| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035232 | A. Building<br>B. Wing | 01/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain View Care Center | 1313 West Magee Road<br>Tucson, AZ 85704 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499<br><br>Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to ensure that one resident (#57) was free from abuse from a visitor, five residents (#116, #59, #126, #112, and #134) were free from abuse from another resident and prevent an injury of unknown origin for one resident (#118). The deficient practice could result in residents being abused.<br><br>Findings include:<br><br>Regarding resident #116 and resident #117:<br><br>-Resident #116 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, necrotizing enterocolitis, anxiety, anemia, gastroesophageal reflux disease, hypertension, dementia with behavior disturbance, fracture of left ulna, fracture of left radius, moderate protein-calorie malnutrition, cellulitis left upper limb, and major depressive disorder.<br><br>A progress note dated [DATE] at 10:56 AM, that stated staff witnessed another resident (#117) place his hands on the resident's (#116) neck. No injuries were noted and no signs of pain.<br><br>The care plan dated [DATE] revealed the resident wandered aimlessly and was disoriented to place with impaired safety awareness with an intervention to document wandering behavior and attempted diversional interventions.<br><br>The Brief Interview for Mental Status (BIMS) score dated [DATE] was 0 indicating resident had severe cognitive impairment.<br><br>The clinical record revealed that the resident was discharged to the hospital on [DATE].<br><br>-Resident #117 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder, major depressive disorder, suicidal ideation's, diabetes mellitus, anxiety, insomnia, hyperlipidemia, and weakness.<br><br>The BIMS score dated [DATE] was 13 indicating he was cognitively intact.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a progress note dated [DATE] at 10:56 AM, that stated the patient was witnessed physically putting his hands on another resident's (#116) neck. The two were immediately separated. The resident (#117) began making suicidal statements and throwing items at staff. The resident #117 was transported by emergency personnel to the emergency room .<br><br>Review of resident #117's care plan did not reveal any behaviors displayed by the resident.<br><br>The clinical record revealed the resident was discharged to the hospital on [DATE].<br><br>The facility's investigative documentation revealed that staff #9 witnessed resident #117 get up during an activity and put his hands around resident #116's neck. The two residents were immediately separated. No injuries were noted. Resident #117 was sent out to the emergency room due to his behaviors.<br><br>During an interview conducted with a certified nursing assistant (CNA/staff #12) on [DATE] at 2:28 p.m., the CNA stated that residents were not allowed to wander into other resident's rooms; and, if a resident wander into another room, she will redirect them to go somewhere else.<br><br>An interview was conducted on [DATE] at 2:45 p.m., with a Registered Nurse (RN/staff #65) who stated that residents were not allowed to wander into other resident's rooms. The RN said that she will redirect the resident from wandering into other resident's room by talking to the resident, changing their direction, or by offering them a snack.<br><br>Regarding resident #57:<br><br>-Resident #57 was admitted to the facility on [DATE], with diagnoses that included dementia, schizophrenia, dysphagia, hyperlipidemia, major depressive disorder, anxiety disorder, hypertension, and convulsions.<br><br>Review of resident #57's clinical records revealed the resident had wandered into another resident's (#47) room on [DATE] at 1:52 PM. The other resident's visitor attempted to redirect the resident out of the room and accidentally scratched the resident's right shoulder/neck area. The visitor was educated to ask staff for assistance and was asked to leave the facility pending further investigation. No injury was noted other than a mark to the right shoulder.<br><br>The care plan dated [DATE], revealed the resident was at risk for wandering and is disoriented to place with impaired safety awareness with an intervention to document wandering behavior and attempted diversional interventions.<br><br>The facility's investigative documentation revealed a summary that stated resident #57 had wandered into another resident's room and when the other resident's visitor attempted to redirect the resident, the visitor scratched resident #57's right shoulder.<br><br>Regarding injury of unknown source for resident #118<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Resident #118 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy, muscle weakness, cognitive communication deficit, hypertension, epilepsy, syncope and collapse, adjustment disorder, anxiety disorder, depression, and adjustment insomnia. The resident discharged on [DATE] and deceased on [DATE].<br><br>The progress notes dated [DATE] at 5:00 PM, revealed the resident had bruising around her left eye. The resident stated that her cousin did it; however, it was documented that no family members had recently visited the resident. No probably cause of the bruising was identified.<br><br>A care plan dated [DATE], revealed the resident was at risk for falls. Interventions included: avoid rearranging furniture, encourage resident to wear appropriate footwear when ambulating or wheeling in wheelchair; keep needed items within reach; maintain a clear pathway, free of obstacles; and physical therapy evaluation.<br><br>A care plan dated [DATE], revealed the resident was at risk for wandering and disoriented to place with impaired safety awareness with an intervention to document wandering behavior and attempted diversion interventions.<br><br>Review of the facility's investigative documentation revealed a summary that stated resident #118 had bruising under her left eye and that her cousin did it. There was no documentation of any falls. The patient was independent with ambulation and wandering behaviors. She was capable of picking things up off the floor so the injury was likely a result from her trying to pick something up from the floor and bumped her eye on a piece of furniture.<br><br>During an interview conducted on [DATE] at 11:00 AM, the Administrator (staff #34) stated that they were unable to interview resident #118 due to her cognitive status to obtain more information. The administrator said that staff were not aware of any visitors; and that, there were no visitors identified on the visitor log as family members of the resident. The administrator said that the facility visitor logs at that time were temperature check logs for Covid and were not actual visitor logs.<br><br>21369<br><br>Regarding resident #59 and resident #109:<br><br>-Resident #59 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, dementia, psychosis, amnesic disorder and major depressive disorder.<br><br>The MDS (Minimum Data Set) assessment dated [DATE] that revealed a BIMS score that the resident had been assessed with severe cognitive impairment.<br><br>-Resident #109 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis due to cerebral infarction, acute kidney failure, depression, and epilepsy.<br><br>An MDS assessment dated [DATE] a BIMS that the resident had been assessed with severe cognitive impairment.<br><br>On [DATE], the facility reported to the State Agency (SA), that resident #109 was found in the room of resident #59 who was in bed; and that, a staff observed resident #109 hitting resident #59.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's investigative documentation dated [DATE] that resident #109 stated he was hitting resident #59 because he thought resident #59 was in his bed and he was kicking him out. Resident #59 was assessed with swelling under his right eye.<br><br>Regarding resident #127 and resident #126:<br><br>-Resident #127 was admitted on [DATE] with diagnoses that included dementia with behavioral disturbances, acute respiratory failure, unspecified psychosis, anxiety disorder, and unspecified mood disorder.<br><br>An MDS assessment dated [DATE] that revealed a BIMS assessed that documented the resident had severe cognitive impairment.<br><br>-Resident #126 was admitted on [DATE] with diagnoses that included unspecified dementia with other behavioral disturbances, stage 3 chronic kidney disease, and dysphagia.<br><br>An MDS assessment dated [DATE] revealed a BIMS that the resident had been assessed with severe cognitive impairment.<br><br>On [DATE], the facility reported to the SA that resident #127 had picked up a chair and repeatedly hit resident #126 with the chair.<br><br>According to the facility documentation, resident #126 went out to the hospital for evaluation and treatment on [DATE]; and the resident had a closed laceration to the top of his head and bruising on his forearms.<br><br>A review of the facility's investigative report dated [DATE] revealed documentation that staff were in the process of getting resident #126 into bed; and, the staff left resident #126 in a chair in his room while the staff left the room to get resident #125's wheelchair. When staff returned to the room, the staff witnessed resident #127 push resident #126 out of the chair and resident #126 went to the floor. Per the documentation, the staff witnessed resident #127 pick up a chair and began hitting resident #126 on his head; and that, the staff separated the residents.<br><br>Further review of the investigative documentation revealed an interview with resident #127 who stated he thought resident #126 had stolen his stuff.<br><br>Regarding resident #112 and resident #114:<br><br>-Resident #112 was admitted on [DATE] with diagnoses that included paraplegia, unspecified convulsions, fibromyalgia, major depressive disorder, mood disorder, and post-traumatic stress disorder.<br><br>An MDS assessment dated [DATE] included the resident had a BIMS score of 14 indicating the resident had intact cognition.<br><br>On [DATE], the facility reported to the State Agency (SA) of an incident where resident #112 was witnessed to be slapped in the face by resident #114.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's investigative documentation revealed statements from staff that stated they had witnessed resident #114 slap resident #112; and that, resident #112 reported that she had been slapped by resident #114.<br><br>48926<br><br>Regarding resident #135 and #134:<br><br>-Resident #135 was admitted on [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease, dementia, cognitive communication deficit, and schizophrenia.<br><br>The MDS assessment dated [DATE] revealed a BIMS score of 00, indicating resident had severe cognitive impairment. Further review of the MDS revealed the resident had exhibited verbal behaviors directed at others on one to three days of the seven-day assessment period.<br><br>The comprehensive care plan revealed the resident received psychotropic medications for auditory hallucinations and angry outbursts. Intervention to provide a calm, quiet environment during episodes of yelling.<br><br>-Resident #134 was admitted on [DATE] with diagnoses of dementia, anxiety, diabetes mellitus type 2, and aphasia.<br><br>Review of the MDS assessment revealed the resident had exhibited verbal behaviors directed at others on one to three days of the seven-day assessment period; and, had a BIMS score of 00 indicating severe cognitive impairment.<br><br>The comprehensive care plan included that the resident received an anti-anxiety medication for anxiety as evidenced by pacing. Intervention included to provide a calm, quiet environment when pacing.<br><br>The nursing progress note dated [DATE] at 11:12 a.m. revealed resident #134 had been in a fight with resident #135 and received a scratch on the neck.<br><br>Review of the facility report dated [DATE] revealed that the licensed practical nurse (LPN) had reported a resident to resident altercation involving residents #134 and #135; and that, resident #134 had a scratch on her arm and on her neck. Resident #135 was reported to have no visible injuries. The facility report concluded that a resident to resident altercation had occurred.<br><br>Review of the facility policy titled Abuse: Prevention and Prohibition Against dated [DATE], revealed that each resident had the right to be free from abuse including injuries of unknown origin. The policy included the facility will take action to protect and prevent abuse and neglect from occurring within the facility by; identifying, correcting and intervening in situations in which abuse is more likely to occur; and identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as: Verbally aggressive behavior, physically aggressive behavior, and wandering into other's rooms/space.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1313 West Magee Road Tucson, AZ 85704 | |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The policy further included that if an allegation of abuse is reported, discovered or suspected, the facility will protect all residents from physical and psychosocial harm during and after the investigation; including increase supervision of the alleged victim and residents. If the allegation of abuse involved another resident, the facility will separate the residents so that they do not interact with each other until circumstances of the reported incident can be determined and the facility would continue to assess, monitor and intervene as necessary to maximize resident health and safety. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499<br><br>Based on clinical record review, staff interviews, facility documentation, and policies and procedures, the facility failed to complete a thorough investigation to rule out abuse regarding an injury of unknown origin for one resident (#118). The deficient practice could result in the injury of unknown origin not investigated and appropriate corrective actions not taken.<br><br>Findings include:<br><br>Resident #118 was admitted on [DATE], with diagnoses of metabolic encephalopathy, muscle weakness, cognitive communication deficit, hypertension, epilepsy, syncope and collapse, adjustment disorder, anxiety disorder, depression, and adjustment insomnia.<br><br>The progress notes dated December 9, 2023 at 5:00 p.m., revealed the resident had bruising around her left eye; and that, the resident reported that her cousin did it.<br><br>The clinical record revealed no documentation that the bruise was assessed to include description on color or size.<br><br>There was no facility documentation found that family members recently visited the resident.<br><br>Review of a care plan dated June 8, 2023, revealed the resident was at risk for falls. Interventions included to avoid rearranging furniture, encourage resident to wear appropriate footwear when ambulating or wheeling in wheelchair; keep needed items, watch, in reach; maintain a clear pathway, free of obstacles; and physical therapy evaluation.<br><br>A care plan dated September 9, 2023, revealed the resident was at risk of wandering, was disoriented to place and had impaired safety awareness. Intervention included to document wandering behavior and attempted diversion interventions.<br><br>The skin evaluation dated December 14, 2023 (approximately 5 days after the bruise was identified) included that the resident continues with bruised on eye.<br><br>A physician progress note dated December 14, 2023 revealed that the resident reported her cousin slapped her in the face; and that, staff reported that the resident kept on saying the same thing.<br><br>Review of the facility's investigative documentation revealed that resident #118 had bruising under her left eye; and that, her cousin did it. Per the documentation, there was no documentation of any falls; the resident was independent with ambulation, had wandering behaviors, was capable of picking things up off the floor; and that, the injury was likely a result from her trying to pick something up from the floor and bumped her eye on a piece of furniture.<br><br>There was no evidence found that this incident was thoroughly investigated by the facility to include any interviews conducted.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview conducted on January 18, 2024 at 11:00 a.m., the Administrator (staff #34) stated that they were unable to interview resident #118 due to her cognitive status. The administrator said that staff were not aware of any visitors; and that, there were no visitors identified on the visitor log as family members of the resident. The administrator said the facility visitor logs at that time were temperature check logs for Covid and were not actual visitor logs. The administrator further stated that the family was not contacted during the investigation to determine if anyone had visited the resident.<br><br>Review of the facility policy titled Abuse: Prevention of and Prohibition Against dated October 2022 revealed that the investigation would include interviews with person(s) reporting the incident, the resident(s) involved, any witnesses to the incident including the alleged perpetrator and staff member(s) on all shifts who may have information regarding the alleged incident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain View Care Center | 1313 West Magee Road Tucson, AZ 85704 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49499<br><br>Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure adequate supervision was provided to prevent resident from wandering into other resident's room for two residents (#57, #116); and, prevent one resident (#129) from elopement. The deficient practice could result avoidable harm to all residents due to lack of adequate supervision.<br><br>Findings include:<br><br>-Resident #57 was admitted on [DATE], with diagnoses that included dementia, schizophrenia, major depressive disorder and anxiety disorder.<br><br>The progress notes dated September 29, 2023 revealed the resident was unable to communicate needs, was monitored for safety, ambulated independently on the hall and wandered in and out of rooms.<br><br>The progress notes dated October 1, 2023 at 1:52 p.m., revealed the resident had wandered into another resident's room; and that, the visitor of the other resident attempted to redirect the resident out of the room.<br><br>The care plan dated August 25, 2023 revealed the resident was at risk for wandering, was disoriented to place and had impaired safety awareness. Intervention included to document wandering behavior and attempted diversional interventions.<br><br>Review of the facility's investigative documentation revealed that resident #57 had wandered into another resident's room; and that, the other resident's visitor attempted to redirect the resident.<br><br>There was no evidence found in the clinical record and facility documentation that adequate supervision was provided to prevent resident #57 from wandering to other resident's room.<br><br>-Resident #116 was admitted on [DATE] with diagnoses of metabolic encephalopathy, necrotizing enterocolitis, anxiety, dementia with behavior disturbance and major depressive disorder.<br><br>The Brief Interview for Mental Status (BIMS) score dated June 15, 2022 was 0 indicating resident had severe cognitive impairment.<br><br>The care plan dated August 18, 2021 revealed the resident wandered aimlessly, was disoriented to place, and had impaired safety awareness. Intervention included to document wandering behavior and attempted diversional interventions.<br><br>A progress note dated July 22, 2022 included that the resident was alert and confused; and that, she was monitored for wandering and poor safety awareness.<br><br>There was no evidence found in the clinical record and facility documentation that adequate supervision was provided to prevent resident #57 from wandering to other resident's room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A progress note dated July 23, 2022 at 11:09 a.m. revealed that the nurse heard a loud thud and found the resident lying on her back on the floor. Per the documentation, the resident was bleeding from her mouth and the back of her head; and, had a skin tear on her left arm. It also included that 911 was called and the resident was transported to the emergency room .<br><br>A progress note dated July 26, 2022 at 1:35 p.m. included that the fall committee interdisciplinary team determined that the resident had wandered into another resident's room and startled the other resident who was sleeping. The other resident raised his arm when he was startled and resulted in resident #116 losing her balance and falling.<br><br>Review of the facility's investigative documentation revealed that resident #116 had wandered into another resident's room.<br><br>During an interview conducted with a certified nursing assistant (CNA/staff #12) on January 19, 2024 at 2:28 p.m., the CNA stated that residents were not allowed to wander into other resident's rooms; and, if a resident wander into another room, she will redirect them to go somewhere else.<br><br>An interview was conducted on January 19, 2024 at 2:45 p.m., with a Registered Nurse (RN/staff #65) who stated that residents were not allowed to wander into other resident's rooms. The RN said that she will redirect the resident from wandering into other resident's room by talking to the resident, changing their direction, or by offering them a snack.<br><br>In an interview with the lead CNA (staff #100) conducted on January 19, 2024 at 2:55 p.m., the lead CNA stated that residents were not allowed to wander in other resident's rooms; and that, she will redirect the resident, ask them to come with her or go over where she is, or get them a drink/snack.<br><br>21369<br><br>-Resident #129 was admitted on [DATE] with diagnoses of epilepsy, unspecified dementia, anxiety disorder, dysphagia, and fibromyalgia.<br><br>The elopement/wandering assessment dated [DATE] included that the resident was a high risk for elopement/wandering.<br><br>The care plan dated December 11, 2023 revealed that the resident was an elopement risk and a wanderer related to disorientation to place and impaired safety awareness; and that, the facility entrances/exits are secured (alarmed), but resident is able to move freely throughout the building. The care plan did not identify any other interventions.<br><br>On December 13, 2023, the facility reported that on December 12, 2023 at approximately 1:30 p.m., staff were looking for the resident; and that, the resident was not in his room. According to the documentation, the resident was found outside the front of the building.<br><br>Per the facility's investigative report dated December 21, 2023, staff reported last seeing the resident at the nurses' station, visiting with staff at approximately 1:15 p.m. The investigative report only documented that the resident was found outside in front of the building; and that, the resident reported that he was looking for his wife.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035232 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/19/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Mountain View Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1313 West Magee Road Tucson, AZ 85704 | |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on January 16, 2023 at 2:30 p.m. with staff #57 who stated that when a resident was assessed as a high risk for elopement/wandering, the care plan interventions would be implemented as soon as possible but within 24 hours of the assessment.<br><br>In an interview with staff #34 conducted on January 18, 2024 at 11:00 a.m., staff #34 stated that resident #129 left the building without staff knowledge; and that, there was no documentation of any alarms going off. Staff #34 further stated that the resident exited the building through the front door which was not alarmed.<br><br>Review of the facility policy titled Abuse: Prevention and Prohibition Against dated October 2022, revealed that each resident had the right to be free from abuse including injuries of unknown origin. The policy included the facility will take action to protect and prevent abuse and neglect from occurring within the facility by; identifying, correcting and intervening in situations in which abuse is more likely to occur, to include validating that the facility has deployed the correct number of competent staff on each shift to meet the needs of the residents; and identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as: Verbally aggressive behavior, physically aggressive behavior, and wandering into other's rooms/space.<br><br>The policy further included that if an allegation of abuse is reported, discovered or suspected, the facility will protect all residents from physical and psychosocial harm during and after the investigation; including increase supervision of the alleged victim and residents. If the allegation of abuse involved another resident, the facility will separate the residents so that they do not interact with each other until circumstances of the reported incident can be determined and the facility would continue to assess, monitor and intervene as necessary to maximize resident health and safety. |