

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 01/15/2026
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview and document review, the facility failed to ensure staff provided adequate supervision for 1 of 26 sampled residents (Resident #87) when staff failed to verify all residents were present after discovering an open window on a secured memory care unit. This deficient practice resulted in delayed identification of a resident elopement and delayed implementation of the facility's elopement response procedures, with the potential to result in psychosocial and physical harm to the resident including injury or death. Findings include: Resident #87 was admitted to the facility on [DATE], with diagnoses including paranoid schizophrenia and unspecified psychosis not due to a substance or known physiological condition. An initial Facility Reported Incident (FRI) dated 12/03/2025, documented Resident #87 eloped from the facility. Elopement Risk Evaluations completed on 03/27/2025, 06/26/2025, 09/25/2025, and 10/03/2025 documented Resident #87 was an elopement risk due to the resident's diagnosis of schizophrenia and wandering behaviors. Resident #87's Care Plan documented behavior monitoring. Target behaviors included exit seeking/pushing on exit doors. Interventions included ensuring the resident's safety on a secured unit. A Nursing Progress Note dated 12/03/2025, documented Resident #87 eloped from the facility. An investigation was initiated, a search of the surrounding area began, the sheriff's department was notified, and the resident was located by facility staff. Upon return to the facility, the resident was assessed by two nurses with no injuries noted. On 01/12/2026 at 10:32 AM, Resident #87 was pacing in the hallway of the 300 unit, one of the facility's secured memory care units. The resident was alert, muttering to self and was not able to engage in logical conversation. On 01/14/2026 at 12:06 PM, a Licensed Practical Nurse (LPN) verbalized the LPN was working the morning Resident #87 eloped from the facility through another resident's bedroom window. The LPN recalled another resident had previously broken multiple windows on the unit and the windows were secured with a piece of plywood until the windows could be repaired. On 12/03/2025 in the morning, the LPN was notified by a Restorative Nurse Aide the plywood was missing from one of the broken windows. The last time the LPN saw Resident #87 was at approximately 6:00 AM standing near the nurses' station. Later in the morning, during breakfast, staff identified Resident #87 was not present in the dining room and began searching for the resident. When staff could not locate Resident #87 on the unit, the facility's Administrator was notified, and several staff members began searching for the resident in the area surrounding the facility. The LPN explained when the LPN was notified of the missing plywood, staff did not confirm all residents were present on the unit as the LPN assumed the plywood was removed by the resident who previously broke the windows. On 01/15/2026 at 12:43 PM, the Administrator confirmed the Administrator was familiar with Resident #87 eloping from the facility in December 2025. The Administrator recalled another resident in the secured unit had broken multiple windows and was exit-seeking prior to the elopement. The broken windows were covered with plywood pending repair. On the morning of 12/03/2025, when</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 295079
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>staff noted the plywood on the window in the resident's room was missing, staff notified the Administrator of the plywood having been removed and the resident residing in the room was present on the unit. Staff did not complete a count of all residents on the unit at the time. During breakfast on 12/03/2025, staff noted Resident #87 was not present in the dining room and began searching for the resident. The Administrator explained if an open or unsecured window or door was identified in one of the facility's secured memory care units, staff were to complete a count to ensure all residents were present. The Administrator verbalized the Administrator felt staff had normalized the exit-seeking behavior of the resident who had broken the windows, resulting in staff's failure to complete a head count when the unsecured window was discovered sometime between 7:00 AM and 8:00 AM. The Administrator confirmed staff's identification of Resident #87 being missing from the unit and response to the resident's elopement was delayed. The facility policy titled Elopement/Wandering, updated 02/2025, defined an elopement as a resident exiting the facility without staff knowledge or the resident entering an unsafe area without staff knowledge or presence. Based on the results of an elopement/exit-seeking evaluation, care plan interventions to manage wandering and/or exit seeking behaviors were initiated. The facility document titled Keeping residents safe (0.02), Elopement risk, undated, documented all staff were to make sure all doors were locked and secured after entering/exiting the memory care unit. Residents in secured units were normally wandering/exit seeking/elopement risks and looked for any opportunity to exit the unit. If any potential risk of elopement were identified such as open doors and windows, a head count was to be completed immediately for the entire facility. FRI #2683842</p>		