STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055316	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Healthcare Center	2530 Solace Place Mountain View, CA 94040

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to accurately assess and complete the Minimum Data Set (MDS, an assessment tool) for one of two sampled residents (Resident 1). This failure had the potential to compromise the facility's ability to develop and implement resident-centered care plans and interventions. Findings: Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including cerebral infarction (a stroke that occurs when blood flow to the brain is blocked, causing brain cells to die off), type 2 diabetes (high blood sugar), hypertension (high blood pressure), and morbid (severe) obesity (overweight). Resident 1's minimum data set (MDS, an assessment tool) dated 3/08/24 was reviewed. Section GG0120 of the MDS asked to check all that were normally used in the last 7 days, and both items B. walker and C. wheelchair were checked. During an interview and record review on 8/26/24 at 10:40 a.m. with the minimum data set coordinator (MDSC) A, she confirmed the above record review and stated that she saw a walker when she visited Resident 1's room. MDSC A further stated that she did not observe Resident 1 using the walker. During an interview on 8/26/24 at 10:55 a.m. with MDSC A, she said she reviewed therapy documentation and could not find any documentation indicating Resident 1 used a walker. MDSC A acknowledged that a walker should not have been checked on Resident 1's MDS dated [DATE] because Resident 1 did not use a walker during the specified time frame. MDSC A confirmed that Resident 1's MDS dated [DATE] was not accurate. During an interview on 8/26/24 at 11:51 a.m. with the director of rehabilitation (DOR), she stated that Resident 1 was not able to use a walker due to her weakness. During a review of Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 October 2023, the manual indicated, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to provide a summary of the baseline care plan for one of two sampled residents (Resident 1) to the resident and resident's representative. This failure had the potential to result in the facility being unable to promote continuity of care, meet the resident's immediate needs, and ensure the resident and representative were informed of the initial plan on the delivery of care and services. Findings: Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including cerebral infarction (a stroke that occurs when blood flow to the brain is blocked, causing brain cells to die off), type 2 diabetes (high blood sugar), hypertension (high blood pressure), and morbid (severe) obesity (overweight). Review of Resident 1's facesheet (a document that summarizes a resident's information) indicated Resident 1's responsible party (RP, a person empowered to make decisions for the resident/person legally responsible and liable for a decision or an action) was 'daughter '. Review of Resident 1's minimum data set (MDS, an assessment tool) dated 3/08/24 indicated she had a brief interview of mental status (BIMS, a tool used to assess cognition) score of 12, meaning she had moderate cognitive impairment. Review of Resident 1's baseline care plan, effective date 3/03/24, indicated missing signatures on the following sections: 3. Resident signature, and 4. Representative signature. During a telephone interview on 8/08/24 at 3:35 p.m. with Resident 1's RP, she stated she was not informed about the facility's plan of care for Resident 1. The RP further stated she did not receive a written plan of care from the facility. During an interview and record review on 8/26/24 at 9:50 a.m. with the Director of Nursing (DON), the DON confirmed Resident 1's baseline care plan with an effective date of 3/03/24 did not include Resident 1's and her representative's signatures. The DON acknowledged that the facility should provide the resident and representative with a summary of the baseline care plan. The DON further stated there was no documented evidence that the summary of the baseline care plan was given to Resident 1 and her RP. During a review of the facility's policy and procedure (P&P) titled Baseline Care Plan, dated 9/01/23, the P&P indicated, A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on interview and record review, the facility failed to develop and implement care plans for one of two sampled residents (Resident 1) when a care plan for a diagnosis of obesity was not developed. This failure had the potential to not meeting the resident's medical, nursing, and mental and psychosocial needs that were identified in Resident 1's comprehensive assessment. Findings: Review of Resident 1's medical record indicated she was admitted on [DATE] and had diagnoses including cerebral infarction (a stroke that occurs when blood flow to the brain is blocked, causing brain cells to die off), type 2 diabetes (high blood sugar), hypertension (high blood pressure), and morbid (severe) obesity (overweight). Resident 1's minimum data set (MDS, an assessment tool) dated 3/08/24 was reviewed. Section I80000 asked to enter diagnosis, and C. morbid (severe) obesity was entered. Review of Resident 1's weekly weight meeting indicated, BMI (body mass index, a measurement of a person's leanness based on their height and weight): 59.7 (40 or over, meaning severe obesity). Review of Resident 1's care plans indicated there was no care plan developed to address her diagnosis of obesity. During an interview on 8/09/24 at 2:05 p.m. with assistant director of nursing (ADON) B, she stated that Resident 1 was a bariatric resident (resident who has a BMI that is equal to or greater than 30). During an interview and record review on 8/09/24 at 2:20 p.m. with ADON B, she reviewed Resident 1's medical record and stated that she could not find a care plan for Resident 1's obesity. ADON B acknowledged that a care plan for Resident 1's diagnosis of obesity should have been developed. During an interview and record review on 8/26/24 at 9:40 a.m. with the director of nursing (DON), she confirmed the above record review. The DON acknowledged that a care plan for Resident 1's diagnosis of obesity should have been developed with the interventions to address it. The DON stated that a care plan should be individualized and person-centered for each resident. During a review of the facility's policy and procedure (P&P) titled Care and Treatment of Bariatric Residents, dated 6/01/23, the P&P indicated, Bariatric residents have special needs. This facility will provide the necessary care and treatment that allows the bariatric resident to remain safe and to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. A person-centered care plan will be developed.