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	10/14/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain privacy of confidential information when Licensed Vocational Nurse (LVN) 1 left electronic health record (EHR- a digital version of a patient's paper chart) open and unattended for one of three sampled residents (Resident 2). This deficient practice violated Resident 2's right to privacy and confidentiality of medical records. Findings: During a Review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 9/25/2025 with diagnoses including muscle weakness (generalized), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 2 usually had the ability to understand and usually had the ability to be understood. The MDS indicated Resident 2 required substantial (helper does more than half the effort) with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. During a concurrent observation and interview on 10/14/2025 at 11:52 a.m., in Nurses Station 3, observed Resident 2's EHR opened and unattended. LVN 1 stated she had logged into the computer and walked away from the computer. LVN 1 stated the computer was out of LVN 1's sight. LVN 1 stated LVN 1 should have logged off the computer. LVN 1 stated LVN 1 should not have the computer opened and unattended. During an interview on 10/14/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated when staff are logged into computers and walk away, they must turn off the computer. The DON stated if staff do not turn off the computer, it is a violation of Health Insurance Portability and Accountability Act (HIPPA- established federal standards protecting sensitive health information from disclosure without resident's consent) violation. The DON stated if the computer is not turned off, there is a potential for unauthorized people to have access to the residents' records. During a review of the facility's Policy and Procedure (P&P) titled, Protected Health Information (PHI), Safeguarding Electronic, last reviewed on 9/10/2025, the P&P indicated electronic protected information (e-PHI) is safeguarded by administrative, technical and physical means to prevent unauthorized access to protected health information. Access to e-PHI is restricted to only individuals who have been granted access rights.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to obtain informed consent (permission granted in the knowledge of the possible consequences, typically that which is given by a resident and or Responsible Party [RP] to a doctor for treatment with full knowledge of the possible risks and benefits) from one of three sampled resident (Resident 2)'s RP for the use of a bed alarm (a safety device that makes a sound or alerts a caregiver when a person gets out of bed, sits up, or moves suddenly). This deficient practice had the potential to violate Resident 2 and their RP's rights to an informed consent. Findings: During a Review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 9/25/2025 with diagnoses including muscle weakness (generalized), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 2 usually had the ability to understand and usually had the ability to be understood. The MDS indicated Resident 2 required substantial (helper does more than half the effort) with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 2's admission and readmission Data Tool, dated 9/25/2025, the admission and readmission Data Tool indicated Resident 2 was at risk for falls. During a review of Resident 2's History and Physical (HP - a fundamental medical document that combines a resident's detailed health background with a comprehensive physical examination by a healthcare provider), dated 9/26/2025, the HP indicated Resident 2 does not have the capacity to understand and make decisions. During a review of Resident 2's Care plan, initiated on 9/30/2025 and updated on 10/12/2025, the Care plan indicated Resident 2 had an actual fall ambulating to bathroom without assistance, history of falls, poor balance, unsteady gait. The Care plan indicated interventions included may apply sensor alarm to reduce potential injury, and to notify the MD and Family of any changes to residents. During a review of Resident 2's Change of Condition (COC - a major decline in a resident's health status) Evaluation, dated 9/30/2025 at 3 a.m., the COC Evaluation indicated Resident 2 had a fall. The COC indicated as Certified Nursing Assistant (CNA) was doing rounds before taking a break, the Resident 2 was found on the floor. Provider notification and feedback indicated the medical doctor (MD) was notified on 9/30/2025 at 3:05 a.m. with an order for bed alarm. During a review of Resident 2's Order Summary Report, dated 9/30/2025, the order summary report indicated may apply sensor alarm (bed alarm) to reduce potential injury. (Informed consent obtained by the MD from family after explanation of risk and benefits and verified by Licensed Nurse). During a review of Resident 2's COC Evaluation, dated 10/12/2025 at 8 p.m., the COC Evaluation indicated Resident 2 attempted to get out of bed, slid off the bed and landed on the floor mat. Provider notification and feedback indicated the MD was notified on 10/12/2025 at 8 p.m. with an order to place bed alarm. During a concurrent observation and interview on 10/14/2025 at 12 p.m. of Resident 2's bed alarm with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 has a bed alarm. CNA 1 stated the bed alarm rings if Resident 2 moves and or attempts to get out of bed unassisted. CNA 1 asked Resident 2 to move, and the alarm sounded. During a review of Resident 2's Facility Verification of Informed Consent, the Facility Verification of Informed Consent indicated for the use of bed alarm. The Facility Verification of Informed Consent indicated Resident 2's RP consented to the use of bed alarms on 10/12/2025 and the MD signed for the consent on 10/13/2025. During a concurrent interview and record review on 10/14/2025 at 4 p.m. with the Director of Nursing (DON), Resident 2's Facility Verification of Informed Consent was reviewed and the DON stated once the bed alarm was ordered by the MD on 9/30/2025, the bed alarm was initiated and used for Resident 2. The DON stated there needs to be a consent for the use of bed alarm because it will make a loud noise, it alarms, and it may cause the resident discomfort. The DON stated Resident 2 cannot make medical decisions and Resident 2's family is the one that consent to the use of the bed alarm. The DON reviewed the Facility Verification of Informed Consent and stated Resident 2's family consented to the use of the bed alarm on 10/12/2025 but the facility should have obtained the consent on 9/30/2025. The DON stated there can be a potential for the family to not consent to the treatment of Resident 2. During a review of the facility's Policy and Procedure (P&P) titled, Use of Restraints, last reviewed on 9/10/2025, the P&P indicated restraints shall only be used upon the written order of a physician and after obtaining consent form the resident and or representative. During a review of facility's P&P titled, Change in a Resident's Condition or Status, last reviewed on 9/10/2025, the P&P indicated our facility promptly notifies the resident, his or her attending physician and the resident representative (RP) of changes in the resident's medical, mental

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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)

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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	Based on interview and record review, the facility failed to maintain accurate medical records for one of three sampled residents (Resident 2) when Resident 2 had two active orders that contradicted (two seemingly opposite ideas are both true) each other. This deficient practice had the potential to negatively impact the delivery of services to Resident 2. Findings: During a Review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 9/25/2025 with diagnoses including muscle weakness (generalized), history of falling, and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 2 usually had the ability to understand and usually had the ability to be understood. The MDS indicated Resident 2 required substantial (helper does more than half the effort) with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 2's History and Physical (HP - a fundamental medical document that combines a patient's detailed health background with a comprehensive physical examination by a healthcare provider), dated 9/26/2025, the HP indicated Resident 2 does not have the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, dated 9/25/2025, the Order Summary Report indicated:- nothing by mouth (NPO) texture, NPO consistency.- Total Parenteral Nutrition (TPN - a method of providing complete nutrition directly into the bloodstream through an intravenous [IV - fluids given directly into the blood stream] line, bypassing the digestive system entirely) start on 9/26 am continuous two to one (2:1) TPN at 75 milliliters (ml - a unit of measurement) per hour via Peripherally Inserted Central Catheter (PICC - a long, thin tube inserted into a vein in the upper arm that goes to a large vein near the heart) (dextrose [sugar] 11.1%, amino acids [organic compounds that serve as the building blocks of proteins] 3.78%) Registered Nurse (RN) to add prior to infusion 10 ml Multivitamin infusion (MVI - solution containing a combination of essential vitamins) one time a day. During a review of Resident 2's Order Summary Report, dated 9/26/2025, the Order Summary Report indicated:- NPO except medications.- TPN electrolytes IV concentration use 75 ml per hour one time a day for at risk of malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). During a review of Resident 2's Progress Noted, dated 10/10/2025, at 11:18 a.m. , the Progress Notes indicated Resident 2 came back from the general surgeon office with new order to continue the TPN, start on clear liquid diet (a short-term diet consisting only of liquids that are see-through, like water, clear broth, and pulp-free juices). During a review of Resident 2's Order Summary Report, dated 10/10/2025, the Order Summary Report indicated clear liquid diet liquidized texture, thin consistency (liquid flows easily, like water, because it has a low viscosity and is not thick or heavy) for clear liquid diet. During a concurrent observation and interview on 10/14/2025 at 12 p.m. of Resident 2's breakfast tray with Certified Nursing Assistant (CNA) 1, CNA 1 stated he (CNA 1) is assigned to Resident 2 but is not assigned to assist Resident 2 with her meals. CNA 1 stated Resident 2 has a tray at bedside with chicken broth, juice and Jello form breakfast that had not been touched or eaten at all. During a concurrent interview and record review on 10/14/2025 at 2 p.m. with the Quality Assurance Nurse (QA), Resident 2's Physician Orders was reviewed and the QA stated is he (QA) is aware Resident 2 had two orders, one for Resident 2's diet being NPO. The QA stated the NPO order was discontinued today because Resident 2 now has an order for a new diet. During an interview on 10/14/2025 at 2:41 p.m. with RN 1, RN 1 stated Resident 2 was admitted to the facility with a previous gastrointestinal bleed (GI - when there is bleeding in any part of the digestive tract, from the esophagus [a hollow, muscular tube that carries food and liquid from your throat to your stomach] to the anus [opening where your bowel movements (also known as poop) come out]) and that is why Resident 2 was placed on TPN. RN 1 stated Resident 2 is now on a clear liquid diet. RN 1 stated she (RN 1) was the one who input the new order for clear liquid diet, RN 1 stated prior to the new order for clear liquid diet, Resident 2 was NPO only medication. RN 1 stated if Resident 2 has both active orders for NPO and clear liquids there will be confusion that can cause an issue with the quality of care for the resident. RN 1 stated the confusion can cause Resident 2 to not get the ordered diet of clear liquids because Resident 2 also has the NPO diet ordered. RN 1 stated can potentially cause Resident 2 to lose weight. During an interview on 10/14/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated regarding Resident 2's NPO order, the order should have been discontinued because it can cause confusion. The DON stated having both NPO diet and clear liquid diet would not be accurate documentation because we have two orders that are