

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Koontz Lane Carson City, NV 89701	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and interview, the facility failed to notify the on-call medical provider after a resident experienced a fall with injury, resulting in bruising to the forehead for 1 of 25 sampled residents (Resident #2). This deficient practice had the potential to result in delayed identification and treatment of serious complications, including intracranial bleeding, for a resident receiving anticoagulation therapy. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including traumatic subdural hemorrhage without loss of consciousness, subsequent encounter, muscle weakness, generalized, difficulty in walking, paroxysmal atrial fibrillation, chronic combined systolic congestive and diastolic congestive heart failure, and long-term and current use of anticoagulants. Resident #2's Care Plan dated 11/11/2021 and updated 08/30/2025, documented the resident was receiving an anticoagulant related to atrial fibrillation. A progress note dated 08/03/2025 at 3:16 AM, entered by the Registered Nurse (RN), documented the resident was found in the resident's room on the floor, with purple lumps on the forehead and smears of blood on the floor. The resident was ensuring the room door was locked and fell and hit the resident's head. The resident was alert but confused and complained of soreness from the lumps on the resident's head. A head-to-toe assessment was done. The resident had a small skin tear on the left wrist, approximately one-half inch in size. Skin tape and a Band Aid were applied. Vitals were taken. The resident was helped into the wheelchair. Pain medications were given. The Executive Director (Administrator), the Resident Care Manager (RCM) on duty, the Nurse Practitioner (NP), and the Guardian were notified. Resident was to be monitored closely. A progress note dated 08/03/2025 at 10:29 AM, entered by a Licensed Practical Nurse (LPN), documented night shift had reported Resident #2 was found on the floor in the resident's room at 2:16 AM early that morning and the resident had bruising to the head and face. The LPN had noticed bruising to the resident's face when obtaining vital signs for the resident's morning medication administration. The resident was sitting up in bed with edema to left side of her face accompanied with purple-blue discoloration. The night shift reported that the resident's left wrist was sensitive to touching along with facial grimacing and winced away when staff touched the left wrist. This nurse reached out to the NP to send the resident out for an X-ray of the left wrist. This nurse requested to add the resident's shoulder to the X-ray as well and evaluation for possible concussion due to the resident not having been at usual cognition per baseline. The NP assessed the resident and decided to send the resident to the Emergency Department (ED). The resident was transferred to the ED via ambulance later that morning. A NP progress note dated 08/03/2025 at 11:53 AM, documented Resident #2 was seen after reports of an unwitnessed fall. The unwitnessed fall happened on August third at approximately 2:15 AM. The resident was found on the ground and had injury to the left head and pain in the left shoulder and wrist. The resident was placed on post fall assessments. The resident was on anticoagulation with Eliquis twice daily and had developed significant bruising to the left forehead and periorbital area. Per staff, the resident was somewhat more confused than normal and continued to have significant pain in the left arm and ribs. The resident was sent to the emergency department for further workup as the resident was high risk due to having been on blood thinning medication. This was discussed with nursing. Nursing notes reviewed and stated that the provider was contacted in the night, however it was unclear what the outcome of the conversation was. On 11/25/2025 at 3:27 PM, the Director of Nursing (DON), verbalized nurses were expected to ensure contact with the NP, as necessary, and should document these communications in a progress note. On 11/25/2025 at 3:34 PM, the DON confirmed the NP was not notified of the resident's fall and injury until the day shift staff had done so later that morning. On 11/25/2025 at 3:43 PM, the Administrator verbalized the RN was suspended for failing to ensure notification of the NP regarding Resident #2's fall. The Administrator verbalized the NP was upset the NP had not been notified sooner due to the resident having been on an anticoagulant and was considered high risk. On 11/25/2025 at 3:48 PM, the Administrator verbalized the facility could not locate a policy for physician notification related to change of condition and confirmed the Medical Director/Physician Coverage in Emergency policy dated January 2025 was in effect during the time of the incident. The facility policy titled, Fall Management and Neurological Check, updated January 2025, lacked documentation of the notification of the physician or provider post fall. The facility policy titled, Medical Director/Physician Coverage in Emergency, dated January 2025, documented the facility staff were to contact the on-call physician if the on-call physician was not available</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>Based on personnel record review, interview and document review, the facility failed to ensure initial elder abuse prevention training was completed timely for 1 of 10 sampled employees (Employee #8). This deficient practice had the potential to place all residents at risk for abuse and neglect. Findings include:Employee #8Employee #8 was hired as a Certified Nursing Assistant on 11/01/2025.Employee #8's personnel record lacked documented evidence elder abuse prevention training was completed upon hire.On 11/25/2025 at 2:36 PM, the Administrator verbalized abuse training was to be completed within the first orientation. Staff were not permitted to work on the floor prior to the completion of abuse training. All staff were required to complete abuse training. The Administrator confirmed Employee #8 lacked timely elder abuse training.The facility policy titled Abuse Training, updated 10/2022, documented facility staff, contract staff and routine volunteers were trained on abuse prevention, reporting, and intervention upon hire, annually and periodically thereafter in accordance with state and federal guidelines and facility needs.</p>		