

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to implement their policy on sexual contact between two residents (#7 and #9) who were not adequately assessed for capacity and consent. The deficient practice could allow for ongoing incidents which could lead to harm of a resident.</p> <p>Findings include:</p> <p>-Resident #7 was readmitted to the facility on [DATE], with diagnoses that included peripheral vascular disease, unspecified dementia, anxiety disorder, paroxysmal atrial fibrillation, polyneuropathy, alcohol abuse, tobacco use, and long-term use of anticoagulants.</p> <p>A brief interview for mental status (BIMS) assessment dated [DATE], revealed the resident had a score of 9, indicating the resident had a moderate cognitive impairment.</p> <p>A quarterly MDS (minimum data set) assessment dated [DATE], revealed the resident had a BIMS assessment score of 11, indicating the resident had a moderate cognitive impairment.</p> <p>A BIMS assessment dated [DATE], revealed the resident had a score of 3, indicating severe cognitive impairment.</p> <p>A care plan dated September 16, 2024, revealed Resident #7 had impaired cognitive function/dementia or impaired thought processes due to dementia. Interventions included to communicate with the resident/family/caregivers regarding resident's capabilities and needs, and to ask yes/no questions.</p> <p>The clinical record was reviewed and there was no evidence of a capacity evaluation or a determination of decision-making ability from a physician.</p> <p>A Healthcare (Medical) Power of Attorney (POA) with Mental Health Authority document, dated May 17, 2023, revealed the resident appointed a friend to represent the resident's choices and healthcare decisions in the event that Resident #7 would be unable to communicate wishes and healthcare decisions due to incapacities, or if the resident's doctor determines the resident unable to make healthcare decisions.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035114
		If continuation sheet Page 1 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Alert Note dated December 19, 2024, revealed Resident #7 was noted to be holding hands with a female resident in the TV room. The writer kept close eye on the residents, and noted that both residents are engaged in kissing. The writer redirected the residents multiple times. Residents are both still sitting in TV room conversating and holding hands. Will notify social services and Assistant Director of Nursing (ADON).</p> <p>A Health Status Note dated December 23, 2024, revealed upper management was notified of a possible romantic relationship with another resident. Social services will contact the resident's wife and set a time for a care plan meeting. The residents are being redirected when behavior is noticed and a possible move to another hall is being considered for one resident.</p> <p>A Behavior Note dated December 23, 2024, revealed Resident #7 was noted to be making out with a female resident. The writer tried redirecting the residents several times, but the behavior continued. Resident #7 was noted to have his hand down the female resident's pants and the other hand up her shirt. A call was placed to the ADON who stated to move the female resident to a different hallway and to keep the residents separated. The writer spoke to both residents. Resident #7 stated, ok, and the female resident, just gave a dirty look.</p> <p>A Communication with Resident Note dated December 23, 2024, revealed the ADON came into the building and sat with Resident #7, and spoke with the resident about the behaviors of his hands being inappropriate with a female resident. Resident #7 put his head down and said he agreed that he was not following the building's protocol and apologized for this behavior. The ADON also instructed the resident to not touch other residents while at the facility, and then notified administration of this occurrence as well. The ADON was instructed to separate the residents and have them not on the same hall moving forward. The female resident was moved to the other side of the building and both residents were placed on close monitoring.</p> <p>There was no evidence that the resident's physician was notified regarding the incidents, or to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>-Resident #9 was admitted to the facility October 30, 2024, with diagnoses that included unspecified dementia, schizophrenia, anxiety disorder, major depressive disorder, drug induced subacute dyskinesia, unspecified disorder of adult personality and behavior, aphasia, and other seizures.</p> <p>An admission MDS assessment dated [DATE], revealed that the resident was coded as having clear speech with distinct intelligible words, and the resident's ability to express ideas and wants which was coded as understood. Additionally, the resident was coded as having clear comprehension in the ability to understand others. However, a discrepancy was noted, as the assessment revealed that no the BIMS assessment should not be conducted due to the resident being rarely/never understood. Additionally, in the Staff Assessment for Mental Status, the resident was coded as having, moderately impaired decision-making regarding tasks of daily life, with, decision poor; cues/supervision required.</p> <p>A care plan dated November 12, 2024, revealed that the resident had impaired cognitive function/dementia or impaired thought processes due to dementia, and difficulty making decisions. Interventions included to ask yes/no questions to determine the resident's needs, and communicate with the resident/family regarding the resident's capabilities and needs. Additionally, an intervention was listed that the resident needs assistance with all decision making.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Alert Note dated December 19, 2024, revealed that the resident was noted to be holding hands with a male resident (#7) in the TV room. The writer kept a close eye on the residents, and both residents are engaged in kissing. The staff redirected the residents multiple times, and the residents are both still sitting in the TV room conversating and holding hands. The ADON and social services will be notified.</p> <p>A BIMS evaluation dated December 19, 2024, revealed the resident had a score of 15, indicating intact cognition.</p> <p>There was no evidence of notification to the physician or the resident's POA/representative regarding the incident or to determine the resident's decision-making ability on December 19, 2024.</p> <p>A Health Status Note dated December 23, 2024, revealed the Resident #9's POA was notified of a romantic relationship with another resident. The POA was notified that the facility staff were redirecting the resident when the residents were observed together, but that Resident #9 might have to be moved to another hall. The note revealed the POA was fine with moving her if necessary.</p> <p>A Behavior Note dated December 23, 2024, revealed Resident #9 was noted to be, making out with the male resident (#7). The writer tried to redirect several times, and the male resident was observed with his hands down the female's pants and up her shirt. The ADON was notified, who stated to move Resident #9 to a different hallway. The resident gave the writer a dirty look when escorted to her new room.</p> <p>There was no evidence of communication with the resident's physician regarding the sexual incident on December 23, 2025, to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>An Alert Note dated December 29, 2024 revealed Resident #9 has displayed inappropriate sexual behaviors towards and with other residents this shift, and was observed being physically and verbally inappropriate several times. Staff have attempted to separate patients several times, ineffectively. The resident was medicated for anxiety, which was ineffective. The physician and nursing management were made aware to follow up. No patients were injured and no patients complained about the behavior. The note indicated the writer will communicate with family.</p> <p>A Behavior Note dated December 31, 2024, revealed Resident #9 was caught by a certified nursing assistant (CNA) kissing the male resident (#7) by the nursing station. The resident had her hands down the male resident's pants. Resident #9 was encouraged to go to her side of the building but preferred to stay in the TV room. There was no evidence of physician notification, POA notification, administrative notification, or further assessment to determine decision-making ability or consent from both residents for this incident.</p> <p>On April 1, 2025, a formal request was made to the facility for a log of any reportable events occurring in 2024. The administrator signed a statement that there were none in 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 1, 2025, at 12:40 PM, an interview was conducted with a Licensed Practical Nurse (LPN / Staff #51), who stated she was aware that Resident #7 and Resident #9 had a relationship, and the residents were told by facility staff that they could not see each other anymore. Staff #51 stated that Resident #9 was behavioral and had a POA, and that Resident #7 was not cognitively intact. She stated that the residents were observed being sexually inappropriate in the dining room, and that Resident #9 was moved to another hall, and that staff were told to monitor the residents.</p> <p>An interview was conducted on April 1, 2025, at 1:33 PM, with the Assistant Director of Nursing (ADON / Staff #45) who stated if staff were to notice possible sexual abuse, to report it to the Director of Nursing, to the physician, and remove the resident from the situation. The ADON stated that allegations of sexual abuse must be reported to mandatory sources within 2 hours. The ADON stated that Resident #7 was holding hands with another resident, and that, staff didn't report anything else. Further, she stated that, we did separate them. Additionally, the ADON stated Resident #9 was, very hypersexual, and that she was not sure if the resident was able to make her own decisions; and that, the resident's sister was her POA and decision maker. Also, the ADON stated that, I don't know if any assessments were done on the residents at the time of the incidents, or if the facility investigated the incidents for possible sexual abuse.</p> <p>A telephonic interview was conducted with an LPN (Staff #65) on April 1, 2025, at 2:31 PM who stated that she was familiar with Resident #9 and that, she was behavioral, and flirty with all the gentleman in the building. Staff #65 stated that Resident #9 was following a male resident around the building, and when asked for further details, Staff #65 stated, I don't want to have to repeat myself and, I'm not answering any more questions. The call was ended.</p> <p>A telephonic interview was conducted with an LPN (Staff #29), on April 1, 2025, at 2:35 PM who stated that Resident #7 has cognitively declined over the past several months. Staff #29 stated that she believed Resident #7 and Resident #9 liked each other; and that, they were caught by staff making out, and that facility staff took steps to keep them separated. Staff #29 stated that she reported the incident to management. Staff #29 stated it was in everybody's best interest if we didn't allow that.</p> <p>An interview was conducted with the Administrator (Staff #3) on April 1, 2025, at 3:00 PM who stated that any allegation of sexual abuse is to be reported within 2 hours and needs to be investigated by the administrator, and the residents need to be protected. Staff #3 stated it was his expectation that residents involved in allegations of abuse would not have access to each other during the investigation process; and that, staff would keep them separated to protect them. Additionally, Staff #3 stated that the physician would be notified to assess the residents.</p> <p>A telephonic interview was conducted with the Social Services Director (Staff #17) on April 1, 2025, at 3:27 PM. Staff #17 stated that she was not employed at the facility during the time frame of the sexual incidents between Residents #7 and #9, however she believed Resident #7's wife was his decision maker. She stated she was aware that Resident #7 had sexual behavior with Resident #9. Staff #17 stated that Resident #9 made her own decisions, and that Adult Protective Services (APS) was involved and stepping in to make decisions for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON / Staff #49) on April 1, 2025, at 3:58 PM. The DON stated if a reportable incident occurs, that she would expect staff to notify leadership and notify the administrator, and report to mandatory sources within 2 hours. The DON stated that the importance of reporting is to have an outside unbiased source investigate the incident. Also, if an allegation of abuse occurred, that staff would be expected to report it, and the facility to investigate and determine whether it happened or not. Regarding Residents #7 and #9, the DON stated that there was sexual contact between the two residents, but never any allegations of sexual abuse. The DON stated that the resident' BIMS scores were appropriate and that they were cognitively intact and consenting adults, and that neither resident had a POA. The DON stated that her understanding was that the resident's had rights to have a relationship, but not to demonstrate their sexual behaviors in public places that would make other residents uncomfortable. The DON stated that she did not know if the physician was consulted to make a determination of whether the residents had capacity for decision making and could consent.</p> <p>The BIMS scores of Resident #7 were reviewed, and the DON stated that the resident had scores indicating moderate to severe cognitive impairment. Additionally, the DON reviewed the clinical record for Resident #7 and stated that a friend was listed as medical POA, and that the DON could not see any note that the POA was contacted for Resident #7 at the start of the incidents. Additionally, the DON stated she could not find any assessment determining ability for decision making from a physician for Resident #7. Further, the DON reviewed the clinical record for Resident #9, and stated that there was a POA listed, and that she did not see any note indicating that the physician or POA were consulted on December 19, 2024 regarding the sexual incidents. The DON stated that she did not believe the facility reported the incident as an allegation of possible sexual abuse, and that she did not know if the facility conducted an investigation. The DON stated that the incidents should have been investigated to determine the residents' decision-making ability and consent.</p> <p>Review of the facility policy titled Abuse Prevention Program, revised September 2021, revealed the facility will not tolerate verbal, sexual, physical and mental abuse. The objective of the policy is to develop and implement a system for identifying, investigating, preventing and reporting any incident, or suspected incident, of abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. All witnessed or suspected events as defined by this policy are to be reported regardless of who is involved or suspected. Abusive examples include various forms of sexual abuse including rape, forced sexual acts, fondling, and sexual harassment. If an incident occurs, or there is an allegation that an incident might have occurred of abuse, the Administrator, or designee will investigate. The person doing the investigation will complete a Resident Abuse/Neglect Investigation Report. The administrator will sign and maintain all reports, and findings will be reported according to state requirements.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to report to the state agency that two residents (#7 and #9) who were not adequately assessed for capacity and consent had sexual contact. The deficient practice could allow for ongoing incidents not being reported which could lead to harm.</p> <p>Findings include:</p> <p>-Resident #7 was readmitted to the facility on [DATE], with diagnoses that included peripheral vascular disease, unspecified dementia, anxiety disorder, paroxysmal atrial fibrillation, polyneuropathy, alcohol abuse, tobacco use, and long-term use of anticoagulants.</p> <p>A brief interview for mental status (BIMS) assessment dated [DATE], revealed the resident had a score of 9, indicating the resident had a moderate cognitive impairment.</p> <p>A quarterly MDS (minimum data set) assessment dated [DATE], revealed the resident had a BIMS assessment score of 11, indicating the resident had a moderate cognitive impairment.</p> <p>A BIMS assessment dated [DATE], revealed the resident had a score of 3, indicating severe cognitive impairment.</p> <p>A care plan dated September 16, 2024, revealed Resident #7 had impaired cognitive function/dementia or impaired thought processes due to dementia. Interventions included to communicate with the resident/family/caregivers regarding resident's capabilities and needs, and to ask yes/no questions.</p> <p>The clinical record was reviewed and there was no evidence of a capacity evaluation or a determination of decision-making ability from a physician.</p> <p>A Healthcare (Medical) Power of Attorney (POA) with Mental Health Authority document, dated May 17, 2023, revealed the resident appointed a friend to represent the resident's choices and healthcare decisions in the event that Resident #7 would be unable to communicate wishes and healthcare decisions due to incapacities, or if the resident's doctor determines the resident unable to make healthcare decisions.</p> <p>An Alert Note dated December 19, 2024, revealed Resident #7 was noted to be holding hands with a female resident in the TV room. The writer kept close eye on the residents, and noted that both residents are engaged in kissing. The writer redirected the residents multiple times. Residents are both still sitting in TV room conversating and holding hands. Will notify social services and Assistant Director of Nursing (ADON).</p> <p>A Health Status Note dated December 23, 2024, revealed upper management was notified of a possible romantic relationship with another resident. Social services will contact the resident's wife and set a time for a care plan meeting. The residents are being redirected when behavior is noticed and a possible move to another hall is being considered for one resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Behavior Note dated December 23, 2024, revealed Resident #7 was noted to be making out with a female resident. The writer tried redirecting the residents several times, but the behavior continued. Resident #7 was noted to have his hand down the female resident's pants and the other hand up her shirt. A call was placed to the ADON who stated to move the female resident to a different hallway and to keep the residents separated. The writer spoke to both residents. Resident #7 stated, ok, and the female resident, just gave a dirty look.</p> <p>A Communication with Resident Note dated December 23, 2024, revealed the ADON came into the building and sat with Resident #7, and spoke with the resident about the behaviors of his hands being inappropriate with a female resident. Resident #7 put his head down and said he agreed that he was not following the building's protocol and apologized for this behavior. The ADON also instructed the resident to not touch other residents while at the facility, and then notified administration of this occurrence as well. The ADON was instructed to separate the residents and have them not on the same hall moving forward. The female resident was moved to the other side of the building and both residents were placed on close monitoring.</p> <p>There was no evidence that the resident's physician was notified regarding the incidents, or to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>-Resident #9 was admitted to the facility October 30, 2024, with diagnoses that included unspecified dementia, schizophrenia, anxiety disorder, major depressive disorder, drug induced subacute dyskinesia, unspecified disorder of adult personality and behavior, aphasia, and other seizures.</p> <p>An admission MDS assessment dated [DATE], revealed that the resident was coded as having clear speech with distinct intelligible words, and the resident's ability to express ideas and wants which was coded as understood. Additionally, the resident was coded as having clear comprehension in the ability to understand others. However, a discrepancy was noted, as the assessment revealed that no the BIMS assessment should not be conducted due to the resident being rarely/never understood. Additionally, in the Staff Assessment for Mental Status, the resident was coded as having, moderately impaired decision-making regarding tasks of daily life, with, decision poor; cues/supervision required.</p> <p>A care plan dated November 12, 2024, revealed that the resident had impaired cognitive function/dementia or impaired thought processes due to dementia, and difficulty making decisions. Interventions included to ask yes/no questions to determine the resident's needs, and communicate with the resident/family regarding the resident's capabilities and needs. Additionally, an intervention was listed that the resident needs assistance with all decision making.</p> <p>An Alert Note dated December 19, 2024, revealed that the resident was noted to be holding hands with a male resident (#7) in the TV room. The writer kept a close eye on the residents, and both residents are engaged in kissing. The staff redirected the residents multiple times, and the residents are both still sitting in the TV room conversating and holding hands. The ADON and social services will be notified.</p> <p>A BIMS evaluation dated December 19, 2024, revealed the resident had a score of 15, indicating intact cognition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidence of notification to the physician or the resident's POA/representative regarding the incident or to determine the resident's decision-making ability on December 19, 2024.</p> <p>A Health Status Note dated December 23, 2024, revealed the Resident #9's POA was notified of a romantic relationship with another resident. The POA was notified that the facility staff were redirecting the resident when the residents were observed together, but that Resident #9 might have to be moved to another hall. The note revealed the POA was fine with moving her if necessary.</p> <p>A Behavior Note dated December 23, 2024, revealed Resident #9 was noted to be, making out with the male resident (#7). The writer tried to redirect several times, and the male resident was observed with his hands down the female's pants and up her shirt. The ADON was notified, who stated to move Resident #9 to a different hallway. The resident gave the writer a dirty look when escorted to her new room.</p> <p>There was no evidence of communication with the resident's physician regarding the sexual incident on December 23, 2025, to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>An Alert Note dated December 29, 2024 revealed Resident #9 has displayed inappropriate sexual behaviors towards and with other residents this shift, and was observed being physically and verbally inappropriate several times. Staff have attempted to separate patients several times, ineffectively. The resident was medicated for anxiety, which was ineffective. The physician and nursing management were made aware to follow up. No patients were injured and no patients complained about the behavior. The note indicated the writer will communicate with family.</p> <p>A Behavior Note dated December 31, 2024, revealed Resident #9 was caught by a certified nursing assistant (CNA) kissing the male resident (#7) by the nursing station. The resident had her hands down the male resident's pants. Resident #9 was encouraged to go to her side of the building but preferred to stay in the TV room. There was no evidence of physician notification, POA notification, administrative notification, or further assessment to determine decision-making ability or consent from both residents for this incident.</p> <p>On April 1, 2025, a formal request was made to the facility for a log of any reportable events occurring in 2024. The administrator signed a statement that there were none in 2024.</p> <p>On April 1, 2025, at 12:40 PM, an interview was conducted with a Licensed Practical Nurse (LPN / Staff #51), who stated she was aware that Resident #7 and Resident #9 had a relationship, and the residents were told by facility staff that they could not see each other anymore. Staff #51 stated that Resident #9 was behavioral and had a POA, and that Resident #7 was not cognitively intact. She stated that the residents were observed being sexually inappropriate in the dining room, and that Resident #9 was moved to another hall, and that staff were told to monitor the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on April 1, 2025, at 1:33 PM, with the Assistant Director of Nursing (ADON / Staff #45) who stated if staff were to notice possible sexual abuse, to report it to the Director of Nursing, to the physician, and remove the resident from the situation. The ADON stated that allegations of sexual abuse must be reported to mandatory sources within 2 hours. The ADON stated that Resident #7 was holding hands with another resident, and that, staff didn't report anything else. Further, she stated that, we did separate them. Additionally, the ADON stated Resident #9 was, very hypersexual, and that she was not sure if the resident was able to make her own decisions; and that, the resident's sister was her POA and decision maker. Also, the ADON stated that, I don't know if any assessments were done on the residents at the time of the incidents, or if the facility investigated the incidents for possible sexual abuse.</p> <p>A telephonic interview was conducted with an LPN (Staff #65) on April 1, 2025, at 2:31 PM who stated that she was familiar with Resident #9 and that, she was behavioral, and flirty with all the gentleman in the building. Staff #65 stated that Resident #9 was following a male resident around the building, and when asked for further details, Staff #65 stated, I don't want to have to repeat myself and, I'm not answering any more questions. The call was ended.</p> <p>A telephonic interview was conducted with an LPN (Staff #29), on April 1, 2025, at 2:35 PM who stated that Resident #7 has cognitively declined over the past several months. Staff #29 stated that she believed Resident #7 and Resident #9 liked each other; and that, they were caught by staff making out, and that facility staff took steps to keep them separated. Staff #29 stated that she reported the incident to management. Staff #29 stated it was in everybody's best interest if we didn't allow that.</p> <p>An interview was conducted with the Administrator (Staff #3) on April 1, 2025, at 3:00 PM who stated that any allegation of sexual abuse is to be reported within 2 hours and needs to be investigated by the administrator, and the residents need to be protected. Staff #3 stated it was his expectation that residents involved in allegations of abuse would not have access to each other during the investigation process; and that, staff would keep them separated to protect them. Additionally, Staff #3 stated that the physician would be notified to assess the residents.</p> <p>A telephonic interview was conducted with the Social Services Director (Staff #17) on April 1, 2025, at 3:27 PM. Staff #17 stated that she was not employed at the facility during the time frame of the sexual incidents between Residents #7 and #9, however she believed Resident #7's wife was his decision maker. She stated she was aware that Resident #7 had sexual behavior with Resident #9. Staff #17 stated that Resident #9 made her own decisions, and that Adult Protective Services (APS) was involved and stepping in to make decisions for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON / Staff #49) on April 1, 2025, at 3:58 PM. The DON stated if a reportable incident occurs, that she would expect staff to notify leadership and notify the administrator, and report to mandatory sources within 2 hours. The DON stated that the importance of reporting is to have an outside unbiased source investigate the incident. Also, if an allegation of abuse occurred, that staff would be expected to report it, and the facility to investigate and determine whether it happened or not. Regarding Residents #7 and #9, the DON stated that there was sexual contact between the two residents, but never any allegations of sexual abuse. The DON stated that the resident' BIMS scores were appropriate and that they were cognitively intact and consenting adults, and that neither resident had a POA. The DON stated that her understanding was that the resident's had rights to have a relationship, but not to demonstrate their sexual behaviors in public places that would make other residents uncomfortable. The DON stated that she did not know if the physician was consulted to make a determination of whether the residents had capacity for decision making and could consent.</p> <p>The BIMS scores of Resident #7 were reviewed, and the DON stated that the resident had scores indicating moderate to severe cognitive impairment. Additionally, the DON reviewed the clinical record for Resident #7 and stated that a friend was listed as medical POA, and that the DON could not see any note that the POA was contacted for Resident #7 at the start of the incidents. Additionally, the DON stated she could not find any assessment determining ability for decision making from a physician for Resident #7. Further, the DON reviewed the clinical record for Resident #9, and stated that there was a POA listed, and that she did not see any note indicating that the physician or POA were consulted on December 19, 2024 regarding the sexual incidents. The DON stated that she did not believe the facility reported the incident as an allegation of possible sexual abuse, and that she did not know if the facility conducted an investigation. The DON stated that the incidents should have been investigated to determine the residents' decision-making ability and consent.</p> <p>Review of the facility policy titled Abuse Prevention Program, revised September 2021, revealed the facility will not tolerate verbal, sexual, physical and mental abuse. The objective of the policy is to develop and implement a system for identifying, investigating, preventing and reporting any incident, or suspected incident, of abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. All witnessed or suspected events as defined by this policy are to be reported regardless of who is involved or suspected. Abusive examples include various forms of sexual abuse including rape, forced sexual acts, fondling, and sexual harassment. If an incident occurs, or there is an allegation that an incident might have occurred of abuse, the Administrator, or designee will investigate. The person doing the investigation will complete a Resident Abuse/Neglect Investigation Report. The administrator will sign and maintain all reports, and findings will be reported according to state requirements. If the events that cause the allegation involve abuse, a report must be made to the state survey agency and local law enforcement, immediately and not later than 2 hours after receiving the allegation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to investigate sexual contact between two residents (#7 and #9) who were not adequately assessed for capacity and consent. The deficient practice could allow for ongoing incidents of sexual abuse, which could lead to harm of a resident.</p> <p>Findings include:</p> <p>-Resident #7 was readmitted to the facility on [DATE], with diagnoses that included peripheral vascular disease, unspecified dementia, anxiety disorder, paroxysmal atrial fibrillation, polyneuropathy, alcohol abuse, tobacco use, and long-term use of anticoagulants.</p> <p>A brief interview for mental status (BIMS) assessment dated [DATE], revealed the resident had a score of 9, indicating the resident had a moderate cognitive impairment.</p> <p>A quarterly MDS (minimum data set) assessment dated [DATE], revealed the resident had a BIMS assessment score of 11, indicating the resident had a moderate cognitive impairment.</p> <p>A BIMS assessment dated [DATE], revealed the resident had a score of 3, indicating severe cognitive impairment.</p> <p>A care plan dated September 16, 2024, revealed Resident #7 had impaired cognitive function/dementia or impaired thought processes due to dementia. Interventions included to communicate with the resident/family/caregivers regarding resident's capabilities and needs, and to ask yes/no questions.</p> <p>The clinical record was reviewed and there was no evidence of a capacity evaluation or a determination of decision-making ability from a physician.</p> <p>A Healthcare (Medical) Power of Attorney (POA) with Mental Health Authority document, dated May 17, 2023, revealed the resident appointed a friend to represent the resident's choices and healthcare decisions in the event that Resident #7 would be unable to communicate wishes and healthcare decisions due to incapacities, or if the resident's doctor determines the resident unable to make healthcare decisions.</p> <p>An Alert Note dated December 19, 2024, revealed Resident #7 was noted to be holding hands with a female resident in the TV room. The writer kept close eye on the residents, and noted that both residents are engaged in kissing. The writer redirected the residents multiple times. Residents are both still sitting in TV room conversating and holding hands. Will notify social services and Assistant Director of Nursing (ADON).</p> <p>A Health Status Note dated December 23, 2024, revealed upper management was notified of a possible romantic relationship with another resident. Social services will contact the resident's wife and set a time for a care plan meeting. The residents are being redirected when behavior is noticed and a possible move to another hall is being considered for one resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Behavior Note dated December 23, 2024, revealed Resident #7 was noted to be making out with a female resident. The writer tried redirecting the residents several times, but the behavior continued. Resident #7 was noted to have his hand down the female resident's pants and the other hand up her shirt. A call was placed to the ADON who stated to move the female resident to a different hallway and to keep the residents separated. The writer spoke to both residents. Resident #7 stated, ok, and the female resident, just gave a dirty look.</p> <p>A Communication with Resident Note dated December 23, 2024, revealed the ADON came into the building and sat with Resident #7, and spoke with the resident about the behaviors of his hands being inappropriate with a female resident. Resident #7 put his head down and said he agreed that he was not following the building's protocol and apologized for this behavior. The ADON also instructed the resident to not touch other residents while at the facility, and then notified administration of this occurrence as well. The ADON was instructed to separate the residents and have them not on the same hall moving forward. The female resident was moved to the other side of the building and both residents were placed on close monitoring.</p> <p>There was no evidence that the resident's physician was notified regarding the incidents, or to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>Regarding Resident #9:</p> <p>Resident #9 was admitted to the facility October 30, 2024, with diagnoses that included unspecified dementia, schizophrenia, anxiety disorder, major depressive disorder, drug induced subacute dyskinesia, unspecified disorder of adult personality and behavior, aphasia, and other seizures.</p> <p>An admission MDS assessment dated [DATE], revealed the resident was coded as having clear speech with distinct intelligible words, and the resident's ability to express ideas and wants was coded as understood. Additionally, the resident was coded as having clear comprehension in the ability to understand others. However, a discrepancy was noted, as the assessment revealed that no the BIMS assessment should not be conducted due to the resident being rarely/never understood. Additionally, in the Staff Assessment for Mental Status, the resident was coded as having moderately impaired decision-making regarding tasks of daily life, with decision poor; cues/supervision required.</p> <p>A care plan dated November 12, 2024, revealed the resident has impaired cognitive function/dementia or impaired thought processes due to dementia, and difficulty making decisions. Interventions included to ask yes/no questions to determine the resident's needs, and communicate with the resident/family regarding the resident's capabilities and needs. Additionally, an intervention was listed that the resident needs assistance with all decision making.</p> <p>An Alert Note dated December 19, 2024, revealed the resident was noted to be holding hands with a male resident (#7) in the TV room. The writer kept a close eye on the residents, and both residents are engaged in kissing. The staff redirected the residents multiple times, and the residents are both still sitting in the TV room conversating and holding hands. The ADON and social services will be notified.</p> <p>A BIMS evaluation dated December 19, 2024, revealed the resident had a score of 15, indicating intact cognition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidence of notification to the physician or the resident's POA/representative regarding the incident or to determine the resident's decision-making ability on December 19, 2024.</p> <p>A Health Status Note dated December 23, 2024, revealed the Resident #9's POA was notified of a romantic relationship with another resident. The POA was notified that the facility staff were redirecting the resident when the residents were observed together, but that Resident #9 might have to be moved to another hall. The note revealed the POA was fine with moving her if necessary.</p> <p>A Behavior Note dated December 23, 2024, revealed Resident #9 was noted to be making out with the male resident (#7). The writer tried to redirect several times, and the male resident was observed with his hands down the female's pants and up her shirt. The ADON was notified, who stated to move Resident #9 to a different hallway. The resident gave the writer a dirty look when escorted to her new room.</p> <p>There was no evidence of communication with the resident's physician regarding the sexual incident on December 23, 2025, to determine the resident's decision-making ability, or that assessment was conducted to determine that the sexual contact was consensual.</p> <p>An Alert Note dated December 29, 2024 revealed Resident #9 has displayed inappropriate sexual behaviors towards and with other residents this shift, and was observed being physically and verbally inappropriate several times. Staff have attempted to separate patients several times, ineffectively. The resident was medicated for anxiety, which was ineffective. The physician and nursing management were made aware to follow up. No patients were injured and no patients complained about the behavior. The note indicated the writer will communicate with family.</p> <p>A Behavior Note dated December 31, 2024, revealed Resident #9 was caught by a certified nursing assistant (CNA) kissing the male resident (#7) by the nursing station. The resident had her hands down the male resident's pants. Resident #9 was encouraged to go to her side of the building but preferred to stay in the TV room. There was no evidence of physician notification, POA notification, administrative notification, or further assessment to determine decision-making ability or consent from both residents for this incident.</p> <p>On April 1, 2025, a formal request was made to the facility for a log of any reportable events occurring in 2024. The administrator signed a statement that there were none in 2024.</p> <p>On April 1, 2025, at 12:40 PM, an interview was conducted with a Licensed Practical Nurse (LPN / Staff #51), who stated she was aware that Resident #7 and Resident #9 had a relationship, and the residents were told by facility staff that they could not see each other anymore. Staff #51 stated that Resident #9 was behavioral and had a POA, and that Resident #7 was not cognitively intact. She stated that the residents were observed being sexually inappropriate in the dining room, and that Resident #9 was moved to another hall, and that staff were told to monitor the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on April 1, 2025, at 1:33 PM, with the Assistant Director of Nursing (ADON / Staff #45) who stated if staff were to notice possible sexual abuse, to report it to the Director of Nursing, to the physician, and remove the resident from the situation. The ADON stated that Resident #7 was holding hands with another resident, and that staff didn't report anything else. Further, she stated that we did separate them. Additionally, the ADON stated Resident #9 was very hypersexual, and that she was not sure if the resident was able to make her own decisions, and that the resident's sister was her POA and decision maker. Also, the ADON stated that I don't know if any assessments were done on the residents at the time of the incidents, or if the facility investigated the incidents for possible sexual abuse.</p> <p>A telephonic interview was conducted with an LPN (Staff #65) on April 1, 2025, at 2:31 PM. Staff #65 stated that she was familiar with Resident #9 and that she was behavioral, and flirty with all the gentleman in the building. Staff #65 stated that Resident #9 was following a male resident around the building, and when asked for further details, Staff #65 stated I don't want to have to repeat myself and I'm not answering any more questions. The call was ended.</p> <p>A telephonic interview was conducted with an LPN (Staff #29), on April 1, 2025, at 2:35 PM. Staff #29 stated that Resident #7 has had a cognitive decline over the past several months. Staff #29 stated that she believed Resident #7 and Resident #9 liked each other and that they were caught by staff making out, and that facility staff took steps to keep them separated. Staff #29 stated that she reported the incident to management and that staff separated the residents. Staff #29 stated it was in everybody's best interest if we didn't allow that.</p> <p>An interview was conducted with the Administrator (Staff #3) on April 1, 2025, at 3:00 PM. Staff #3 stated that any allegation of sexual abuse needs to be investigated by the administrator, and the residents need to be protected from further abuse. Staff #3 stated it was his expectation that residents involved in allegations of abuse would not have access to each other during the investigation process, and that staff would keep them separated to protect them. Additionally, that the physician would be notified to assess the residents. Staff #3 stated he was not aware of any allegations of sexual abuse regarding Resident #7. He stated he was aware that Resident #7 was trying to be more than friends with another resident, and that she was fond of him, but that Staff #3 did not know who the female resident was.</p> <p>A telephonic interview was conducted with the Social Services Director (Staff #17) on April 1, 2025, at 3:27 PM. Staff #17 stated that the sexual contact between Resident #7 and #9 was consensual and that the residents were coherent enough to make their own decisions, and that is why the facility decided not to call it sexual abuse.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #49) on April 1, 2025, at 3:58 PM. The DON stated if an allegation of abuse occurred, that staff would be expected to report it, and the facility to investigate and determine whether it happened or not. Regarding Residents #7 and #9, the DON stated that there was sexual contact between the two residents, but never any allegations of sexual abuse. The DON stated that the resident' BIMS scores were appropriate and that they were cognitively intact and consenting adults, and that neither resident had a POA. The DON stated that she did not know if the physician was consulted to make a determination of whether the residents had capacity for decision making and could consent.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The interview with the DON continued and the BIMS scores of Resident #7 were reviewed, and the DON stated that the resident had scores indicating moderate to severe cognitive impairment. Additionally, the DON reviewed the clinical record for Resident #7 and stated that a friend was listed as medical POA, and that the DON could not see any note that the POA was contacted for Resident #7 at the start of the incidents. Additionally, the DON stated she could not find any assessment determining ability for decision making from a physician for Resident #7. Further, the DON reviewed the clinical record for Resident #9, and stated that there was a POA listed, and that she did not see any note indicating that the physician or POA were consulted on December 19, 2024 regarding the sexual incidents. The DON stated that she did not know if the facility conducted an investigation on the incident. The DON stated that the incidents should have been investigated to determine the residents' decision-making ability and consent.</p> <p>Review of the facility policy titled Abuse Prevention Program, revised September 2021, revealed the facility will not tolerate verbal, sexual, physical and mental abuse. The objective of the policy is to develop and implement a system for identifying, investigating, preventing and reporting any incident, or suspected incident, of abuse. Sexual abuse is non-consensual sexual contact of any type with a resident. All witnessed or suspected events as defined by this policy are to be reported regardless of who is involved or suspected. Abusive examples include various forms of sexual abuse including rape, forced sexual acts, fondling, and sexual harassment. If an incident occurs, or there is an allegation that an incident might have occurred of abuse, the Administrator, or designee will investigate. The person doing the investigation will complete a Resident Abuse/Neglect Investigation Report. The administrator will sign and maintain all reports, and findings will be reported according to state requirements. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in process. The results of all investigations must be reported to officials in accordance with State law within 5 working days of the incident.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#7) was free from an accident of elopement. The deficient practice could lead to accidents resulting in harm to residents.</p> <p>Findings include:</p> <p>Resident #7 was readmitted to the facility on [DATE], with diagnoses that included peripheral vascular disease, unspecified dementia, anxiety disorder, paroxysmal atrial fibrillation, polyneuropathy, alcohol abuse, tobacco use, and long-term use of anticoagulants.</p> <p>The clinical record was reviewed and there was no evidence of an elopement risk assessment upon re-admission in October 2023 for Resident #7.</p> <p>An Elopement Risk Tool dated January 13, 2024, revealed, No the resident does not display cognitive deficits, disorientation, intermittent confusion, or any other cognitive impairments that contribute to poor decision making skills.</p> <p>A quarterly MDS (minimum data set) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) assessment score of 11, indicating the resident had a moderate cognitive impairment.</p> <p>An additional BIMS assessment dated [DATE], at 10:21 AM, revealed the resident had a score of 3, indicating the resident was severely cognitively impaired.</p> <p>There was no evidence of a re-assessment of the resident's elopement risk with the resident's decline in cognitive status.</p> <p>A progress note dated March 25, 2025, at 1:05 AM, revealed facility staff were, unable to locate resident, and a search was started by facility staff. The resident was found outside, on the opposite side of the parking lot, on the ground, away from his wheelchair. The resident stated that he went to smoke a cigarette. The resident was assessed, and was brought back in the facility. The resident had a new cut over the right eye and a small abrasion to the right ankle and foot.</p> <p>An Elopement Evaluation dated March 25, 2025, at 2:12 AM, revealed that the resident scored 1.0, indicating the resident was at risk of elopement.</p> <p>A care plan dated March 25, 2025, revealed Resident #7 was an elopement risk due to disorientation to place and impaired safety awareness, with an intervention to assess for fall risk, identify pattern of wandering, and monitor for fatigue and weight loss.</p> <p>There was no evidence of a care plan for elopement risk prior to March 25, 2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 1, 2025, a formal request was made to the facility for any elopement risk assessments for Resident #7 prior to March 25, 2025. The administrator signed a statement that there were none.</p> <p>An observation was conducted with the Administrator (Staff #3) on April 1, 2025, at 2:56 PM, the administrator indicated the spot in the parking lot where Resident #7 was found during the elopement incident, and estimated that the distance the resident had traveled from the door to where he was found lying down was approximately 50 to 100 feet.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA / Staff #22) on April 1, 2025, at 12:31 PM who stated that the facility's process for monitoring residents for elopement or wandering is that if the staff know a resident is a wanderer, then closely monitor the resident or place an additional staff member with the resident. Staff #22 stated that this is usually communicated through verbal report. Staff #22 stated that she was notified after the incident of Resident #7's elopement that the 300 hall door was not locking, and that now it is locked. Staff #22 stated that she believed she saw repairs being done to the door today. Regarding Resident #7's elopement, Staff #22 states that she was informed that a resident had gotten out of the building, a couple minutes, and that she was instructed not to use the 300 hall door. Staff #22 stated that normally, that door is locked at all times and you need a code to open the door. After the incident, on March 25, 2025, there was a staff meeting, and Staff #22 was informed that whoever had used that door must not have shut it all the way, and all staff were instructed not to use that door.</p> <p>On April 1, 2025, at 12:40 PM, an interview was conducted with a Licensed Practical Nurse (LPN / Staff #51), who stated the facility's process for assessing a resident's risk for elopement is for nursing staff to complete an elopement assessment. Staff #51 stated that the facility does the elopement assessment for each resident on admission; and that, it is also triggered to complete periodically. Staff #51 stated that facility staff perform frequent checks on residents, and are alerted to which residents have wandering behaviors, and this is communicated during verbal report. Staff #51 stated that every exterior door in the facility is a locked door that requires a code to open. Staff #51 stated that about a week ago, Resident #7 had an incident of elopement. She stated that she was the day shift nurse on March 24, 2025; and that, the incident happened later that day after her shift was over. She stated that she noticed the resident was more active that day, and that he was up in his wheelchair. She stated that she came to work on March 25, 2025, and heard about the incident at the staff meeting that day; and that, she was informed Resident #7 had gotten out of the facility and fallen. She stated staff were instructed not to use the 300 hall door because a resident had gotten out, and that the staff were checking the door.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on April 1, 2025, at 1:33 PM, with the Assistant Director of Nursing (ADON / Staff #45) who stated that the facility had a screening process to assess resident's for elopement risk; and that, the assessment gives a score, and the resident's care plan is adjusted according to the risk score. The ADON stated that if a resident were to have an elopement incident, that the facility staff must locate the resident, notify the provider and responsible parties, the nurse reports to the director of nursing, and the interdisciplinary team would investigate the incident. Regarding Resident #7's elopement incident, Staff #45 stated that she received a text message at 12:33 AM from the floor nurse that the resident fell on pavement, during night shift between March 24-25, 2025. The ADON stated she did not receive a response, when she questioned the nurse further regarding the incident. The ADON stated she came to work the following morning around 8:30 AM, and was told that the resident had gotten out of the 300 hall coded door, and that staff found the resident approximately 30 minutes after they had last rounded on the resident. Staff #45 stated that the administrator was completing the investigation into the incident to see what happened with the door. Regarding Resident #7, the ADON stated she was told, he scratched his face when he fell in the parking lot. The clinical record was reviewed together and the ADON stated that she could not see any elopement risk assessments completed for Resident #7 prior to the incident.</p> <p>A telephonic interview was conducted with an LPN (Staff #29), on April 1, 2025, at 2:35 PM who stated that she was Resident #7's nurse on the night of the incident; and that, she noticed the resident had a cognitive decline over the past few months. Staff #29 stated that recently, Resident #7 had been spending more time in bed, however on the date of the incident, the resident had been more active and had been, going around the building, and walking around the halls by his bedroom. Staff #29 stated that night, the staff had noticed approximately 15 minutes after rounding on the resident, that he was unable to be located. Staff #29 sent the 100 hall nurse outside to search for the resident, and that is where the resident was found. Staff #29 stated that at the back of the facility parking lot, there is a space between the facility's parking lot and the apartment next door, where the resident was laying, and his wheelchair was still on the pavement. The resident had a laceration above his eye, and Staff #29 did an assessment and noted no other injuries. Staff #29 stated she informed the provider, the facility management, and the resident's responsible party.</p> <p>An interview was conducted with the Administrator (Staff #3) on April 1, 2025, at 3:00 PM who stated that he was informed of Resident #7's elopement incident on March 25, 2025, at approximately 7:00 AM, and that the resident had gotten out the 300 hall door. Since the incident, Staff #3 stated that the facility has ordered alarms for the doors, and that a door repairman had replaced the magnets on the door that were starting to give. The administrator also stated that a staff or visitor could have used the door and the wind could have kept it open. Additionally, since the incident, visitors and staff had been instructed to use an alternate door. Staff #3 stated that his expectation for staff is to look at things all the time to make sure accidents are preventable. Also, Staff #3 stated that he did an in-service with staff on reporting incidents right away.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1045 Sandretto Drive Prescott, AZ 86305	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON / Staff #49) on April 1, 2025, at 3:58 PM. The DON stated her expectation for the facility preventing accidents is that staff do everything they can immediately to address items that are identified. The DON stated the facility screens residents for elopement risk to try to prevent incidents, on admission and quarterly on the MDS assessment. If there was a significant change in a resident, then staff would try to arrange a care plan to address the changes. The DON stated that regarding Resident #7's incident, that staff had rounded on the resident around 11:30 PM on March 24, 2025, and about 15 minutes later the resident was unable to be located. The DON stated the resident was located in the rear parking lot, and that the resident was assessed for injury and brought back inside the building with all responsible parties notified. The DON stated that she is aware the resident is cognitively impaired and has had a decline in his health recently. The DON stated that the door was assessed, and it was determined that the magnet holding the top of the door started to fail, and that likely somebody went through the door and failed to double check that the door closed properly. The DON stated that the facility replaced the magnet for the door.</p> <p>Review of the facility policy titled Elopement Precautions / Missing Resident, revised 2007, revealed the objective of the policy is the prevention of residents leaving facility without supervision when assessed to be an elopement risk and measures to take when a resident is found missing. All residents at the time of admission will be identified as an elopement risk if it is reported that there has been elopement incidents in the prior living arrangement. Any resident that demonstrates or verbalizes elopement will immediately be considered an elopement risk and immediate care interventions will be adopted to prevent unplanned elopement. If a resident is found to be an elopement risk and if the facility has a Special Care Unit, placement of the resident in the unit will be considered. If the resident demonstrates behaviors that cause the facility to believe the resident is at significant risk, the resident may be placed in the unit until further notification of physician, family, legal authority, and case worker, if applicable, can be made and a more permanent interdisciplinary team decision can be determined. For facilities that do not have a Special Care Unit, or for areas of the facility outside of the Special Care Unit in order to manage residents in the general facility population and assure the safe whereabouts of each resident at all times, the following physical plant features are to be in place: All exit doors from the facility that are not under direct observation shall be alarmed. In this facility, the following doors are alarmed: all exit doors are alarmed. Additionally, exit doors that are not alarmed are to remain under direct observation when there is any resident in the facility deemed to be an elopement risk in this facility, the following doors remain unsecured and without alarm with direct observation: Include which doors, how direct observation is provided, hours doors are unsecured and observed, and how periods of time when assigned individual is not available, the observation continues.</p>		