STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Conv Hosp	13333 Fenton Avenue Sylmar, CA 91342

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse (is harsh and insulting language directed at a person) by another resident for one of three sampled residents (Resident 1). On 10/16/2024 at 10:30 a.m., Resident 1 reported the incident of alleged verbal abuse of Resident 2 towards Resident 1 to Social Service Assistant 1 (SSA1). This deficient practice resulted in Resident 1 feeling anxious (feeling of worry, nervousness, or uneasiness) and verbalizing feeling depressed (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities) and stressed in the facility. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 8/3/2024 with diagnoses including chronic systolic heart failure (a specific type of heart failure that occurs in the hearts left bottom chamber), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a record review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The Mood section of the MDS indicated Resident 1 had little interest or pleasure in doing things, feeling down, depressed, or hopeless for 12 to 14 days or nearly every day. During a record review of Resident 1's Care Plan on daily preferences, last revised on 8/19/2024, the Care Plan Goal indicated the resident will express satisfaction with the type of daily preferences and activities. The Care Plan Interventions indicated Resident 1 preferred to go outside to get fresh air when the weather was good and preferred to do things with a group of people. During a record review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 2/27/2019 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), low back pain, and essential hypertension. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 2's Care Plan on behaviors, last revised on 5/4/2022, the Care Plan indicated the resident had the potential to demonstrate verbally offensive behaviors. The Care Plan Indicated Resident 2 retreats to own room after an incident of verbal outburst. During a record review of Resident 2's Care Plan on aggressive behavior, initiated on 6/9/2022, the Care Plan indicated the resident was verbally aggressive towards another resident. The Care Plan Interventions indicated to notify Attending Physician (MD) for any changes in condition or psychosocial well-being (the state of mental, emotional, and social health of an individual). During a record review of Resident 2's Care Plan on aggressive behavior, initiated 3/19/2024, the Care Plan indicated the resident had a verbal aggression. The Care Plan Interventions indicated to notify the MD. During a record review of Resident 2's History and Physical (H&P), dated 4/12/2024, the H&P indicated the resident had the capacity to understand and make a decision. During a record review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. During an interview on 10/29/2024 at 1:54 p.m. with Resident 1, Resident 1 stated Resident 2 had called the resident (Resident 1) derogatory names. Resident 1 stated Resident 2 told facility staff and other residents in a loud voice, that Resident 1 was gay, fat, and disgusting. Resident 1 verbalized feeling stressed and depressed. Resident 1 stated the Administrator (ADM) and SSA1 were informed about the alleged verbal abuse received from Resident 2. During an interview on 10/29/2024 at 2:19 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was inside Resident 2's room when Resident 2 stated Resident 1 was gay in a loud voice. CNA 1 stated Resident 2's voice was loud enough for Resident 1 to hear Resident 2's comment. CNA 1 stated she spoke to Resident 1 after, and Resident 1 was upset at Resident 2. CNA 1 stated she informed the nurse in charge about Resident 2's statement against Resident 1. CNA 1 stated Resident 1's allegation against Resident 2 was considered an alleged verbal abuse. During an interview on 10/29/2024 at 2:34 p.m. and concurrent record review of Resident 1's Care Plan on depression, last revised on 8/27/2024, reviewed with Licensed Vocational Nurse 2 (LVN 2), the Care Plan indicated the resident had depression. The Care Plan Interventions indicated to monitor, document, and report to the nurse and medical doctor (MD) the signs and symptoms of depression including hopelessness, anxiety, sadness . verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. LVN 2 stated Resident 1 was not monitored for signs and symptoms of depression as indicated in the resident's Care Plan. LVN 2 stated Resident 1's behavior not monitored had the potential for facility staff to miss behavioral changes on the resident. During an interview on 10/29/2024 at 2:47 p.m. with Physical Therapist 1 (PT 1), PT 1 stated Resident 1 reported that Resident 2 had verbally harassed Resident 1. PT 1 stated verbal bullying was a type of verbal abuse. PT 1 stated Resident 1's alleged verbal abuse was not reported. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056333	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 2:55 p.m. and concurrent record review of Resident 1's clinical records, reviewed with SSA 1, SSA 1 stated Resident 1 reported to her on 10/16/2024 at 10:30 a.m., about Resident 2's alleged verbal harassment towards Resident 1. SSA 1 stated Resident 2 allegedly called Resident 1 unspecified mean names. Resident 1's behavioral notes indicated MD 1 saw the resident on 9/25/2024. SSA 1 stated MD 1's documented Progress Notes indicated Resident 1's affect during the session were periods of depression and tearfulness, anxious, agitated, and irritable due to the verbal bullying Resident 1 received from Resident 2. SSA 1 stated verbal bullying would be considered as a form of verbal abuse. SSA 1 stated she did not document and report Resident 1's allegation of verbal bullying received from Resident 2. SSA 1 stated not reporting the alleged verbal abuse had the potential for Resident 1's concerns to not be addressed and prevent further abuse. During an interview on 10/29/2024 at 4:40 p.m. and a concurrent record review of Resident 1's Progress Notes, reviewed with the Director of Nursing (DON), the Progress Notes, dated 9/25/2024, indicated MD 1 saw the resident for a behavioral session and documented the session under Behavioral Note. The Behavioral Note indicated Resident 1's goal for the session was to address the reported feelings of depression and anxiety in relation to the resident's experience of bullying within the skilled nursing home with another resident. The Intervention section of the Behavioral Note indicated Resident 1 reported feeling tired of one of the residents bullying him and calling him names like fat, ugly, disgusting, etc. Resident 1 reported significant sadness due to the history of being bullied at school for being obese (having too much body fat). The Response section of the Behavioral Note indicated Resident 1's affect during the session were periods of depression and tearfulness, anxious, agitated, and irritable. Resident 1's Progress Notes, dated 10/18/2024, indicated MD 1 saw the resident for a behavioral session for managing symptoms of Resident 1 major depressive disorder. The behavioral note indicated Resident 1 discussed the concerns about bullying received from another resident. The DON stated she was not informed about Resident 1's allegation of verbal abuse received from Resident 2. The DON stated MD 1's documentation indicated Resident 1 reported harassment which was a form of abuse. The DON stated not reporting the alleged verbal abuse had the potential for the abuse to get worst. The DON stated the facility failed to monitor and address the alleged verbal abuse of Resident 2 to Resident 1. During an interview on 10/29/2024 at 5:19 p.m. with the ADM, the ADM stated she was the facility's abuse coordinator. The ADM stated she was not aware of Resident 1's allegation of bullying received from Resident 2. During a record review of the facility's policy and procedure (PnP) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, last reviewed on 9/11/2024, the PnP indicated if resident abuse . is suspected, the suspicion must be reported immediately to the administrator and to other officials according to State law. The PnP defined the word immediately as within two hours of an allegation involving abuse or result in serious bodily injury. During a records review of the facility's PnP titled, Resident Rights, last reviewed on 9/11/2024, the PnP indicated federal and state laws guarantee certain basic rights to all residents. These rights include the resident rights to .c. be free from abuse, neglect, misappropriation of property, and exploitation.

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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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

46445

Based on interviews and record review, the facility failed to report the allegation of a resident-to-resident verbal abuse ((is harsh and insulting language directed at a person) to the State Survey Agency (SSA) for one of three sampled residents (Resident 1). On 10/16/2024, Resident 1 reported an allegation of abuse by Resident 2 to Social Service Assistant 1 (SSA 1). The Abuse Coordinator reported the allegation to the SSA on 10/29/2024, 13 days after the allegation of abuse was made.

This deficient practice had the potential to result in unidentified abuse and failure to protect other residents from abuse.

Findings:

During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 8/3/2024 with diagnoses including chronic systolic heart failure (a specific type of heart failure that occurs in the hearts left bottom chamber), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition).

During a record review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The Mood section of the MDS indicated Resident 1 had little interest or pleasure in doing things, feeling down, depressed, or hopeless for 12 to 14 days or nearly every day.

During an interview on 10/29/2024 at 1:54 p.m. with Resident 1, Resident 1 stated Resident 2 had called the resident derogatory names. Resident 1 stated Resident 2 told facility staff and other residents in a loud voice, that Resident 1 was gay, fat, and disgusting. Resident 1 verbalized feeling stressed and depressed. Resident 1 stated the Administrator (ADM) and Social Service Assistant 1 (SSA 1) were informed about the alleged verbal abuse received from Resident 2.

During an interview on 10/29/2024 at 2:19 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was inside Resident 2's room when the resident stated Resident 1 was gay in a loud voice. CNA 1 stated Resident 2's voice was loud enough for Resident 1 to hear Resident 2's comment. CNA 1 stated she spoke to Resident 1 after, and the resident was upset at Resident 2. CNA 1 stated she could not remember the date Resident 2 made the statement against Resident 1. CNA 1 stated she informed the nurse in charge about Resident 2's statement against Resident 1. CNA 1 stated Resident 1's allegation against Resident 2 was considered an alleged verbal abuse.

During an interview on 10/29/2024 at 2:47 p.m. with Physical Therapist 1 (PT 1), PT 1 stated Resident 1 reported that Resident 2 had verbally harassed Resident 1. PT 1 was not able to recall the date Resident 1 reported the alleged verbal abuse. PT 1 stated verbal bullying was a type of verbal abuse. PT 1 stated Resident 1's alleged verbal abuse was not reported.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 2:55 p.m. with SSA 1, SSA 1 stated Resident 1 reported to her on 10/16/2024 at 10:30 a.m., about Resident 2's alleged verbal harassment towards Resident 1. SSA 1 stated Resident 2 allegedly called Resident 1 unspecified mean names. SSA 1 stated verbal bullying would be considered as a form of verbal abuse. SSA 1 stated she did not document and report Resident 1's allegation of verbal bullying received from Resident 2. SSA 1 stated not reporting the alleged verbal abuse had the potential for Resident 1's concerns to not be addressed and prevent further abuse. During an interview on 10/29/2024 at 5:19 p.m. with the ADM, the ADM stated she was the facility's Abuse Coordinator. The ADM stated she was not aware of Resident 1's allegation of bullying received from Resident 2. The ADM stated she was aware all allegations of abuse must be reported within two hours to the SSA, Ombudsman, and law enforcement. During a record review of the facility's policy and procedure (PnP) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, last reviewed on 9/11/2024, the PnP indicated if resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to State law. The PnP defined the word immediately as within two hours of an allegation involving abuse or result in serious bodily injury.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46445 Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for one of three sampled residents (Resident 1). On 10/16/2024 at 10:30 a.m., Resident 1 reported the incident of alleged verbal abuse (is harsh and insulting language directed at a person) of Resident 2 towards Resident 1 to Social Service Assistant 1 (SSA 1). SSA 1 did not document the conversation with Resident 1 in Resident 1's clinical record. This deficient practice resulted in inaccurate information in Resident 1's clinical record. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 8/3/2024 with diagnoses including chronic systolic heart failure (a specific type of heart failure that occurs in the hearts left bottom chamber), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a record review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The Mood section of the MDS indicated Resident 1 had little interest or pleasure in doing things, feeling down, depressed, or hopeless for 12 to 14 days or nearly every day. During an interview on 10/29/2024 at 1:54 p.m. with Resident 1, Resident 1 stated Resident 2 had called the resident derogatory names. Resident 1 stated Resident 2 told facility staff and other residents in a loud voice, that Resident 1 was gay, fat, and disgusting. Resident 1 verbalized feeling stressed and depressed. Resident 1 stated the Administrator (ADM) and SSA1 were informed about the alleged verbal abuse received from Resident 2. During an interview on 10/29/2024 at 2:55 p.m. and concurrent record review of Resident 1's clinical records, reviewed with SSA 1, SSA 1 stated Resident 1 reported to her on 10/16/2024 at 10:30 a.m., about Resident 2's alleged verbal harassment towards Resident 1. SSA 1 stated Resident 2 allegedly called Resident 1 unspecified mean names. SSA 1 stated verbal bullying would be considered as a form of verbal abuse. SSA 1 stated she did not document Resident 1's allegation of verbal bullying received from Resident 2 in Resident 1's clinical records. SSA 1 was not able to provide documented evidence of Resident 1's reported allegation of verbal abuse received from Resident 2. SSA 1 stated conversations with Resident 1 regarding the resident's concerns should be documented. SSA 1 stated not documenting had the potential for resident concerns to be overlooked and not resolved. SSA 1 stated it is the facility's policy to ensure complete documentation in the resident's clinical records. SSA 1 stated the facility failed to ensure all resident concerns were documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 4:40 p.m. with the Director of Nursing (DON), the DON stated all resident concerns and conversations with the residents should be documented in the resident's clinical records. The DON stated the facility failed to effectively communicate and document Resident 1's reported allegation of abuse. During a record review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 9/11/2024, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's clinical records. The PnP indicated the clinical record should facilitate communication between the interdisciplinary team (IDT, a coordinated group of experts from several different fields) regarding the resident's condition and response to care.