valley, CA 92708

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was provided with the appropriate respiratory care. * The facility failed to ensure Resident 1's oxygen tubing was changed accordingly. This failure had the potential to lead to respiratory infection and affect the overall health status of Resident 1.Findings: Review of the facility's P&P titled Oxygen Administration (undated) showed the oxygen is administered under orders of the physician. The oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. On 5/14/26 at 1152 hours, Resident 1 was observed wearing a nasal cannula attached to a portable oxygen tank with a setting of three liter per minute. The oxygen tubing was observed with a label dated 4/23/26. Medical record review for Resident 1 was initiated on 5/14/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary Report dated 5/14/26, showed a physician's order dated 5/12/26, to administer oxygen at three liters per minute via nasal cannula every shift for CHF. On 5/14/26 at 1208 hours, RN 1 was called and verified the findings. When RN 1 was asked how often the oxygen tubing was changed, RN 1 stated the facility had an order for the oxygen tubing to be changed every Thursday and as needed. On 5/20/26 at 1235 hours, the Administrator and ADON were informed of the findings.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication errors. * Resident 1 received more than the recommended dose of insulin (medication to lower blood sugar levels) as order by the physician. This failure posed the risk for hypoglycemia (a condition characterized by abnormally low blood sugar) and other health complications for Resident 1.Findings: Review of the facility's P&P titled Insulin Administration revised 3/2025 showed the type of insulin, dosage requirements, strength, and method of administration are verified with the order on the medication sheet and the physician's order before administration. Medical record review for Resident 1 was initiated on 5/14/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 4/14/26, for HumaLog injection solution 100 unit/ml (Insulin Lispro-a prescribed insulin medication used to control high blood sugar for those with diabetes mellittus) to give subcutaneously before meals for DM. Inject as per sliding scale as follows: If BS <70, call the doctor; 70-150 give no insulin; 151-200 = 2 units;201-250 = 4 units;251- 300 = 6 units;301-350 = 8 units;351- 400 = 10 units;BS > 400 = 12 units and call MD. Review of Resident 1's Medication Administration Record for April 2026 showed a documentation of a blood glucose result of 155 and 2 units of insulin Lispro was administered at 1130 hours on 4/23/26. Review of Resident 1's eINTERACT Change in Condition Report dated 4/23/26, showed documentation Resident 1 received the insulin medication over the amount as ordered by the physician. Further review of the nursing addendum showed Resident 1 received four units of insulin Lispro, instead of two units per sliding scale order at 1154 hours on 4/23/26. On 5/14/26 at 1320 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 stated a medication error was made with Resident 1 on 4/23/26. Resident 1 had a blood sugar level of 155 obtained at 1154 hours. Per the sliding scale order, Resident 1 wass to receive two units of Insulin Lispro but instead he received four units. RN 2 stated the resident's physician was made aware immediately and ordered to monitor the resident's blood glucose level every 30 minutes for four hours after the incident. RN 2 further stated she was not able to document the four units administered in the system as it was defaulted to the sliding scale order. When asked what could happen if resident received too much insulin, RN 2 stated it could affect the resident's health and place him at risk for hypoglycemia. On 5/20/26 at 1235 hours, the Administrator and ADON were informed of the findings.