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	05/29/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the Responsible Party (RP, the designated person who oversees a patient's medical, personal, or legal care decisions) for 1 of 2 residents (Resident 1) when:There was no written documentation in Resident 1's medical record that Resident 1's RP was notified prior to discontinuation of 1:1 observation (sitter) on 5/1/26 andThere was no written documentation in Resident 1's medical record that Resident 1's RP was informed of room changed on 12/4/25.These failures deprived Resident 1's RP of the opportunity to advocate alternative choices/options and participate in care planning for Resident 1's welfare and safety. Findings:1.Review of Resident 1's medical record indicated he was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), dementia (a progressive state of decline in mental abilities), depression (persistent feeling of sadness, emptiness, and a loss of interest in activities), anxiety (constant feeling of worries or fear), difficulty walking, and generalized muscle weakness.Review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool) dated 3/11/26 indicated he had a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 5, which means his cognition (thinking and processing information) was severely impaired.Review of Resident 1's physician's orders dated 2/26/26 indicated, Resident 1 was incapable of understanding rights, responsibilities, and informed consent. Resident 1 was very high risk for fall. Ensure bed in lowest position between care. Communicate with bedside sitter throughout shift. Provide frequent safety reminders every shift.Review of Resident 1's medical record indicated the daughter was the RP for Resident 1's care.Review of Resident 1's Fall Risk Assessments (screening to determine patient's risk of falling) dated 12/10/25 indicated a score of 11; dated 3/11/26 indicated a score of 10; and 5/4/26 indicated a score of 16 (a total score of 10 or above represents high risk for falls). During an interview with Licensed Vocational Nurse A (LVN A) on 5/19/26 at 2:20 p.m., she confirmed that 1:1 observation (sitter) was discontinued on 5/1/26 for Resident 1.During an interview and staffing schedule review on 5/29/26 at 10:43 a.m. with the Director of Nursing (DON), she confirmed that one member of facility staff was assigned as a sitter in Resident 1's room from 4/25/26 through 4/30/26. Then, starting on 5/1/26, the 1:1 observation (sitter) was discontinued for Resident 1.Review of Resident 1's Interdisciplinary Team (IDT, a coordinated group of healthcare professionals within the facility who work together to plan, deliver, and evaluate patient care) dated 5/5/26 indicated, Resident 1 was provided a 1:1 observation (sitter) upon admission to the facility due to Resident 1 was a high risk for fall. The 1:1 observation was discontinued on 5/1/26 due to Resident 1 demonstrated improved stability in overall condition. Resident 1 was scheduled on regular checks for safety.During an interview and record review on 5/29/26 at 10:54 a.m. with DON, she confirmed there was no written evidence in Resident 1's medical record that Resident 1's RP was notified of the discontinuation of the 1:1 observation (sitter) for Resident 1 prior to 5/1/26. DON acknowledged the facility should have notified Resident 1's RP prior to discontinuation of 1:1 observation (sitter) on 5/1/26.Review of the facility's revised policy and procedures dated 11/2025 titled, Health, Medical (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Condition and Treatments Options, Informing Residents of indicated, Each resident is informed of their health status and medical condition, including diagnosis, treatment recommendations, and prognosis, in advance of treatment and on an on-going basis. If resident has an appointed representative, the representative is also informed. The resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of their medical condition. Such information includes providing the resident/representative with information about resident's: i. type of care or treatment recommended (based on the assessment and care plan) .I. treatment alternatives or options 2.Review of Resident 1's medical record indicated he was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included encephalopathy, dementia, depression, anxiety, difficulty walking, and generalized muscle weakness.Review of Resident 1's MDS dated [DATE] indicated that he had BIMS score of 5, which means his cognition (thinking and processing information) was severely impaired.Review of Resident 1's medical record indicated the daughter was the RP for Resident 1's care.Review of Resident 1's medical record dated 12/4/25 indicated, Resident 1 was offered a room change and agreed to room change. Resident 1 was moved to another room.During an interview and Resident 1's medical record review on 5/29/26 at 10:43 a.m. with the DON, she confirmed there was no written evidence in Resident 1's medical record that Resident 1's RP was notified of the room changed on 12/4/25. DON acknowledged Resident 1's RP should have notified of room change.Review of the undated facility's policy and procedures titled Room Change/Roommate Assignment indicated, Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents or their representatives, will be given advance notice of such a change as is possible.