STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation Center	201 Koontz Lane Carson City, NV 89701

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure a resident's right to self determination was respected when the facility failed to inform a new Certified Nursing Assistant (CNA) of the resident's wishes not to be disturbed for care during the night. The CNA continued to attempt to turn the resident after the resident had asked the CNA to stop, resulting in bruising to the resident's thigh for 1 of 28 sampled residents (Resident #23). Findings include: Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including other specified arthritis, unspecified site, essential primary hypertension, and chronic obstructive pulmonary disease. An initial Facility Reported Incident (FRI) submitted to the State Agency (SA) on 10/29/2024, documented Resident #23 complained of being provided rough care by a CNA on 10/26/2024. The CNA was identified, and the date of the incident was determined to be 10/27/2024. Resident #23's Comprehensive Care Plan included a care plan with a revision date of 08/19/2024 related to grooming and personal hygiene. The care plan documented the resident did not want to be awakened for rounds and would use the call light if the resident needed assistance. On 11/04/2024 at 10:42 AM, Resident #23 verbalized the resident was provided rough care by a CNA and had bruises on the resident's thigh. The distal portion of Resident #23's thigh had three oblong purple marks measuring approximately 7-8 centimeters (cm) x 1.5 cm. Adjacent to the three oblong purple marks was a round purple mark approximately 1.5 -2.0 cm in diameter. The resident explained the CNA entered the resident's room in the middle of the night, woke the resident, ripped the sheets off of the resident, and started pulling on the resident. Resident #23 verbalized the resident told the CNA to stop, but the CNA would not listen and did not stop. Resident #23 verbalized the CNA spoke very rudely to the resident and told Resident #23 the resident had to be changed, and added do you just want to get bedsores?. A Social Services note dated 10/29/2024, documented Resident #23 had made an allegation of abuse from a staff member. The incident was reported to the Executive Director and an investigation was pending. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/2024 at 2:55 PM, the Executive Director confirmed Resident #23 had correctly identified the CNA. The Executive Director explained on the night of the incident, the CNA informed the Registered Nurse (RN) Resident #23 had complained about the CNA being too rough with care. The Executive Director further explained the CNA was not informed of the resident's wishes not to be disturbed during the middle of the night unless the resident called for assistance. The facility policy titled Notice of Resident Rights Under Federal Law, updated 11/2016, documented residents had the right to a dignified existence and self-determination. Residents had the right to be treated with respect and dignity. Residents had the right to reasonable accommodation of individual needs or preferences, except where the health or safety of the resident or other residents was endangered. FRI #NV00072571

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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 - 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** 43310 Based on observation, clinical record review, interview, and document review the facility failed to protect residents from physical abuse for 2 of 28 sampled residents (Resident #72 and #104) from resident to resident abuse. Resident #104 obtained a facial fracture resulting in actual harm. Resident #72 obtained lacerations requiring eight staples resulting in actual harm. Findings include: Resident #72 Resident #72 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease and anxiety disorder. Diagnoses added on 10/31/2024, included laceration without foreign body of scalp, subsequent encounter, and unspecified injury of the head, subsequent encounter. A Minimum Data Set 3.0 (MDS) assessment dated [DATE], Section C (Cognition), documented a Brief Interview for Mental Status (BIMS) assessment was not conducted for Resident #72 due to the resident was rarely and/or never understood. Resident #72's cognitive skills for daily decision making was severely impaired. A Nursing Progress Note dated 10/09/2024, documented Resident #72 walked past Resident #240, cutting in between Resident #240 and a staff member. Resident #240 grabbed and spun Resident #72 around and hit Resident #72 in the face and on the body with open hand and closed fist. Resident #72's Comprehensive Care Plan, initiated on 04/02/2021, documented the resident was at risk for resident to resident altercations related to dementia with behavioral disturbances. Interventions included redirecting Resident #72 away from other residents if Resident #72 became too friendly. The Comprehensive Care Plan documented throughout Resident #72's stay at the facility, there had been multiple resident to resident incidents where Resident #72 was hit, grabbed, and shoved by other residents. Resident #240 Resident #240 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy, schizoaffective disorder, bipolar type, borderline personality disorder, generalized anxiety disorder, personal history of traumatic brain injury, and other symptoms and signs involving cognitive functions and awareness. A final Facility Reported Incident (FRI) submitted to the State Agency (SA) on 10/09/2024, documented on 10/09/2024, Resident #240 was standing in the hallway outside of the nutrition room and a staff member was standing across from Resident #240. Resident #72 walked between Resident #240 and the staff member. Resident #240 grabbed Resident #72, spun the resident around and hit Resident #72 multiple times on the face and body with an open hand and a closed fist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #240's MDS assessment dated [DATE], Section C (Cognition), documented a BIMS score of 10, indicating the resident had moderate cognitive impairment. Section E (Behavior) documented the resident had delusions and verbal behaviors directed towards others occurred daily. Resident #240's Comprehensive Care Plan documented the following: -A care plan initiated on 01/09/2024, documented Resident #240 had an escalation in behaviors and had pushed and punched another resident on 01/24/2024, hit another resident in the face with a teddy bear on 04/02/2024, punched another resident in the arm on 04/12/2024, and pulled another resident's hair on 08/08/2024. -A care plan initiated on 01/10/2024 documented Resident #240 had the potential to be physically aggressive. On 01/09/2024, Resident #240 hit a resident on the shoulder and hit another resident in the stomach with the back of Resident #240's hand. -On 07/22/2024, Resident #240 hit a resident on the back of the resident's shoulder. -On 09/20/2024, Resident #240 pushed a resident. -On 10/03/2024, Resident #240 pushed another resident in the hallway resulting in a fall. -On 10/09/2024, Resident #240 hit a resident who walked past Resident #240 on 10/09/2024. The resident had uncontrollable behaviors, destruction of property, and refused care and medications. Resident #240's Medication Administration Record (MAR) for October 2024, documented the resident refused medications as follows: -Aripiprazole oral tablet, 15 milligrams (mg), give one time per day for mania, was documented as refused by the resident each day from 10/01/2024-10/09/2024. -Lorazepam oral concentrate 2 mg/milliliter (ml), give one ml by mouth two times a day for anxiety, documented the morning dose of the medication was refused by the resident on 10/01 and 10/03-10/09/2024. The evening dose of the medication was refused by the resident on 10/02, 10/03, and 10/05 -10/09/2024. On 11/07/2024 at 1:45 PM, a Registered Nurse (RN) recalled being present when Resident #240 hit Resident #72. The RN explained Resident #72 walked between Resident #240 and a staff member. Resident #240 began hitting Resident #72. The RN confirmed Resident #240 often refused to take medications and had increased behaviors directed towards others, including on 10/09/2024. On 11/07/2024 at 1:53 PM, a Licensed Practical Nurse (LPN), verbalized the Executive Director was the Abuse Coordinator. On 11/07/2024 at 2:24 PM, the Executive Director verbalized on 10/09/2024, Resident #240 was in a common area of the Memory Care Unit when Resident #72 walked past Resident #240. The Executive Director confirmed Resident #240 hit Resident #72 several times in the face with an open hand and a fist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/07/2024 at 2:28 PM, the Executive Director confirmed Resident #240 had been escalating all day and had refused medication. The Executive Director explained Resident #240 was non-ambulatory when first admitted to the facility, but now walked all over the unit and the resident was getting more difficult to handle. FRI #NV00072412 A final FRI submitted to the SA on 10/31/2024, documented on 10/30/2024, Resident #72 was wandering the halls and attempted to enter Resident #135's room. Resident #135 grabbed Resident #72 by the shoulder and pushed the resident to the floor, resulting in a laceration to the back of Resident #72's head. Both Residents resided in the Memory Care Unit. (Resident #72) An Alert Charting Note for Resident #72, dated 10/30/2024, documented at approximately 7:35 PM, Resident #72 was in the hallway near the door of Resident #135's room. A Licensed Practical Nurse (LPN) was requested to assist with Resident #72 following an altercation between Resident #72 and Resident #135. The nurse arrived to the scene and observed Resident #72 sitting on the floor. A staff member was assisting Resident #72 to a sitting position and was holding a compress on the back of Resident #72's head. The LPN visualized excessive blood pooling onto Resident #72's neck and draining onto the resident's clothing. The resident was transported to an acute care hospital for further evaluation. A Nurse Progress note dated 10/31/2024, documented Resident #72 arrived back at the facility at 9:00 AM. The resident had eight staples on the right side of the resident's head. Resident #135 Resident #135 was admitted to the facility on [DATE], with diagnoses including paranoid personality disorder, bipolar type, generalized anxiety disorder, auditory hallucinations, and restlessness and agitation. A diagnosis of schizoaffective disorder was added on 10/04/2024. An MDS assessment dated [DATE], Section C (Cognition), documented Resident #135's BIMS score was 99, indicating the resident did not participate in the assessment. Section E (Behavior) documented the resident had delusions, and verbal behaviors directed towards others daily. Resident #135's Medication Administration Record (MAR) for October 2024, documented the resident refused medications as follows: -Doxepin hydrochloride (HCL) 25 mg capsules, give four capsules by mouth one time a day for insomnia, was documented as refused by the resident each day from 10/02 - 10/07, 10/09, 10/11-10/16, 10/18, 10/19, 10/24-10/26, 10/30, and 10/31/2024. Doxepin HCl is a tricyclic antidepressant. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Quetiapine fumarate oral tablet 200 mg, give one tablet by mouth four times a day for mood. The medication had a stop date of 10/15/2024. The medication was refused by the resident during the morning on 10/01, 10/02, 10/04-10/11, and 10/13/-10/15. The medication was refused by the resident during each afternoon on 10/02 - 10/11, and 10/13 - 10/15. The medication was refused by the resident during each evening on 10/10/01- 10/06, 10/08 - 10/11, and 10/14/2024. The medication was refused by the resident each night on 10/03 - 10/07, 10/09, and 10/11 - 10/14/2024. -Quetiapine fumarate oral tablet 200 mg, give two tablets by mouth two times a day for mood. The medication had a start date of 10/15/2024 during the evening shift. The medication was refused by the resident each day shift on 10/16. 10/17, 10/19-10/21, 10/23, and 10/27-10/30/2024. The Medication was refused by the resident each evening shift on 10/15/10/16, 10/17, 10/18, 10/19, 10/22, 10/24 - 10/27, and 10/29 - 10/31/2024. -Diazepam oral tablet, 5 mg, give one tablet by mouth three times per day for generalized anxiety disorder. The medication was refused by the resident during each day shift on 10/01, 10/02, 10/04-10/11, 10/13-10/17, and 10/19-10/30/2024. The Medication was refused by the resident during each afternoon shift on 10/03-10/11, 10/13-10/17, 10/19-10/25, and 10/27-10/30. The Medication was refused by the resident during each evening shift on 10/02 -10/07, 10/09 -10/15, 10/18, 10/19, 10/22, and 10/24-10/31/2024. Resident #135's clinical record documented the following behaviors were noted throughout the day on 10/30/2024. -Was having auditory/visual hallucinations and responded to the hallucinations by yelling, growling and making statements which could not be understood. -Was noted to have had hallucinations and was known to respond to internal stimuli and would yell out in response. -Continued to respond to auditory and internal stimuli while in the resident's room and was grunting, laughing, and yelling. -Continued to have auditory/ visual hallucinations and was laughing maniacally in the resident's own room. -Was wandering the hallways and making noises with the resident's mouth in response to auditory/visual hallucinations and was wandering into different (resident) rooms. A Social Service Follow Up Note dated 10/31/2024, documented a Social Worker (SW) met with Resident #135, observed the resident and spoke with staff. Resident #135 did not appear to remember the altercation with Resident #72. Resident #135 was agitated and yelled at the SW to get out of the resident's room before the resident messed the SW up, the sentiments were expressed using profanities and Resident #135 was growling. The SW attempted to complete a room change for Resident #135 to move to another unit. However, the resident refused to change rooms and became more agitated and using profanities verbalized the resident was not moving to another room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/07/2024 at 2:37 PM, the Executive Director verbalized the altercation between Resident #72 and Resident #135 occurred when Resident #72 wandered into Resident #135's room. The Executive Director verbalized Resident #135 did not push Resident #72, as documented in the FRI and explained Resident #135 grabbed Resident #72 and threw the resident to the ground. On 11/07/2024 at 2:44 PM, the Executive Director explained nurses were expected to write behavioral notes for each adverse behavior observed. The notes were then reviewed in the facility's stand up meeting the following day, or the following Monday for observations documented during the weekend. Therefore, the Interdisciplinary Team (IDT) would not have received the information to review until the next day. The Executive Director verbalized if the facility had a system to review behavioral documentation prior to the next shift, Resident #135 could have been placed on 1:1 supervision and the altercation between Resident #135 and #72 could have been prevented. The Executive Director confirmed the altercation between Resident #135 and Resident #72 occurred on 10/30/2024, and resulted in a laceration to Resident #72's head, requiring eight staples. The facility policy titled Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, dated 12/2023, documented abuse was the willful infliction of injury resulting in physical harm, pain or mental anguish and was irrespective of any mental or physical condition. Willful meant the individual acted deliberately and did not mean the individual must have intended to inflict injury or harm. FRI #NV00072575 49557 Resident #104 Resident #104 was admitted to the facility on [DATE], with diagnoses including vascular dementia, unspecified severity, with other behavioral disturbance and other symptoms and signs involving cognitive functions following cerebrovascular disease. Resident #140 Resident #140 was admitted to the facility on [DATE], with diagnoses including bipolar disorder, unspecified and other symptoms and signs involving cognitive functions following cerebral infarction. A FRI dated 10/15/2024, documented Resident #140 was observed hitting Resident #104. Resident #140 pushed Resident #104 to the ground and bit Resident #104's left ear. Resident #104 was evaluated in the emergency room and was found to have sustained scratches to the resident's left ear and a facial fracture. The following notes were documented in Resident #104's clinical record: -An Emergency Department (ED) Provider Note dated 10/15/2024, documented a computed tomography (CT) scan was completed on 10/15/2024, and indicated Resident #104 had an acute fracture of the anterior wall of the left maxillary [NAME]. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-A Nursing Progress Note dated 10/15/2024, documented a nurse saw a resident pushing, punching and biting another resident. The residents were separated and sent to the hospital. -An Interdisciplinary Note dated 10/16/2024, documented Resident #104 was involved in an altercation with another resident. Resident #104 sustained the following injuries: bruising to the resident's left ear, scratches to the resident's face and nose, and a fracture. -A Social Services Note dated 10/17/2024, documented Resident #104 was tearful due to not understanding why the resident was uncomfortable following the incident. The resident had noted confusion and did not recall the incident. -A Psych Follow Up Note dated 10/21/2024, documented Resident #104 was attacked and beaten up by the resident's roommate. Staff reported the resident appeared more scared and withdrawn and was demonstrating regressive behaviors. -A Social Services Note dated 10/21/2024, documented Resident #104 was displaying regressive behaviors as evidenced by urinating in the resident's closet. -A Social Services Note dated 10/22/2024, documented Resident #104 was displaying regressive behaviors as evidenced by defecating on the floor. -A Social Services Note dated 10/25/2024, documented Resident #104 had new regressive behaviors as evidenced by peeing in public or in closets rather than the restroom. -A Social Services Note dated 11/05/2024, documented Resident #104 was displaying regressive behaviors as evidenced by urinating in the trashcan. On 11/04/2024 at 4:13 PM, during a telephone interview with Resident #104's guardian, the guardian recalled the guardian was notified of a resident-to-resident incident involving Resident #104. The guardian recalled Resident #104 was sent to the emergency room following the incident and was found to have a fracture. On 11/06/2024 at 12:21 PM, a Licensed Practical Nurse (LPN) verbalized the LPN was aware of a resident-to-resident incident involving Resident #104 and Resident #140. The LPN explained the LPN was not working the day of the incident however was informed Resident #140 had attacked Resident #104 and both residents were sent out of the facility. On 11/06/2024 at 12:30 PM, a CNA verbalized physical abuse included hitting a resident. If staff observed abuse or an allegation of abuse was reported to staff, staff were to separate the residents, assure the residents' safety, and report to the Abuse Coordinator. The CNA recalled the CNA worked the evening shift on the day of the resident-to-resident incident involving Resident #104 and Resident #140. The CNA verbalized Resident #140 started hitting Resident #104. Both residents were sent out of the facility. The CNA recalled Resident #104 seemed scared and was intermittently tearful after returning to the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/07/2024 at 11:42 AM, the Executive Director explained abuse could be intentional or non-intentional and included physical and sexual abuse, neglect, involuntary seclusion and misappropriation of resident property. The Executive Director verbalized all allegations of abuse were to be reported to the Executive Director who was also the facility's Abuse Coordinator. The Executive Director verbalized the Executive Director was familiar with a resident-to-resident incident on 10/15/2024, involving Resident #104 and Resident #140. The initial altercation was unwitnessed, however staff heard the residents fighting and immediately tried to separate the residents. The Executive Director recalled Resident #104 sustained a significant injury, a facial fracture, during the incident. The Executive Director verbalized when Resident #104 returned to the facility, the Executive Director interviewed the resident who did not recall the incident however the resident's body language and demeanor appeared to the Executive Director the resident was fearful. Resident #104 had some difficulty chewing for one to two days after return to the facility and required soft foods. The Executive Director verbalized the facility would provide social services visits for emotional support and to monitor for mental anguish following an incident of abuse. The Executive Director reviewed Resident #104's clinical record and verbalized, since the incident on 10/15/2024, Resident #104 had been visited by the facility's social worker and a talk therapist from behavioral health services. The Executive Director verbalized the clinical record indicated Resident #104 had recently developed regressive behaviors including urinating in trash cans. The Executive Director explained the development of regressive behaviors after an incident of abuse could indicate psychosocial harm. The facility policy titled Abuse, Neglect, or Exploitation, updated November 2016, defined abuse as an act by an individual which injured, exploited, or jeopardized an individual's health, welfare, or safety. Examples included physically damaging or potentially damaging non-accidental acts and emotionally damaging verbal behavior. The facility document titled Notice of Resident Rights Under Federal Law, updated November 2016, documented residents had the right to be free from verbal, sexual, physical, or mental abuse. FRI #NV00072457