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	06/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that a resident representative was notified of an accident involving the resident, which resulted in injury, to one of three sampled residents (#21). The deficient practice could result in harm to the resident without their representative being aware. Findings include:Resident #21 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction, chronic obstructive pulmonary disease, type 2 diabetes, chronic osteomyelitis, acute embolism and thrombosis, pulmonary hypertension, metabolic encephalopathy, pressure ulcer of the sacral region, mood affective disorder, iron deficiency anemia, hypothyroidism, benign prostatic hyperplasia, and chest pain. A power of attorney (POA) document uploaded into the resident record, signed and dated on October 14, 2025, revealed that Resident #21's son was his POA. A provider progress note dated January 13, 2026, revealed that the resident had a POA and that the resident elected his son, who was designated as his health care surrogate. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS also revealed one documented fall after admission. An incident progress note dated January 16, 2026, at 11:50 p.m. revealed that at 10:30 p.m., the resident was heard yelling for help and was found in his room on the floor. The note revealed that the resident stated he was attempting to get up to go to the bathroom when his legs buckled, and he slid to the floor. The note revealed that the resident was found with no injuries, and he stated that he did not bump his head. The note also revealed that the resident was barefoot, he did not use his call light for assistance, and that team health and the Director of Nursing (DON) were notified. There was no evidence in the note that the POA was notified of the incident. An order administration progress note dated January 17, 2026, at 3:19 a.m. revealed that oxycodone HCl Oral Tablet 10 MG was administered for pain in the resident's legs, feet, and lower back. An order administration progress note dated January 17, 2026, at 5:21 p.m. revealed that the resident refused wound care on his sacral wound because he stated he was in too much pain. An order administration progress note dated January 18, 2026, at 6:57 p.m. revealed that oxycodone HCl Oral Tablet 10 MG was administered for pain in the resident's hips, lower back, and knees. An order administration progress note dated January 19, 2026, at 2:51 a.m. revealed that oxycodone HCl Oral Tablet 10 MG was administered for pain on movement in the resident's thighs and knees. A health status progress note dated January 19, 2026, at 2:59 p.m. revealed that the resident reported increasing pain since he fell on Friday. January 16th, and that he was unable to bear weight on his right leg. The note revealed that the nurse practitioner (NP) was notified, and that the POA and resident wanted to be sent to the emergency room (ER). The note revealed that when emergency services (EMS) arrived, the resident was in too much pain to be moved, so EMS provided the resident with intravenous pain medication.An order administration progress note dated January 19, 2026, at 3:04 p.m. revealed that oxycodone HCl Oral Tablet 10 MG was administered for pain, and was ineffective with a follow-up pain scale of 9. An alert progress note dated January 19, 2026, at 8:46 p.m. revealed that the resident's son went to the facility to pick up the resident's belongings because he was being admitted to the hospital for a hip (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury. A care plan focus initiated on January 19, 2026, revealed that the resident had an actual fall on January 16, 2026, with no injury, with interventions to continue interventions on the at-risk plan, determine and address causative factors of the fall, and to monitor, document, and report as needed for 72 hours to the provider. An interview was conducted on June 10, 2026, at 9:03 a.m. with a Licensed Practical Nurse (LPN/Staff #9) who stated that a POA was a legal document that could be used medically or financially when indicated, so that an individual could make decisions for a resident. The LPN stated that he would know if a resident had a POA because it would be listed in their medical chart under contacts and would be uploaded as a document. The LPN stated that when residents have a fall, their process was to check for injuries, help the resident to bed, start neuro checks, notify the doctor, the family or POA, and the DON right away. The LPN stated that he would notify the emergency contacts even if the resident did not have a POA, and he would ensure that a party was notified other than the resident. The LPN stated that there was a rule of notifying 3 people: one person from the contacts in the chart, the DON, and the doctor. The LPN stated that they would then be expected to document and chart who was notified of the fall. The LPN also stated that the risk of failing to notify a POA of a fall would include the resident's physical or mental well-being, as well as their inability to track a resident's fall history if the POA was never notified that a fall occurred. The LPN opened Resident #21's clinical record and stated that the resident had a signed POA document that listed his son as his POA. The LPN stated that on the contacts page, the resident's son was listed as an emergency contact, but should have been listed as the POA. The LPN stated that if the resident had a fall at the facility, they would be expected to notify his son. The LPN stated that on January 16, 2026, there was a progress note that revealed the resident was heard yelling for help and was found on the floor of his room, with details that he experienced a fall. The LPN stated that the health team and the DON were notified, but there was no evidence that the POA was notified, even though the POA should have been notified. The LPN stated that there was a progress note on January 19, 2026, that revealed the resident's son came to pick up the resident's belongings because he went to the hospital for a hip injury after complaining of increased pain since the fall, and was unable to bear weight. An interview was attempted on June 10, 2026, at 9:24 a.m. with Resident #21, with no success. An interview was conducted on June 10, 2026, at 9:51 a.m. with the DON, Staff #51, who stated that a POA was the person who could make decisions for a resident who could not make decisions for themselves. The DON stated that when a resident enters the facility with a designated POA, it would be uploaded into their chart, and the contact information would be listed under POA. The DON stated that there were times when a POA might be listed as an emergency contact #1, but the POA document would be uploaded as a way to communicate the designation in the medical record. The DON stated that staff would be expected to notify a POA of a change in condition, falls, new psychotropic medications, medication changes, a change in the plan of care, or any incident. The DON stated that the only time they would not notify the POA was if the resident specifically told them not to, but generally, staff were expected to always notify the emergency contact or POA of a fall or incident. The DON stated that a POA should be notified of a fall even if there was no injury because sometimes a resident could experience a fall and not know there was an injury. The DON also stated that the timeframe for reporting a fall to the POA was within an hour, unless they could not get in touch with them, then they would be expected to leave a message and make a progress note for the attempt to reach them. The DON stated that the risk of failing to notify a POA of a fall could be that the resident might not be able to articulate or communicate that they need the hospital, or if there was an injury. The DON further stated that there was a potential for harm to the resident if the facility failed to notify the POA. The DON opened the clinical record for resident #21 and stated that the resident had an emergency contact listed, which was his son, and that there was a POA document uploaded into the medical record. The DON stated that the POA document was in effect on January 12, 2026, and that the resident was admitted to the facility on [DATE], which indicated that the POA paperwork was in effect on admission. The DON stated that Resident #21 was (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact, but that they still should have notified the son of the fall unless the resident specifically told them not to, and further stated that there was no documentation or evidence that the resident told them not to. The DON looked at the progress notes and stated that the fall occurred on January 16, 2026, and that team health and the DON were notified, but there was no evidence to show that the POA was notified of the fall. The DON stated that the handling of the fall incident with Resident #21 did not meet her expectations. An interview was attempted on June 10, 2026, at 10:12 a.m. with Resident #21's POA, with no success. An interview was attempted on June 10, 2026, at 10:14 a.m. with the Licensed Practical Nurse (LPN/Staff #25) who wrote the progress note regarding the fall, with no success. Review of policy titled, Change in a Resident's Condition or Status, dated February 2021, revealed that the facility would promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The policy revealed that, unless otherwise instructed by the patient, the nurse would notify the resident's representative when the resident was involved in an accident or incident or if there was a significant change in the resident's status.Review of a policy titled, Resident Rights, dated February 2021, revealed that federal and state laws guaranteed certain basic rights to all residents of the facility, including the resident's rights to be notified of his or her medical condition and of any changes in his or her condition.