

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 06/02/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Conv Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide copy of medical records upon written request for two of three sampled residents (Resident 1 and Resident 2). On 5/9/2025 at 10:32 a.m., Resident 1 requested for medical records and the medical records were sent electronically on 5/27/2027 at 3:57 p.m. (18 days). On 5/27/2025 at 12:01 p.m., Family Member (FM) 1 requested for Resident 2's medical records and the medical records were not received as of 6/2/2025.</p> <p>This deficient practice violated the rights of Resident 1 and Resident 2 to obtain a copy of their medical records.</p> <p>Findings:</p> <p>a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/6/2024 and readmitted the resident on 1/14/2025 with diagnoses including acute respiratory failure (your lungs are not working properly to get enough oxygen into your blood and/or remove enough carbon dioxide), end stage renal disease (ESRD- irreversible kidney failure), and dependent on renal dialysis (a treatment that filters blood when your kidneys are not working properly).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 1 usually understood and was usually able to make self understood. The MDS indicated Resident 1 required substantial to maximal assistance (helper does more than half the effort) with eating, oral hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.</p> <p>During a review of the facility-provided record titled, Medical Records Request Summary (MRRS), for 5/2025, the MRRS indicated on 5/9/2025 at 10:32 a.m. Resident 1, through a Law Office (LO), requested medical records and Skilled Nursing Facility (SNF) 1 called and informed LO that SNF 1 received the request. The MRSS indicated on 5/19/2025 at 2:43 p.m. an invoice was sent to LO for the copy of medical records via email. The MRSS further indicated on 5/27/2025 at 3:57 p.m. SNF 1 sent medical records electronically.</p> <p>(continued on next page)</p>

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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 5/19/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure (the inability of the respiratory system to meet the oxygenation, ventilation, or metabolic requirements of the patient) with hypoxia (the body is not getting enough oxygen), and adult failure to thrive (a gradual decline in health and well-being, often marked by weight loss, poor nutrition, and a reduced ability to perform daily activities).</p> <p>During a review of the MDS, dated [DATE], the MDS indicated Resident 2 sometimes understood and sometimes was understood. The MDS indicated Resident 2 was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off footwear and required substantial assistance with upper body dressing.</p> <p>During a review of the facility-provided record MRRS, dated 5/2025, the MRRS indicated on 5/27/2025 at 12:01 p.m. Family Member (FM) 1 requested for Resident 2's records and on 5/27/2025 at 12:52 p.m. FM 1 sent signed authorization to release form via email.</p> <p>During an interview on 6/2/2025 at 1:32 p.m. with the Medical Records Director (MRD), the MRD stated the process for requesting medical records is once the facility receives the request the MRD contacts the party to sign the authorization to release form. The MRD stated the facility will let the requesting party know the total number of papers and the cost of the request. The MRD stated there was a delay in retrieving the records for Resident 1 because the facility was attempting to collect the dialysis binder from the dialysis center. The MRD stated the facility decided to just send the invoice without the dialysis records to the LO. The MRD stated records should have been given within forty-eight (48) hours. The MRD stated records were not provided within 48 hours to Resident 1.</p> <p>During an interview on 6/2/2025 at 2:17 p.m. with the MRD, the MRD stated for Resident 2, the facility was waiting on the Medical Doctor (MD) to sign the discharge paperwork. The MRD stated FM 1 requested for records on 5/27/2025 and the invoice was provided on 6/2/2025, hence, the record request was not provided within 48 hours. The MRD stated that not being able to provide the records as per policy may cause the requester to not be able to get the records if it is for an emergent purpose because the facility should be providing records within the 48 hours. The MRD was not able to provide documented evidence Resident 2's medical records were provided to FM 1 as of 6/2/2025.</p> <p>During an interview on 6/2/2025 at 3 p.m. with the Director of Nursing (DON), the DON stated when residents and/or family requests for medical records the MRD is the one that is responsible for providing records within 48 hours. The DON stated there was a six (6) day delay in providing Resident 1 with the invoice to obtain the medical records and a delay of four (4) days in providing Resident 2's family with invoice. The DON stated the potential for not providing records within the 48 hours would be not following the policy.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Release of Information, last reviewed on 9/2024, the P&P indicated, A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 1) when Resident 1's Dialysis Communication Records binder went missing on 2/20/2025 with Resident 1's Dialysis Communication Records.</p> <p>This deficient practice had the potential to negatively impact the delivery of services to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/6/2024 and readmitted the resident on 1/14/2025 with diagnoses including acute respiratory failure (your lungs are not working properly to get enough oxygen into your blood and/or remove enough carbon dioxide), end stage renal disease (ESRD- irreversible kidney failure), and dependent on renal dialysis (a treatment that filters blood when your kidneys are not working properly).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 1 usually understood and was usually able to make self understood. The MDS indicated Resident 1 required substantial to maximal assistance (helper does more than half the effort) with eating, oral hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.</p> <p>During a review of Resident 1's Order Summary Report, dated 1/15/2025, the Order Summary Report indicated:</p> <ul style="list-style-type: none"> - dialysis schedule Tuesday/Thursday/Saturday chair time at 2 p.m. - dialysis monitor dialysis site (right upper chest) for tenderness, redness, and or bleeding. N=no abnormal findings, y= presence of abnormal findings, Notify the Medical Doctor (MD). <p>During a review of Resident 1's Order Summary Report, dated 2/20/2025, the Order Summary Report indicated to transfer Resident 1 to General Acute Care Hospital (GACH) 1 from dialysis center due to altered mental status.</p> <p>During a review of Resident 1's Progress Notes, dated 2/20/2025 at 2:50 p.m., the Progress Notes indicated the facility received a call from the dialysis center that Resident 1 was transferred to GACH 1.</p> <p>During an interview on 6/2/2025 at 1:10 p.m. with Registered Nurse (RN) 1, RN 1 stated when a dialysis resident go to the dialysis center, the resident takes the dialysis binder that is a communication binder with the Skilled Nursing Facility (SNF) 1 and the dialysis center but if the resident does not come back then the facility does not get the binder back. RN 1 stated Resident 1 went out to GACH 1 from the dialysis center and Resident 1 never came back and SNF 1 never got the dialysis binder back.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/2025 at 3 p.m. with the Director of Nursing (DON), the DON stated for dialysis residents we have a form called Dialysis Communication Record where the SNF 1 nurses will document prior to resident's dialysis and then the dialysis center will communicate to SNF 1 if anything special was done to the resident while at the dialysis center, then SNF 1 will assess the resident and document the post assessment in the Dialysis Communication Record. The DON stated the nurses are the ones responsible to ensure the Dialysis Communication binder goes and returns with the resident. The DON stated for Resident 1 we are not sure where the Dialysis Communication binder went. The DON stated facility staff should have communicated with the dialysis center to get the binder back. The DON stated SNF 1 does not have Resident 1's Dialysis Communication binder. The DON stated the reason to have the Dialysis Communication binder is to have continuity of care to see if there has been a Change of Condition (COC), so each side knows the care that the resident was given and status of the resident. The DON stated it is for continuity and consistency of the care. The DON stated there can be an issue with possible missing treatment, and an issue with having accurate documentation.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documenting, last reviewed on 9/2024, the P&P indicated documentation in the medical record will be objective, complete, and accurate.</p>		