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)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review and document review, the facility failed to ensure a comfortable, homelike environment when staff were reported as being loud and disruptive to a resident's sleep during the night shift for 1 of 28 sampled residents (Resident #112). Findings include: Resident #112 Resident #112 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including generalized anxiety disorder and insomnia, unspecified. On 11/04/2024 at 2:03 PM, Resident #112 verbalized the resident was concerned about staff waking the resident up in the middle of the night. Resident #112 explained night shift staff were loud, and the resident often heard staff talking in the hallway about staff's personal lives and other residents' care. The resident had been offered to move rooms as the resident was previously near the nurses' station however the resident reported the noise level on the night shift had not improved since the resident moved to another room. The resident verbalized being frustrated as the resident could not sleep due to staff being loud. A Psych Evaluation Note dated 08/13/2024, documented Resident #112 yelled out toward the hallway for people to be quiet. Resident #112 reported being tired of the noise in the facility. The facility's grievance log from January 2024 through November 2024 documented the following: -On 01/16/2024, the facility received a grievance from resident council indicating Certified Nursing Assistants (CNAs) were loud and yelled down the hall on the night (NOC) shift. The concern was documented as confirmed and resolved on 01/16/2024. Action taken documented CNAs would approach the nurse on shift to relay a message and would not yell down the hall. -On 02/13/2024, the facility received a grievance from resident council indicating CNAs on the NOC shift were loud and would yell in the hallways while residents tried to sleep. The concern was documented as confirmed and resolved on 02/15/2024. Staff were coached on being respectful of residents' space. -On 04/10/2024, the facility received a grievance from resident council indicating NOC shift CNAs were loud in the hallways while residents were sleeping. The concern was documented as confirmed and resolved on 04/11/2024. Action taken included an in-person discussion with CNAs and the addition of a full-time charge nurse. Recommended actions included spot checks from management. -On 08/13/2024, the facility received a grievance from resident council indicating staff were loud on the NOC shift in the hallways. The concern was documented as confirmed and resolved on 08/15/2024. Staff were reminded to talk quietly even when at the nurses' station as residents in nearby rooms could hear the staff's conversations. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/17/2024, the facility received a grievance from resident council indicating CNAs on the NOC shift were yelling in the hallways. The concern was documented as confirmed and resolved on 09/19/2024. Staff were educated and provided an in-service. On 11/07/2024 at 3:22 PM, the Executive Director explained the facility reviewed grievances during clinical meetings, facility leadership would ensure follow up was completed with the person filing the grievance, and grievances were tracked for trends. The Executive Director verbalized the facility had received several grievances related to noise levels at night, it was a known issue in the facility, and had been consistent over the last few months. Staff had been re-educated regarding appropriate noise levels on the NOC shift. To monitor the effectiveness of implemented interventions in response to grievances, the facility conducted rounds with residents to ask about any concerns or complaints the residents had. The Executive Director explained the facility had last completed rounds in August and September and had not received any feedback regarding noise at night. However, the Executive Director had recently met with a member of the facility's resident council who reported the noise on the NOC shift was increasing. The Executive Director explained the facility could have conducted a root cause analysis to help determine what the noises were and how to better address resident concerns of excessive noise at night however the facility had not yet conducted a root cause analysis. The Executive Director verbalized excessive noise at night would cause the facility to not feel homelike for residents. The facility document titled Notice of Resident Rights Under Federal Law, updated November 2016, documented residents had the right to a safe, clean, comfortable, and homelike environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on clinical record review and interview, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 1 of 28 sampled residents (Resident #27). This deficient practice had the potential to deprive the resident of a person-centered care plan relative to their current health management needs. Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of other low back pain. Resident #27's quarterly MDS assessment dated [DATE], section J1900 (Health Conditions-Number of Falls Since Prior Assessment) documented Resident #27 had two falls with no injury, one fall with injury, and two falls with major injury since the last assessment. Resident #27's progress notes documented the resident fell on ce on 09/14/2024 but lacked documented evidence any other falls occurred in 2024. On 11/07/2024 at 12:01 PM, the MDS Coordinator Licensed Practical Nurse (LPN)verbalized using the Resident Assessment Instrument (RAI) Manual to guide MDS activities. The MDS Coordinator verbalized Resident #27 had one fall with no injury on 09/14/2024, however the MDS assessment reflected five falls. The MDS Coordinator confirmed Resident #27's quarterly MDS assessment was inaccurate.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review and document review the facility failed to provide showers for 1 of 28 sampled residents (Resident #108). The deficient practice had the potential to negatively impact the resident's overall well-being. Findings include: Resident #108 Resident #108 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including spinal stenosis, cervical region, chronic pain syndrome, and difficulty in walking. On 11/04/2024 at 4:07 PM, Resident #108 verbalized the resident did not get showers or bed baths. Resident #108's Comprehensive Care Plan dated 09/09/2024, documented shower two times weekly. On 11/06/2024 at 2:11 PM, a Certified Nursing Assistant (CNA)/Shower Aid verbalized residents should receive two showers a week, but the CNA was aware the Resident #108 preferred showers more often. Resident #108 only received showers once a week, although the resident's preference was three times a week. The resident did not refuse showers when offered. On 11/06/2024 at 2:13 PM, the Director of Nursing Services (DNS) verbalized all residents received showers twice a week. The DNS explained shower documentation was kept in a shower book. The Shower Book documented the following showers for Resident #108: -10/04/2024 -10/08/2024, four days between offered showers/bed bath. -10/15/2024, seven days between offered showers/bed bath. -10/29/2024, 14 days between offered showers/bed bath. -11/05/2024, six days between offered showers/bed bath. On 11/06/2024 at 2:16 PM, the Shower Aid verbalized to the DNS the resident was only showered once a week due to time constraints. The Shower Aid explained they gave shower priority to residents with skin issues. On 11/06/2024 at 4:37 PM, the DNS verbalized residents should be showered twice a week and per their preference. The DNS explained there was not a facility policy followed related to showering and/or bathing however the facility followed their standard of practice. The facility's Standard of Practice was [NAME]. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DNS did not provide the Standard of Practice for activities of daily living, to include showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, clinical record review, interview, and document review, the facility failed to ensure 1) a resident's significant surgical wounds were evaluated weekly for 1 of 28 sampled residents (Resident #67), 2) a resident's change in condition was reported timely to a physician for 2 of 28 sampled residents (Resident #36 and #62) and 3) ensure a resident's blood sugar levels were checked according to a physician's order for 1 of 28 sampled residents (Resident #52). The deficient practices had the potential to result in 1) overlooked skin integrity decline, 2) a change in condition going unmonitored, placing residents at risk for infection to spread and for poor clinical outcomes, and 3) a resident experiencing hyperglycemia (elevated blood sugar) or hypoglycemia (low blood sugar) without adequate monitoring and intervention. Findings include: Wound Evaluations Resident #67 Resident #67 was admitted to the facility on [DATE], with a diagnosis of unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, subsequent encounter. Resident #67's care plan revised 09/25/2024, documented a problem of potential for skin integrity impairment related to fragile skin to include chronic abdominal midline surgical wounds. Interventions included following facility protocols for treatment of injury and documenting weekly treatment with measurement of each area of skin breakdown, width, length, depth, type of tissue and other notable changes. Resident #67's clinical record lacked documented evidence of weekly wound evaluations. On 11/06/2024 at 2:41 PM, a Licensed Practical Nurse (LPN) verbalized Resident #67 had surgical wounds on the resident's abdomen. The LPN verbalized wound evaluations were useful in detecting signs of infection, fever and pain; however, weekly wound evaluations were not completed for Resident #67. On 11/07/2024 at 8:33 AM, the Director of Nursing Services (DNS) verbalized Resident #67's abdominal wounds would be considered significant surgical wounds because they were chronic and nonhealing. The DNS verbalized the DNS completed weekly wound evaluations for residents with pressure ulcers but did not do weekly wound evaluations for residents with surgical wounds to include Resident #67. The DNS confirmed this practice did not follow the facility policy. The facility policy titled, Skin Integrity, updated October 2022, documented wounds were evaluated weekly by center clinicians and significant surgical wounds were evaluated, measured, and findings documented in the medical record. 49557 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change in condition Resident #36 Resident #36 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, recurrent, unspecified and unspecified dementia, severe, with agitation. Section C0200 of a Minimum Data Set 3.0 (MDS) assessment dated [DATE], documented Resident #36 had a Brief Interview for Mental Status (BIMS) score of 12. A score of 12 indicated moderate cognitive impairment. The BIMS evaluation was completed by the MDS Coordinator LPN. Section C0200 of an MDS assessment dated [DATE], documented Resident #36 had a BIMS score of four. A score of 4 indicated severe cognitive impairment. The BIMS evaluation was completed by the Social Worker. On 11/07/2024 at 1:47 PM, during an interview with the MDS Coordinator LPN and the Social Worker, the MDS Coordinator LPN explained the facility's Social Worker typically completed the BIMS evaluation for the MDS assessments. The MDS Coordinator LPN reviewed the MDS assessments completed for Resident #36 and confirmed the assessments documented the resident had a BIMS score of 12 on 07/12/2024, and a score of four on 10/03/2024. The Social Worker recalled Resident #36 was not wanting to answer questions during the BIMS evaluation completed on 10/03/2024. The MDS Coordinator LPN explained the process when a resident experience a decline in BIMS score would be to determine if there was a medical reason for the change, perform a repeat BIMS evaluation to determine if the first one was accurate, and notify the physician. The Social Worker verbalized the BIMS score of four on 10/03/2024 was accurate at the time the evaluation was completed. The Social Worker denied the Social Worker performed a repeat BIMS evaluation or notified the physician of the decline in score. On 11/07/2024 at 2:31 PM, the DNS verbalized a BIMS evaluation checked a resident's mental status and cognition. The DNS verbalized a decline in BIMS score from 12 to four would be considered a significant change. The DNS explained the DNS's expectation of staff, if there was a significant change in BIMS score, was to repeat the BIMS to ensure the score was accurate and report to the physician. Resident #62 Resident #62 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including Alzheimer's disease, unspecified and type two diabetes mellitus without complications. On 11/04/2024 at 1:35 PM, Resident #62 was ambulating in the hallway. A clean, dry dressing was noted on the resident's left elbow. Resident #62 recalled staff placed the dressing after a recent fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 11:06 AM, an LPN verbalized Resident #62 had an abrasion on the resident's left elbow related to a fall. On 11/06/2024 at 2:09 PM, the LPN explained signs and symptoms of a wound infection included swelling, redness, pain, and drainage. The LPN verbalized Resident #62 had recently completed antibiotics for cellulitis in the resident's left elbow. The LPN recalled the LPN had called the physician the week prior as Resident #62's left elbow had become swollen and red. A Nursing Progress Note dated 10/25/2024, documented Resident #62 had a low-grade fever. An Orders Administration Note dated 10/25/2024, documented Resident #62's left elbow had a large circular red area. An Orders Administration Note dated 10/26/2024, documented Resident #62's left elbow remained red. A Nursing Progress Note dated 10/30/2024, documented Resident #62's left elbow was red, swollen, and painful. The physician was contacted and prescribed Augmentin for seven days. On 11/06/2024 at 2:23 PM, the DNS verbalized wounds included open skin, skin tears, abrasions and lacerations. Signs and symptoms of a wound infection included redness, warmth, drainage, pain and odor. If there was a change in a wound, the DNS expected staff to notify the DNS and the physician. On 11/06/2024 at 4:44 PM, during an interview with the DNS and the MDS Coordinator LPN, the DNS verbalized a low-grade fever and a large circular red area, as noted in the progress notes dated 10/25/2024, were signs and symptoms of infection and should have been reported to the physician immediately. The MDS Coordinator and the DNS reviewed Resident #62's record and denied the physician was notified of any signs or symptoms of infection prior to the documented notification on 10/30/2024. The facility policy titled Change in Condition: When to report to the physician, undated, documented immediate notification of the physician was required when any symptom, sign or apparent discomfort was acute or sudden in onset and a marked change in relation to usual signs/symptoms or was unrelieved by measures already prescribed. Non-immediate notification of the physician was required when new or worsening symptoms were present and did not meet the above criteria. Blood glucose monitoring Resident #52 Resident #52 was admitted to the facility on [DATE], with a diagnosis of type two diabetes mellitus with diabetic neuropathy, unspecified. A physician's order dated 06/04/2024, documented Humalog injection solution 100 units/ milliliter (ml), inject per sliding scale: -If blood sugar 200-250, give two units. -If blood sugar 251-300, give four units. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If blood sugar 301-350, give six units. -If blood sugar 351-400, give eight units. Subcutaneously before meals and at bedtime for diabetes mellitus type two. If blood sugar less than 80 or greater than 400, call physician. The October 2024 Medication Administration Record (MAR) for Resident #52 documented Humalog injection solution 100 units/ ml. The scheduled administration times were 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. The 10/31/2024 9:00 PM blood sugar reading was documented as Not Applicable (NA) and the Humalog administration was documented as 4 - vitals outside of parameters for administration. The November 2024 MAR for Resident #52 documented Humalog injection solution 100 units/ ml. The scheduled administration times were 9:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM. The 11/01/2024 and 11/02/2024 9:00 PM blood sugar readings were documented as Not Applicable (NA) and the Humalog administration was documented as 4 - vitals outside of parameters for administration. On 11/06/2024 at 8:54 AM, an LPN explained blood sugars were to be checked per physician orders. The frequency and documentation of blood sugar monitoring for residents could be seen on the resident's MAR. The LPN verbalized Resident #52 had an order to check the resident's blood sugar four times per day, at meals and at bedtime. On 11/06/2024 at 2:39 PM, the DNS explained the frequency of blood sugar monitoring depended on the physician's order. The DNS verbalized Resident #52 had an order to check blood sugar levels four times per day, before meals and at bedtime. The DNS reviewed the October and November MARs for Resident #52 and confirmed the blood sugar readings for 10/31/2024, 11/01/2024, and 11/02/2024 were documented as NA and the Humalog administration was documented as 4. The DNS verbalized the portion of the MAR documented as NA should have included the resident's bedtime blood sugar reading. The DNS explained NA indicated the nurse did not check the resident's blood sugar and confirmed failure to check Resident #52's blood sugar at bedtime was not following the physician's order. The facility policy titled Blood Glucose Monitoring Protocol, updated October 2017, documented the nurse would conduct blood glucose testing as ordered by the physician. Diabetic guidelines for residents prescribed sliding scale insulin included blood glucose testing routinely prior to meals and at bedtime.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review and document review the facility failed to ensure oxygen was administered according to a physician's order for 1 of 28 sampled residents (Resident #80). This deficient practice had the potential to cause worsening of the resident's diagnosed chronic obstructive pulmonary disease. Findings include: Resident #80 Resident #80 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified bacterial pneumonia, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease with acute exacerbation. On 11/04/2024 at 8:44 AM, Resident #80 was lying in bed and receiving Oxygen via nasal cannula (NC). The resident's Oxygen concentrator was set at three liters per minute (LPM). Resident #80 verbalized Resident #80 wore Oxygen continuously and was supposed to be receiving two LPM. On 11/05/2024 at 4:04 PM, Resident #80 was lying in bed and receiving Oxygen via NC. The resident's Oxygen concentrator was set at three LPM. A physician's order dated 06/16/2023, documented Oxygen two LPM per cannula to keep saturations (sats) greater than 90 percent (%). Resident #80's Care Plan included pneumonia. Interventions included Oxygen, two liters per NC to keep sats greater than 90%. The initiated and revision date was 09/13/2024. On 11/05/2024 at 4:06 PM, a Licensed Practical Nurse (LPN) verbalized licensed nurses were able to administer Oxygen to residents with a physician's order. The LPN explained the physician's order would specify the liter flow the resident's Oxygen concentrator should be set at. The LPN confirmed Resident #80 had a physician's order for Oxygen to be administered via NC at two LPM. On 11/05/2024 at 4:10 PM, the LPN entered Resident #80's room. The LPN verbalized the Oxygen concentrator was set at three LPM and adjusted the flow rate down to two LPM. The LPN confirmed three LPM did not match the physician's order. On 11/05/2024 at 4:51 PM, the Director of Nursing Services (DNS) verbalized the DNS's expectation of nursing staff when administering Oxygen to residents was to follow the physician's order. The DNS explained a physician's order for Oxygen would include how many LPM the resident was to receive. The DNS reviewed Resident #80's clinical record and verbalized Resident #80 had a physician's order for Oxygen to be administered at two LPM via NC. The DNS confirmed administering oxygen to Resident #80 at three LPM was not following the physician's order. (continued on next page)

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Mountain View Health & Rehabilitation Center	201 Koontz Lane Carson City, NV 89701

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Respiratory Care; Oxygen Administration, published December 2017, documented Oxygen was to be administered per physician order. Oxygen liter flow was to be set by a licensed nurse in accordance with physician's orders.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to identify triggers for a resident diagnosed with post-traumatic stress disorder (PTSD) for 1 of 28 sampled residents (Resident #52). This deficient practice placed the resident at risk for re-traumatization. Findings include: Resident #52 Resident #52 was admitted to the facility on [DATE], with diagnoses including post-traumatic stress disorder, chronic and paranoid schizophrenia. Resident #52's Care Plan documented Resident #52 was at risk for feelings of trauma or re-traumatization due to a diagnosis of PTSD. Goals included Resident #52 would be free of feelings of trauma or re-traumatization and would be safe and supported. Interventions included assisting Resident #52 with obtaining mental health or other services to support the resident as indicated and displaying warmth, compassion, and non-judgmental approach. On 11/06/2024 at 11:30 AM, a Licensed Practical Nurse (LPN) verbalized residents' behaviors were monitored every shift and if a resident's behavior changed staff would notify the physician. The LPN explained staff would know a resident's baseline behaviors because staff knew the residents. The LPN was not able to verbalize where a resident's baseline behaviors were documented. On 11/07/2024 at 12:10 PM, the Director of Nursing Services (DNS) explained the facility's interdisciplinary team would identify triggers for residents diagnosed with PTSD and the triggers would be added to the resident's care plan. Staff were informed through the care plan of how to eliminate or mitigate triggers which may cause residents diagnosed with PTSD to feel re-traumatized. The DNS verbalized the DNS had no idea what Resident #52's PTSD was related to or what may trigger the resident to feel re-traumatized. The DNS reviewed Resident #52's clinical record and denied the resident's care plan identified the resident's triggers and the interventions included on the care plan were not specific to the resident's experiences or preferences. The facility policy titled Trauma-Informed Care, updated October 2022, documented the facility wanted to guarantee residents who were trauma survivors received trauma-informed care and account for residents' experiences and preferences to eliminate or mitigate triggers which may cause re-traumatization.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure medications were administered with an error rate of less than five percent (%). There were 26 opportunities and 14 medication errors. The medication error rate was 53.85%. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. On 11/07/2024 at 8:07 AM, a Licensed Practical Nurse (LPN) began preparing to administer medications to Resident #4. Among the medications prepared were the following: -Cholecalciferol (Vitamin D) 1000 units, two tablets. -Loratadine 10 milligrams (mg), one tablet. -Fish Oil 1000 mg, one capsule. -Multivitamin, one tablet. -Fluticasone 50 micrograms (mcg) per spray. -Vitamin B1 (Thiamine) 100 mg, one tablet. -Lisinopril 10 mg, one tablet. On 11/07/2024 at 8:15 AM, the LPN administered the prepared medications to Resident #4. The November 2024 Medication Administration Record (MAR) and Order Summary Report for Resident #4 documented the following: -Cholecalciferol (Vitamin D) tablet 1000 units, give two tablets by mouth one time a day for supplement. The scheduled administration time was 7:00 AM. -Loratadine tablet 10 mg, give 10 mg by mouth one time a day for allergies. The scheduled administration time was 7:00 AM. -Fish Oil capsule, give one capsule by mouth one time a day for supplement. The scheduled administration time was 7:00 AM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Multivitamin tablet, give one tablet by mouth one time a day for supplement. The scheduled administration time was 7:00 AM. -Fluticasone Propionate Suspension 50 mcg/ actuation (act), one spray in each nostril one time a day for allergic rhinitis. The scheduled administration time was 7:00 AM. -Thiamine (Vitamin B1) tablet 100 mg, give one tablet by mouth one time a day for supplement. The scheduled administration time was 7:00 AM. -Lisinopril oral tablet 10 mg, give one tablet by mouth one time per day for hypertension. The scheduled administration time was 7:00 AM. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of allergic rhinitis, unspecified. On 11/07/2024 at 8:17 AM, the LPN administered one spray of Fluticasone Propionate 50 mcg/act into Resident #12's left nostril. Resident #12 then requested to self-administer the remainder of the medication. Resident #12 took the bottle of Fluticasone Propionate and administered two sprays into the resident's right nostril. A physician's order dated 08/03/2024, documented Flonase Allergy Relief nasal suspension 50 mcg/act (Fluticasone Propionate), one spray in both nostrils one time a day for allergies. Resident #46 Resident #46 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side. On 11/07/2024 at 8:29 AM, the LPN began preparing to administer medications to Resident #46. Among the prepared medications were the following: -Baclofen 10 mg, one tablet. -Sertraline 100 mg, one tablet. -Docusate Sodium 100 mg, one capsule. -Gabapentin 100 mg, one capsule. -Quetiapine Fumarate (Seroquel) 50 mg, one tablet. On 11/07/2024 at 8:34 AM, the LPN administered the prepared medications to Resident #46. The November 2024 MAR and Order Summary Report for Resident #46 documented the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Baclofen oral tablet 10 mg, give one tablet by mouth three times a day for muscle spasms. The scheduled administration time was 7:00 AM. -Sertraline Hydrochloride (HCl) tablet 100 mg, give one tablet by mouth one time a day for depression. The scheduled administration time was 7:00 AM. -Docusate Sodium capsule 100 mg, give 100 mg by mouth two times a day for constipation, hold for loose stool. The scheduled administration time was 7:00 AM. -Gabapentin capsule 100 mg, give 100 mg by mouth three times a day for anxiety, hold for sedation. The scheduled administration time was 7:00 AM. -Quetiapine Fumarate (Seroquel) tablet 50 mg, give 50 mg by mouth two times a day for psychosis. The scheduled administration time was 7:00 AM. Resident #111 Resident #111 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of heart disease, unspecified. On 11/07/2024 at 8:36 AM, the LPN began preparing to administer medications to Resident #111. Among the prepared medications was two tablets of Cyanocobalamin (Vitamin B12) 500 mcg. On 11/07/2024 at 8:40 AM, the LPN administered the prepared medication to Resident #111. The November 2024 MAR and Order Summary Report for Resident #111 documented the following: -Cyanocobalamin oral tablet 1000 mcg, give one tablet by mouth one time a day for nutritional support. The scheduled administration time was 7:00 AM. On 11/07/2024 at 9:16 AM, the Director of Nursing Services (DNS) verbalized the DNS's expectation of nursing staff when administering medications to residents was to first review physician orders and ensure the nurse was administering the correct dose to the correct resident. The DNS explained medications were to be administered within one hour before and one hour after the scheduled administration time reflected on the resident's MAR. The DNS confirmed if a medication was scheduled for 7:00 AM and administered after 8:00 AM the medication was considered late. The DNS explained residents could be allowed to self-administer medications if the resident was evaluated for safety and the facility obtained a physician's order. The DNS verbalized documentation would be in the evaluations section of the resident's electronic clinical record. Resident #12's clinical record lacked documentation of a physician's order and an evaluation for safety to self-administer medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/2024 at 11:37 AM, the LPN verbalized medications were to be administered to residents within one hour before and one hour after the scheduled administration time on the resident's MAR. The LPN confirmed the medications administered to resident #4, #46, and #111 during the AM medication pass, with a 7:00 AM scheduled administration time, were given late. The LPN explained the LPN had been running behind during the AM medication pass. The LPN explained residents were allowed to self-administer medications only after the resident was evaluated for safety. The evaluation included assuring the resident knew what medications were prescribed to the resident, the correct dose and the correct time. The LPN denied Resident #12 had an evaluation for self-administration of medications and should not have self-administered the Fluticasone Propionate nasal spray. The LPN verbalized the resident should have received one spray in each nostril. On 11/07/2024 at 4:25 PM, the Executive Director verbalized the facility did not have a policy defining what a medication error was. The Executive Director explained medication errors included administering a medication at the wrong time and the wrong dose. The facility policy titled Medication Administration, General Guidelines, dated January 2024, documented medications were to be administered according to written orders of the prescriber. Medications were to be administered within 60 minutes of the scheduled time. Residents were allowed to self-administer medications when specifically authorized by the prescriber, the interdisciplinary team, and in accordance with procedures for self-administration. The facility policy titled Medication Administration, Self-Administration by Resident, dated January 2023, documented residents who desired to self-administer medications were permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team had determined the practice would be safe.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34524 Based on observation, interview, and document review, the facility failed to ensure 1) a medication cart containing resident medications was secure, 2) an open multi-dose vial had the date opened and initials of the first person to use the vial written on it in 1 of 2 medication storage rooms reviewed and 3) outdated medications were removed from 3 of 3 medication carts reviewed and 1 of 2 medication storage rooms reviewed. The deficient practice could have facilitated unauthorized access to medications in the cart and had the potential for outdated/expired medications to be administered to residents. Findings include: Unsecured Medications On 11/07/2024 at 9:14 AM, the Director of Nursing Services (DNS) verbalized medication carts should be secure when not in use. On 11/07/2024 at 10:24 AM, an unattended medication cart in the 100 hall was unlocked. A resident was standing next to the unlocked medication cart. On 11/07/2024 at 10:27 AM, a Registered Nurse (RN) returned to the unsecured medication cart and confirmed the medication cart was unlocked. The RN confirmed a resident was standing next to the medication cart and could have accessed resident medications. The facility policy titled Storage of Medication, revised 01/2024, documented in order to limit access to prescription medications, only license nurses and those authorized to administer medications were allowed to access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access. 49557 Multi-dose vial On 11/05/2024 at 10:08 AM, during a review of the station one medication storage room and in the presence of a Licensed Practical Nurse 1 (LPN), an open vial of Tubersol 5 units/0.1 milliliters (ml) was found in the medication fridge. The vial did not have the date opened or the initials of the first person to use the vial written on it. On 11/05/2024 at 10:20 AM, the Director of Nursing Services (DNS) verbalized a multi-dose vial was required to have the date opened and the initials of the staff member opening the vial written on it. The DNS confirmed the vial of Tubersol was open and lacked the date opened or initials of the first person to use it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Medication Administration, Injectable Vials and Ampules, dated January 2024, documented the date opened and the initials of the first person to use the vial were to be recorded on multi-dose vials. Outdated medications On 11/05/2024 at 10:27 AM, during a review of the station two medication cart and in the presence of an LPN2, the following medications were found: -Albuterol Sulfate inhaler 90 micrograms (mcg) per actuation (act). The discard after date printed on the pharmacy label was 06/06/2024. -Albuterol Sulfate Inhaler 90 mcg/act. The discard after date printed on the pharmacy label was 01/31/2024. -Tramadol 50 milligram (mg) tablet, 56 tablets remaining in the bubble pack. The discard after date printed on the pharmacy label was 10/26/2024. The LPN2 verbalized the discard after dates printed on the pharmacy labels for the two Albuterol Sulfate inhalers and the Tramadol tablets had passed and the medications should have been removed from the medication cart. On 11/05/2024 at 10:59 AM, during a review of the station three medication storage room and in the presence of an LPN3, a tube of Diclofenac Gel one percent was found. The discard after date printed on the pharmacy label was 08/06/2024. The LPN3 confirmed the discard after date printed on the pharmacy label for the Diclofenac Gel had passed and the medication should have been removed from stock in the medication storage room. On 11/05/2024 at 11:13 AM, during a review of the station three medication cart and in the presence of an LPN3, the following medications were found: -Hyosciamine 0.125 mg. The discard after date printed on the pharmacy label was 09/28/2024. -Liquid Pain Relief (Acetaminophen) 160 mg/5 ml. The expiration date printed on the bottle was April 2024. -Geri-Tussin (Guaifenesin) 200 mg/10 ml. The expiration date printed on the bottle was October 2024. -Cetirizine, ten mg tablets. The expiration date printed on the bottle was September 2024. -Acetaminophen suppositories, 650 mg. The expiration date printed on the box was June 2024. -Bisacodyl suppositories, 10 mg. The expiration date printed on the box was April 2024. The LPN3 confirmed the discard after date and the expiration dates for the medications had passed and the medications should have been removed from the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/05/2024 at 3:35 PM, during a review of the station one medication cart, and in the presence of an LPN4, an Albuterol inhaler was found. The discard after date printed on the pharmacy label was 06/18/2024. The LPN4 verbalized the LPN4 could not read the discard after date as the print was too small. On 11/05/2024 at 3:43 PM, an LPN1 viewed the Albuterol inhaler and verbalized the discard after date printed on the Albuterol inhaler's pharmacy label was 06/18/2024. The DNS explained medications were to be removed from stock in medication carts and medication storage rooms on or before the expiration/discard after date printed on the medication. The DNS verbalized the facility abided by the discard after date printed on the pharmacy label for medications delivered from the pharmacy. The facility policy titled Medication Storage, Storage of Medications, dated January 2024, documented medications were stored according to manufacturer or provider pharmacy recommendations. Outdated medications were to be immediately removed from stock and disposed of.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review and document review, the facility failed to ensure 1) resident information was not visible on an unattended computer screen, and 2) records were accurate for 1 of 28 sampled residents (Resident #62). Findings include: On 11/03/2024 at 12:24 PM, a computer screen on an unattended medication cart in the 100 hall displayed resident information. On 11/03/2024 at 12:25 PM, a Licensed Practical Nurse (LPN) returned to the medication cart and verbalized the computer screen should not display resident information. The LPN confirmed the computer screen was unlocked and unattended with resident information on display. On 11/06/2024 at 4:35 PM, a computer screen on an unattended medication cart in the 100 hall displayed resident information. On 11/06/2024 at 4:36 PM, a Registered Nurse (RN) returned to the cart and verbalized computer screens should be locked when not attended and confirmed the computer screen displayed resident medical records. On 11/07/2024 at 9:14 AM, the Director of Nursing Services (DNS) verbalized medication carts and computer screens should be secure when not in use. On 11/07/2024 at 10:24 AM, a computer screen on an unattended medication cart in the 100 hall displayed resident information. A resident was standing next to the medication cart with the computer displaying resident information. On 11/07/2024 at 10:27 AM, an RN returned to the unsecured medication cart and verbalized the computer screen displayed resident information, and the medication cart was unlocked. The RN confirmed a resident was standing next to the medication cart and could have accessed resident information. The facility policy titled Privacy - HIPAA Health Insurance Portability and Accountability Act, updated 05/2023, documented the facility was required to protect the privacy of health information of residents. 49557 Resident #62 Resident #62 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including Alzheimer's disease, unspecified and type two diabetes mellitus without complications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #62's October 2024 Treatment Administration Record (TAR) documented abrasion to left elbow related to fall. Cleanse with wound cleanser (WC), pat dry, apply triple antibiotic ointment and cover with Band-Aid, monitor for signs and symptoms (s/s) of infection and notify provider, every day shift. Negative (-) for s/s of infection, positive (+) for s/s of infection. The start date was 09/07/2024. There were no positive (+) responses documented in the month of October 2024. On 11/06/2024 at 2:09 PM, the LPN explained signs and symptoms of a wound infection included swelling, redness, pain, and drainage. The LPN verbalized Resident #62 had recently completed antibiotics for cellulitis at the site of an abrasion on the resident's left elbow. The LPN recalled the LPN had called the physician the previous week, on 10/30/2024, due to Resident #62's left elbow being swollen and red. The LPN explained a dash (-) on Resident #62's TAR indicated no s/s of infection and a positive (+) would indicate s/s of infection were present. The LPN reviewed Resident #62's progress notes and confirmed the date the LPN noted swelling and redness on the resident's left elbow was 10/30/2024. The LPN verbalized the documentation on the Resident #62's TAR indicated no s/s of infection were present and was inaccurate. A Nursing Progress Note dated 10/30/2024 documented Resident #62's left elbow was red, swollen, and painful. The physician was contacted and prescribed Augmentin for seven days. An Alert Charting Infection Note dated 11/02/2024 documented Resident #62's left elbow remained red and tender. On 11/06/2024 at 2:23 PM, the DNS verbalized s/s of a wound infection included redness, warmth, swelling, drainage, pain and odor. The DNS confirmed Resident #62 had a wound on the resident's left elbow. The facility policy titled Skin Integrity, updated October 2022, documented in an effort to maintain residents' optimal level of skin integrity the facility had a systematic approach and monitoring process for evaluating and documenting skin integrity. Significant abrasions were to be evaluated weekly and documented in the medical record. The licensed nurse was to remove dressings two times per week. The licensed nurse would examine the skin underneath and document the findings on the TAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review the facility failed to ensure ordered Enhanced Barrier Precautions (EBP) were implemented for a resident with chronic pressure ulcers for 1 of 28 sampled residents (Resident #60). The deficient practice had the potential for spreading infectious illnesses to the vulnerable resident. Findings include: Resident #60 Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus with hyperglycemia and pressure ulcer of right heel, stage three. A physician's order dated 02/20/2024, documented Enhanced Barrier Precautions (EBP) every shift for wounds. Resident #60's care plan revised 10/30/2024, documented a potential and actual impairment to skin integrity to include a healing stage three pressure ulcer to right heel. An intervention documented EBP due to wounds. On 11/03/2024 at 10:45 AM, EBP signage was not posted at the entrance of Resident #60's room. On 11/07/2024 at 9:27 AM, EBP signage was not posted at the entrance of Resident #60's room. On 11/07/2024 at 9:41 AM, a Certified Nursing Assistant (CNA) verbalized the CNA used gloves when providing care to all residents. The CNA explained EBP required glove use but was unsure what other personal protective equipment was used, when EBP was warranted, or which residents were on EBP. The CNA verbalized Resident #60 had a wound on their right leg, but the CNA did not do anything different or special when providing care to the resident. The CNA confirmed there was no EBP signage outside Resident #60's room. On 11/07/2024 at 9:51 AM, a Licensed Practical Nurse (LPN) entered Resident #60's room wearing gloves, greeted Resident #60 by name, and informed the resident the LPN was going to look at the resident's heel. On 11/07/2024 at 10:32 AM, the LPN verbalized Standard Precautions required the use of gloves during care while EBP required the use of gloves during care except during wound care when the LPN was required to wear gloves and a gown. The LPN verbalized Resident #60 was not on EBP, so the LPN has not been wearing personal protective equipment when providing wound care. The LPN confirmed Resident #60 did have an order for EBP. On 11/07/2024 at 10:45 AM, the Director of Nursing Services (DNS) verbalized staff were expected to follow EBP orders and EBP signage should be posted outside corresponding resident rooms. The DNS confirmed Resident #60 was on EBP. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/2024 at 11:24 AM, the Infection Preventionist (IP) verbalized the intent of EBP was to prevent residents from getting infections. The IP confirmed staff were expected to wear gowns and gloves when providing high contact care to residents on EBP. The facility policy titled, Enhanced Barrier Precautions, revised 03/26/2024, documented EBP was indicated for residents with chronic wounds including pressure ulcers. EBP expanded the use of personal protective equipment to donning of gown and gloves during high contact resident care activities. High-contact resident care activities included dressing, bathing, transferring, providing hygiene, changing linens, toileting, and wound care. When EBP was implemented, the IP or designee posts the appropriate notice on the room entrance door, so personnel were aware of precautions.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on interview, clinical record review, and document review, the facility failed to ensure 1 of 5 residents (Resident #392) reviewed for vaccinations, including influenza vaccines (Resident #392) was adminitstered the vaccine after the resident's guardian had consented for the vaccine to be administered. The deficient practice had the potential to place the resident at risk for not being protected against serious illness. Findings include: Resident #392 Resident #392 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, type II diabetes mellitus, and adult failure to thrive. Resident #392's State Immunization Record documented the resident last received an influenza vaccine on 12/27/2023. Resident #392's clinical record included a Resident Multi-Vaccine Consent Form. The form was signed and dated by the resident's guardian on 10/29/2024, giving consent for the resident to receive an influenza vaccine. The form documented the resident was eligible to recieve the vaccine and education regarding the vaccine was provided to the resident's guardian. A form titled Standing Vaccine Consent and Administration, revised on 10/13/2023, was signed by Resident #392's guardian on 10/29/2024. The form documented the guardian was provided a copy of the Vaccine Information Sheet (VIS) and understood the information/education related to the vaccine. Resident #392's clinical record lacked documented evidence the resident was administered an influenza vaccine. On 11/06/2024 at 4:08 PM, the Infection Preventionist (IP) verbalized Resident #392's guardian consented for the resident to receive an influenza vaccine on 10/29/2024. The IP confirmed the resident had not been administered the vaccine and should have been administered the vaccine on the day of consent, but it was missed. The facility policy titled Influenza and Pneumococcal Vaccine Administration, updated October 2024, documented influenza vaccination was provided to residents annually.