STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 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** Based on recorded review, interview and document review the facility failed to ensure physician orders were followed for the treatment of hypoglycemia (low blood sugar) and the physician notified of a change of condition for 1 of 20 sampled residents (Resident 52). The deficient practice had the potential to lead to worsened symptoms of hypoglycemia, hospitalization, or even death.Findings include: Resident 52 (R52) was admitted on [DATE] with diagnoses including type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema.A review of R52's weights and vitals summary dated 10/21/2025 through 10/31/2025 documented a blood sugar value of 43 milligrams per deciliter (mg/dL), a unit for measuring substance concentration (like blood sugar) on 10/29/2025. The summary documenting a warning low of 70.2 mg/dL exceeded.A review of R52's Medication Administration Record (MAR) revealed an order for Glucose Gel 15 grams/32 milliliter (GM/ML) (a fast-acting sugar solution used to treat low blood sugar). Give 15 grams by mouth as needed (prn) for a blood sugar below 60 for conscious patients. Start date 06/07/2025.The MAR lacked documented evidence Glucose Gel 15 GM/32ML was given as ordered for blood sugar under 60 mg/dL. On 12/04/2025 at 3:42 PM, a Licensed Practical Nurse (LPN), verified R52's glucose level was 43 mg/dL and Glucose Gel was not administered. The LPN stated R52's blood sugar should have been retaken 15 minutes after the initial test. The LPN a change in condition was completed or the provider notified regarding R52's low blood sugar. On 12/05/2025 at 7:28 AM, a Unit Manager confirmed R52s initial glucose level was 43 mg/dL and Glucose Gel was not administered. The Unit Manager clarified R52 blood sugar should have been re-checked within 15 minutes, a change in condition documentation completed and the provider notified regarding to R52s blood sugar levels. On 12/05/2025 at 7:30 AM, the Unit Manager provided standing orders document titled for Diabetic Management, located on each medication cart documented to give Glucose Gel 1 tube orally if blood sugar less than (<) 60 for conscious patients, call primary care provider (PCP) to review insulin orders. Recheck blood sugar in 15 minutes, if the sugar has not increased call 911 and the PCP. If the blood sugar has increased but is still <60 give another dose of Glucose. On 12/05/2025 at 8:00 AM, the Director of Nursing (DON), verified R52s glucose level was 43 mg/dL and Glucose Gel was not administered. The DON stated a blood sugar re-take was necessary and a four-hour delay from the initial blood sugar check should not have happened. The documentation was not present and the provider needed to be contacted for low and high blood sugar levels. On 12/05/2025 at 8:51 AM, a Clinical Resource Nurse confirmed the assigned nurse did not Glucose Gel for R52s low blood sugar of 43 mg/dL and a blood sugar re-take was needed, documentation should have been present and the provider contacted for the low and high blood sugar readings. Facility policy titled Administering Medications, revised April 2019, documented medications were administered in accordance with prescriber orders, including any required time frame. Facility policy titled Change in Residents Condition or Status, revised February 2021, documented the nurse will notify the attending physician or physician on call when there has been specific instruction to notify the physician of changes in the resident's condition.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a pharmacist's recommendation for a gradual dose reduction (GDR) was act upon for 1 of 20 sampled residents (Resident 30). The deficient practice had the potential for significant side effects including drowsiness, blurred vision, fatigue, trouble sleeping, and changes in mood. Findings include:Resident 30 (R30) was admitted [DATE], readmitted [DATE], with diagnosis including phantom limb syndrome with pain, major depressive disorder recurrent moderate and dementia unspecified severity with agitation.A physician order dated 10/18/2025, documented Fluoxetine Hydrochloride (HCl) oral capsule 40 milligrams (mg), give one capsule by mouth one time a day, related to major depressive disorder recurrent moderate. Record review revealed R30 had been receiving the same dose of Fluoxetine HCl 40 mg since 08/18/2023.A Medication Regimen Review dated 09/29/2025, documented a recommendation from the consultant pharmacist to consider a trial dose reduction to Fluoxetine 20 mg daily. The Physician/Prescriber section of the form indicated the Agree box was checked and the practitioner's signature was dated 10/24/2025.R30's electronic medical record lacked evidence the Fluoxetine dose was reduced as agreed upon by the practitioner.On 12/03/2025 at 3:33 PM, the Medical Records Coordinator stated GDR forms were sometimes given to the nurses and sometimes to the Director of Nursing (DON). The Medical Records Coordinator was unsure why R30's GDR form did not reach the DON and was instead filed in the medical record. The Medical Records Coordinator acknowledged the signed GDR recommendation should have been provided to the DON for review rather than filed without action.On 12/03/2025 at 4:11 PM, the Consultant Pharmacist explained the recommendation for a dose reduction was made because R30 had been receiving Fluoxetine 40 mg for over one year. The Consultant Pharmacist reported a gradual dose reduction would have helped ensure R30 was not taking more medication than necessary.On 12/03/2025 at 4:20 PM, the DON explained completed GDR forms signed by the practitioner were to be given to the records department and then routed to the DON for processing. New medical records staff members were not fully clear on the process and filed the signed form in the medical record. The signed GDR form had not reached the DON for review and not acted on to clarify the order or process the recommended change. A GDR was to ensure the resident was on the lowest therapeutic dose while still having the intended benefits of the medication.A facility policy titled Tapering Medications and Gradual Drug Dose Reduction, Revised July 2022, documented residents who used psychotropic medications received gradual dose reductions and behavioral interventions, unless clinically contraindicated, to discontinue these drugs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and document review, the facility failed to ensure the medication error rate was less than five percent (%) resulted in a medication error rate of 6.67%. This deficient practice had the potential to put the resident at risk for adverse drug reactions, ineffective treatment, and compromised health outcome.Findings include:On 12/03/2025 at 7:40 AM, Licensed Practical Nurse (LPN4) was observed preparing medications for Resident 61 (R6). LPN4 administered Aspirin 81 milligrams (mg) chewable, 1 tablet and Losartan Potassium 50 mg 1 tablet orally to R61. R61 was admitted on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD) and essential hypertension.A physician order dated 11/19/2025 indicated, Aspirin Oral Capsule 81 mg, give 1 tablet by mouth once daily for deep venous thrombosis.A physician order dated 11/22/2025 Losartan Potassium 100 mg 1 tablet by mouth one time a day for hypertension.On 12/03/2025 at 7:50 AM, the LPN acknowledged the discrepancies and stated the physician orders should have been verified prior to administration.The facility's policy titled Administering Medications, last revised April 2019, directed staff administering the medications to verify the right medication and right dosage. The policy indicated medications should be administered in accordance with prescriber orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 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** Based on observation, interview, and record review, the facility failed to ensure 1) safe and sanitary medication administration practices for 1 of 3 residents (Resident 61) during the medication pass observation, and 2) the Water Management Program included all requirements to prevent the growth and spread of Legionella. This deficient practice had the potential to compromise resident safety by increasing the risk of infection and cross contamination during medication administration, and exposure to waterborne pathogens.Findings include:Resident 61(R61) was admitted on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD). On 12/03/2025 at 7:40 AM, during a medication administration observation a Licensed Practical Nurse (LPN), retrieved a new bottle of aspirin intended for R61. The LPN used a bare finger to remove a tablet from the container. The inspector directed the LPN to discard the tablet since it was contaminated after being touched with a bare finger. During this process, four aspirin tablets fell onto the surface of the medication cart. The LPN returned the contaminated tablets to the original bottle instead of discarding them. On 12/03/2025 at 7:50 AM, the LPN performed a blood glucose test on R61. Upon completion, the LPN placed the used blood glucose meter into their scrub pocket without disinfecting the device. On 12/03/2025 at 9:30 AM, the LPN acknowledged the four aspirin tablets were contaminated after falling onto the medication cart surface and should have been discarded and the blood glucose meter should have been disinfected after use and not stored in a pocket. On 12/05/2025 at 11:30 AM, the Director of Nursing (DON) acknowledged the blood glucose meter should have been disinfected before and after each use to prevent the transmission of bloodborne pathogens and stored in the LPN's pocket, as this practice increases the risk of cross-contamination and resident exposure. The DON verbalized the LPN should not have handled aspirin tablets with bare hands, and tablets should have been discarded in accordance with infection control protocols. The facility policy titled Administering Medications, last revised April 2019, documented staff administering medications should follow established infection control procedures such as hand hygiene and antiseptic technique. The facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, last revised September 2022, indicated resident-care equipment, including reusable items should have been cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations. CDC recommendation titled Considerations for Blood Glucose Monitoring and Insulin Administration dated 08/07/2024, documented blood glucose meters should be cleaned and disinfected after every use, per the manufacturer's instructions. The manufacturer's instructions for the blood glucose meter recommended the use a disinfectant approved by the United States Environmental Protection Agency (EPA) to be used in clinical settings. A review of the facility policy titled Legionella Water Management Program (LWMP), last revised in July 2017, identified the composition of the Water Management Team and the appropriate standards (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or recommendations on which the plan was based. The LWMP outlined a number of elements that were to be written into the plan. These included an interdisciplinary water management team, the standards used for the development and implementation of the LWMP based on CDC and ASHRAE recommendations, and a detailed description and diagram of the water system in the facility in both written and illustrated form. The plan also included the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, the identification of situations that could lead to Legionella growth, and specific measures used to control the introduction and/or spread of Legionella. In addition, the plan addressed the control limits or parameters that were acceptable and monitored, a system to monitor control limits and the effectiveness of control measures, a plan for when control limits were not met and/or control measures were not effective, and documentation of the LWMP. The LWMP also outlined that the plan would be reviewed annually or sooner if control measures were not met, major maintenance or water service changes occurred, associated disease cases were identified from the water system, or if there were changes in laws, regulations, standards, or guidelines. On 12/04/2025 in the morning, a detailed review of the LWMP policy revealed the following elements were not provided, specified, or followed as outlined. The LWMP, referred to as the plan, included a written narrative of the water flow in the building but did not include an illustrated flow diagram for the path of water through the facility. The plan stated the LWMP will be reviewed at least once a year, or sooner. The plan provided during this survey was dated July 2017, and no information was received that indicated the plan had been reviewed since 2017. The plan indicated control measures would be monitored. The control measures included weekly water temperature checks and inspection of water fixtures for biofilm (slime). However, the plan did not define details of the required hot water temperature range, where the temperatures would be taken, and how or where to document the water temperatures. The plan also did not define the water fixtures to check, their locations, or the frequency of inspections. The plan indicated there were ways to intervene when control limits were not met. However, those ways included taking corrective action, limiting the risk to residents, and testing the water system until normal conditions returned. The plan did not define the specific corrective actions that could be taken, nor did it define the meaning of testing the water system or normal conditions. The plan indicated that water heaters would be inspected and the results recorded. However, there were no specific instructions on what the water heater was being inspected for or how the results were to be recorded. On 12/04/2025 morning, the Maintenance Director (MD) stated there were no written records of water fixture inspections, except for ice machine cleanings provided on 12/05/2025. The MD confirmed there were no documented records of water heater inspections. The MD explained the facility flushed seldom-used fixtures and adjusted water temperatures but did not document these actions or results. The MD also stated the facility did not use disinfectants in the water system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295080	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	601 Adams Boulevard Boulder City, NV 89005

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/2025 morning, the Infection Preventionist confirmed the facility had not had any residents with Legionella since the last survey.