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	08/05/2025

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 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. (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Resident 1's intermittent catheterization (a procedure where a hollow tube is temporarily inserted into the bladder to drain urine and then removed) procedure was documented. This deficient practice had the potential to result to inaccurate medical interventions for Resident 1. Findings: During a review of Resident 1's admission Record (AR), AR indicated facility originally admitted Resident 1 on 5/30/2025 and readmitted on [DATE] with diagnoses including anxiety disorder (feeling of anxiousness that affects daily life), urinary tract infection (UTI- an infection in the bladder/urinary tract), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 1's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was intact. The MDS further indicated Resident 1 required maximal assistance from staff for toileting hygiene and lower body dressing. During a review of Resident 1's History and Physical (H&P), dated 8/1/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-8/2/2025: May insert a straight catheter (a thin flexible tube used to drain urine from the bladder) to collect urine sample for ordered urinalysis (a series of tests performed on a urine sample to detect the presence of diseases or conditions) and urine culture (a test used to identify and detect bacteria in urine sample). During an interview on 8/5/2025 at 11:03a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the procedure of intermittent catheterization for Resident 1 was completed on 8/2/2025. LVN 1 stated the procedure was not documented in Resident 1's medical record. LVN 1 further stated the procedure and resident's response to the procedure should have been documented in Resident 1's medical record to indicate the procedure was completed. During an interview on 8/5/2025 at 12:55a.m. with the Director of Nursing (DON), the DON stated the facility should have documented Resident 1's procedure of intermittent catheterization in Resident 1's medical record as it was part of Resident 1's record and was part of communication for safety and comfort. The DON stated this failure had the potential for miscommunication and for Resident 1 to miss important treatments. During a record review of the facility-provided policy and procedure titled, Catheterization, Intermittent, Female Resident, last reviewed on 9/2024, the policy and procedure indicated, The following information should be recorded in the resident's medical record:1. The date and time of the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. The amount of urine drained. 4. The character, clarity, and color of the urine. 5. Any observation of obstruction; evidence of blood, pus, etc. 6. Any change in the resident's condition (e.g., swelling, discomfort, etc.). 7. Any problems or complaints made by the resident related to the procedure. 8. The resident's response to the treatment. 9. All assessment data obtained during the procedure. 10. If the resident refused the procedure, the reason(s) why and the intervention taken 11. The signature and title of the person recording the data. During a record review of the facility-provided policy and procedure titled, Charting and Documentation, last reviewed on 9/2024, the policy and procedure 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 medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Documentation of procedures and treatments will include care-specific details.