STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035114	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50116 Based on observation, clinical record review, facility documentation, and staff interviews, the facility failed to ensure that adequate supervision was provided to prevent one resident (#3) from wandering into other resident rooms. The deficient practice may result in higher liklihood of wandering and reduced safety for the residents. Findings include: -Resident #3 was admitted to the facility on [DATE] with diagnoses including Traumatic hemorrhage of left cerebrum, delirium due to known physiological condition, other symptoms and signs involving cognitive functions and awareness. A review of the minimum data set (MDS) dated [DATE] revealed a brief interview mental status (BIMS) score of 08, indicating that the resident had moderate cognitive impairment. A review of the resident's care plan initiated April 03, 2025 revealed a focus that the resident was an elopement risk/wanderer related to disoriented to place. History of attempts to leave facility unattended. Impaired safety awareness, entering other resident rooms. Interventions that were initiated on April 03, 2025 included distract resident from wandering by offering pleasant diversions, structed activities, food, conversation, television, book. Resident #3's triggers for wandering/eloping are wants to go to his car, the behaviors are de-escalated by redirection, snacks and TV (westerns). Identify patterns of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. The final intervention was added on April 04, 2025 and was monitor location every 15 minutes, document wandering behavior and attempted diversional interventions in behavior log. -Resident #1 was admitted to the facility on [DATE] with diagnoses including wedge compression fracture of first lumbar vertebra, low back pain, difficulty walking, and history of traumatic brain injury. A review of the minimum data set (MDS) dated [DATE] revealed a brief interview mental status (BIMS) score of 10, indicating that the resident had moderate cognitive impairment. (continued on next page)

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
	035114	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a progress note dated April 6, 2025 at 02:00 a.m. by Licensed Practical Nurse (LPN) Staff #3 revealed that a confused male resident entered Resident #1's room and approached her bed. This was witnessed by a staff member that responded to her room. Staff intercepted the male resident and directed that resident out of the room. No physical contact occurred and Resident #1 felt unsafe and called 911 to report an attempted sexual assault. Police Department arrived to file a report. Resident #1 stated she was emotionally distraught and in need of reassurance for her safety. Emotional support was provided by staff. A staff member was then posted outside her door and was visible to her. A progress note dated April 6, 2025 at 12:04 revealed that Licensed Practical Nurse (LPN) Staff #2 documented that she spoke to Resident #3's wife, face to face about the police report related to sexual assault. A psychological evaluation would be done, a care conference and 15 minute checks would be conducted. An interview was conducted on April 22, at 11:11 a.m. with Resident #1 who stated that a male resident (Resident #3) came into her room and had on a diaper brief with one hand in the brief and kept on touching her walker. Resident #1 stated that when you are flat on your back and can't sit up it is scary. Resident #1 also revealed that she was afraid that he was going to crawl up and get her. Resident #1 confirmed that she called the police. An interview was attempted on April 22 2025 at 11:56 a.m. with Licensed Practical Nurse (LPN) Staff #3, after the list of phone numbers was completed and returned. However, when attempting to call Staff #3, was told wrong number by the person who answered. An interview was attempted on April 22, 2025 at 12:27 p.m. with Licensed Practical Nurse (LPN) Staff #2. Staff #2 did not answer and a voicemail message was left, asking Staff #2 to return the call. An interview was conducted on April 22, 2025 at 12:35 p.m. with Certified Nursing Assistant (CNA) Staff #1 who revealed that when residents tend to wander into other resident rooms, you need to know their schedules and if the resident likes cartoons, turn on cartoons. Then bring the resident to the common areas to interact with other residents. An interview was conducted on April 22, 2025 at 12:37 p.m. with LPN Staff #5 who revealed that there are a couple residents in the building that like to go into other resident rooms. One of them is not mentally capable to understand not to go in. Sometimes rooms are changed and the resident might wander back to the old room. The best way to prevent them is to keep an eye on them, redirect them. Say why don't we watch T.V. An interview was conducted on April 22, 2025 at 12:41 p.m. with Director of Nursing (DON) Staff #4 who stated that she had heard of the incident; and that, a man went to Resident #1's door and did not actually enter the room. However, Staff #4 admitted was out of town when the incident happened. When asked how to prevent residents from going into other resident rooms, Staff #4 revealed that it's a challenge and depends on the resident's cognition. Educate and redirect, care plan, meet with family. Keep an eye on them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035114	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted April 22, 2025 at 12:57 p.m. with Staff #2 and revealed was the nurse to follow night LPN Staff #3. Staff #2 was the person who informed the family/wife and the Nurse Practitioner (NP), that Resident #3 went into resident #1's room. Resident #3 would wander and take off his pants. Resident #1 had been sexually assaulted in the past. Resident #1 called the police. While the police were there interviewing Resident #1, Resident #3 attempted to go into Resident #1's room again and the police observed the resident attempting to come back in. Review of the policy Abuse Prevention Program (revised September 2021) revealed that employees will be annually trained to recognize situations in which abuse is more likely to occur and how to intervene for prevention, such as characteristics of residents which have the potential to trigger an abusive incident like wandering into other resident rooms.