STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425027	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainview Nursing Home	340 Cedar Springs Road Spartanburg, SC 29302

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, record review, and facility policy review, the facility failed to revise a comprehensive person-centered care plan to reflect the Resident's (R)1 current fall interventions for 1 of 3 sampled residents reviewed for falls. Findings include: Review of the facility's undated policy titled, Care Plans, Comprehensive Person-Centered, revealed, 11. Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: and included, d. at least quarterly, in conjunction with the required quarterly MDS [Minimum Data Set] assessment. Review of the facility policy titled, Fall Management, dated 05/19/2024, revealed under the heading, C. Intervention included, g. Update the resident's care plan. Review of R1's admission Record revealed the facility admitted R1 onˆ03/12/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of Alzheimer'sˆdisease with early onset, emphysema, generalized muscle weakness, and contracture of the right and left knee. Review of R1's Annual MDS assessment with an assessment reference date (ARD) of 02/23/2026, revealed that R1 had a Brief Interview for Mental Status (BIMS) score ofˆ00 out of 15, which indicated the resident had severe cognitive impairment. Review of R1's Order Summary Report, with active orders as of 05/28/2026, contained an order, dated 02/16/2026, for bed bolsters to define the parameter of the bed for safety. Review of R1's Order Summary Report, with active orders as of 05/28/2026, contained an order dated 03/11/2026, for two fall mats, for safety. Review of R1's Care Plan Report included a focus area initiated on 06/24/2025 and revised on 02/26/2026, that indicated the resident had an actual fall related to gait, balance problem. Interventions directed staff to increase staff monitoring (initiated 02/26/2026) and to conduct neurological checks, physical assessments, and vital signs as ordered by the physician (initiated 02/26/2026). The Care Plan Report revealed no focus area or interventions that included bed bolsters or fall mats. During an observation on 05/30/2026ˆat 9:20 AM, revealed R1 lying in bed on an air mattress with a perimeter defining overlay (a mattress overlay with raised/defined edges, sometimes referred to as bolsters), over the air mattress. Fall mats were observed on the floor on each side of the bed. During an interview on 06/10/2026 at 11:14 AM, Registered Nurse (RN)13 stated that since December 2025, she was responsible Monday through Friday to follow up on the nursing assessment after a fall to determine if the appropriate fall interventions were in place, and if the care plan was up to date with the interventions. RN13 stated that she reviewed and updated care plans along with the MDS staff. RN13 stated meetings were conducted each morning, Monday through Friday, to discuss falls, fall interventions, and interventions that should be added to the care plan. RN13 stated that the care plan should be updated at the same time as the meeting. She stated that the fall mats, bed in lowest position, and the bed perimeter defining mattress cover should all be included as interventions on R1's care plan. RN13 said she was not certain why the interventions were not on the resident's care plan, but that the interventions should be added. During an interview on 06/10/2026 at 11:35 AM, RN14 stated she was the MDS Coordinator and had started in that role the prior week. RN14 stated that when a fall occurred, the facility discussed the fall in the facility's clinical meeting with supervisors (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from each unit. RN14 stated she reviewed care plans within 48 hours of the clinical meetings to ensure the care plan had all the interventions. RN14 stated that the new process was developed because the facility had identified that care plans were not being updated consistently. During an interview on 06/12/2026 at 3:13 PM, the Assistant Administrator stated that care plans should be updated immediately after each fall and as needed. During an interview on 06/12/2026 at 3:34 PM, the Director of Nursing (DON) stated that she expected care plans to be updated immediately after a fall and as needed.During an interview on 06/12/2026 at 3:38 PM, the Staff Development Coordinator stated that the care plan should be updated immediately after an intervention was added and as needed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of manufacturer guidelines, the facility failed to ensure a sheet was not applied in a manner that flattened the perimeter defined mattress cover which created the potential for accidents for 1 (Resident (R)1) of 3 sampled residents reviewed for falls. Findings include: Review of a document provided by the Maintenance Manager (MM) for a Posey Defined Perimeter Mattress Cover, revised on 09/07/2016, indicated, Wedge-shaped foam sections line the perimeter of the covers and help provide a gentle reminder to those lying in bed of the location of the mattress edges, and help provide a less restrictive environment than side rails. A graph on the document indicated Foam Sections - Height 4 (10 cm [centimeter).Review of R1's admission Record revealed the facility admitted R1 onˆ03/12/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of Alzheimer'sˆdisease with early onset, emphysema, generalized muscle weakness, and contracture of the right and left knee.Review of R1's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/23/2026, revealed that R1 had a Brief Interview for Mental Status (BIMS) score ofˆ00 out of 15, which indicated the resident had severe cognitive impairment.Review of R1's Order Summary Report, with active orders as of 05/28/2026, contained an order, dated 02/16/2026, for bed bolsters to define the perimeter of the bed for safety. During an observation on 05/30/2026ˆat 9:20 AM, revealed R1 lying in bed on an air mattress with a defining perimeter mattress cover with wedge-shaped foam sections that lined the perimeter (commonly referred to as bolsters), over an air mattress. Further observation revealed a fitted sheet was covering the perimeter mattress cover and fall mats were observed on the floor on each side of the bed. During a concurrent observation and interview on 06/09/2026 at 12:00 PM, with the MM, R1's bed was observed with a perimeter mattress cover over an air mattress, and a fitted sheet covering the perimeter mattress cover. The bolsters of the defining perimeter mattress cover were flattened, and not in an upright position. R1 was not in their bed. The MM stated the fitted sheet should not be on the defining perimeter mattress cover because it caused the bolsters of the mattress cover to be flattened, potentially causing the fall intervention to be ineffective.During a concurrent observation and interview on 06/09/2026 at 12:21 PM, with the Staff Development Coordinator (SDC), R1's bed was observed with a fitted sheet covering the perimeter mattress cover. The SDC stated that the fitted sheet was not on the bed when they rounded earlier that morning at 5:30 AM and that staff were trained not to have a fitted sheet over the perimeter mattress cover because it could cause the bolster cushions to flatten.During an interview on 06/09/2026 at 12:20 PM, Certified Nursing Assistant (CNA)15 stated she was assigned to care for R1 that day (06/09/2026) for the 7AM to 3PM shift. CNA15 stated that when she arrived that morning around 7:00 AM, R1 was in bed, and a fitted sheet was on the bed. CNA15 said she was trained not to use a fitted sheet to cover an air mattress with a perimeter mattress cover in place. During an interview on 06/09/2026 at 3:00 PM, CNA16 stated she was assigned to care for R1 on the 11PM to 7AM shift the prior night. Per CNA16, when she arrived at 11:00 PM, R1 was in bed with a fitted sheet over the defining perimeter mattress cover. CNA16 stated she had applied a fitted sheet to the resident's bed over the perimeter mattress cover in the past and noticed that the bolsters of the perimeter mattress cover flattened and were not raised upright. CNA16 said she was trained not to use a fitted sheet over a perimeter mattress cover, but since a fitted sheet was already on the resident's bed, she left the fitted sheet on the bed.During a telephone interview on 06/10/2026 at 7:37 PM, Licensed Practical Nurse (LPN)1 said she was trained not to use a fitted sheet to cover a perimeter mattress cover.During an interview on 06/10/2026 at 4:25 PM, the Director of Nursing (DON) revealed she expected staff not to use a fitted sheet over the defining perimeter mattress cover because it caused the bolster cushions to be flat instead of being raised which defeated the purpose of the perimeter mattress cover.