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	01/24/2025

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 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 42311 Based on interview and record review, the facility failed to develop a baseline individualized care plan for one of three sampled residents (Resident 1). Resident 1 had no care plan to address safety precautions related to history of epilepsy (repeatedly uncontrolled electrical activity in the brain, which may produce a jerking movement of a part or the entire body. This deficient practice had the potential for Resident 1 to not receive appropriate care and treatment specific to their needs. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/10/2024, with diagnoses that included unspecified (unconfirmed) epilepsy (recurrent seizures, which are brief episodes of abnormal brain activity that can cause involuntary movements), loss of consciousness, or other symptoms, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and other lack of coordination. During a record review of Resident 1's History and Physician (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 12/11/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/14/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting and dressing. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. During a record review of Resident 1's Order Summary Report dated 12/11/2024, the Order Summary Report indicated Resident 1 was on the following medications: 1. Depakote (medication used to treat seizure [temporary disruptions in brain electrical activity that can cause involuntary movements, changes in awareness, or other symptoms] disorders) oral tablet delayed release 250 milligram (mg- metric unit of measurement, used for medication dosage and or amount), give one tablet by mouth three times a day for seizures. (continued on next page)

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	2. Keppra (medication used to treat seizure) oral tablet 500 mg, give one tablet by mouth two times a day for seizure 3. Phenytoin sodium (medication used to treat seizure) extended (release at a delayed or slower rate) oral capsule, give 260 mg by mouth at bedtime for seizure. During a record review of Resident 1's Change in Condition Evaluation (CIC-a medical document used by healthcare professionals to document and report any significant changes in a patient's physical or mental status) dated 12/14/2024, the CIC indicated Resident 1 had a seizure. The CIC indicated the physician was notified at 11 a.m. and ordered lorazepam (medication used to treat seizure) one mg every eight hours as needed for seizure. During a review of Resident 1's Care Plan about episode of seizure dated 12/14/2024, the Care Plan indicated only the following interventions: 1. Notify family. 2. Notify the physician 3. Administer medications as ordered 4. Neurology (concerned especially with the structure, function, and diseases of the nervous system) consults as ordered. During a record review of Resident 1's Change in Condition Evaluation (CIC) dated 12/18/2024, the CIC indicated Resident 1 had a seizure. The CIC indicated the physician was notified at 2 p.m. and ordered to transfer Resident 1 to the hospital. During an interview on 1/24/2025, at 9:24 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he (LVN 1) was the assigned LVN when Resident 1 had a seizure on 12/14/2024. LVN 1 stated seizure precautions (safety measures taken to reduce the risk of injury to people who have seizures) involve padded side rails and foam padding on sharp edges to prevent injury. LVN 1 stated there should be a care plan for seizure precautions. During a concurrent interview and record review on 1/24/2025 at 10:31 a.m., with Registered Nurse 1 (RN 1), Resident 1's Care plan was reviewed. RN 1 stated there were no care plan on seizure precaution and at risk for fall related to seizure and there should be one created. RN 1 stated upon admission RN Supervisor creates a care plan for pain, safety, fall and activities of daily living. RN 1 stated the MDS Nurse (MDSN) creates the other care plans the next day or within 72 hrs. RN 1 stated the importance of care plan for seizure and fall was to provide quality of care and guides the nurses on what are the seizure precaution interventions. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025, at 11:22 a.m., with the MDS Nurse (MDSN), the MDSN stated the care plan for seizure history was not created. The MDSN stated the importance of care plan was to individualized focus of care. The MDSN stated the intervention included in the care plan for seizure precaution should include seizure prevention like padding the side rails, low bed, oxygen if available and after seizure intervention should include keep resident safe from injury, check vital signs (measure the basic functions of your body. They include your body temperature, blood pressure, pulse and respiratory [breathing] rate), call the physician and administer medication. During an interview on 1/24/2025, at 11:34 a.m., with the Director of Nursing (DON), the DON stated baseline care plan for risk for fall and risk for seizure should have been created for safety During a review of policy and procedure titled, Seizures and Epilepsy- Clinical Protocol, dated 11/2018 and last reviewed on 9/25/2024, the PnP indicated, 1. The physician and staff will help identify individuals who have a history of seizure or epilepsy, and individuals who are receiving antiepileptic (medications used to prevent or control seizures, which are abnormal electrical activity in the brain) medications for any reason; for example, seizure prophylaxis (prevention) after a recent stroke (occurs when blood flow to the brain is interrupted, causing brain cells to die) or treatment for behavioral symptoms related to dementia (progressive state of decline in mental abilities). 3. The staff and physician will monitor for complications related to antiepileptic medications, for example, dizziness, ataxia (a condition characterized by a loss of muscle coordination, balance, and movement control), somnolence (an excessive feeling of drowsiness and sleepiness), headache, diplopia (is a condition where a person sees two distinct images of a single object), blurred vision, nausea, vomiting, and rash. During a record review of facility's PnP, titled, Care Plans-Baseline, dated 11/2022 and last reviewed on 9/25/2024, the PnP indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. 4. The resident and or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.