STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455471	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Murchison Rd El Paso, TX 79902

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observations, interviews, and record review the facility failed to develop and implement comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident medical and nursing needs to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #5) reviewed for care plans. The facility failed to develop and implement a comprehensive person-centered care plan for Resident #5 who had two different transfers (two-person transfer with mechanical lift and transfer 1 person transfer) implemented at the same time. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings included: Record review of Resident #5's face sheet dated 09/05/24, revealed, admission on 02/28/24 and re-admission on 06/26/24 to the facility. Resident #5 was a [AGE] year-old male diagnosed with history of other (healed) physical injury and trauma (a serious injury to the body), repeated falls, lack of coordination (due to a muscle control problem that causes an inability to coordinate movements), abnormalities of gait (change to your walking pattern) and mobility (a person is having difficulty walking and moving as they normally would), muscle wasting (decrease in size and wasting of muscle tissue), muscle weakness (difficulty rising from a chair, brushing your hair, lifting an object off a high shelf, or dropping thing), cervical disc degeneration (neck pain), and intervertebral disc degeneration (spinal disks wear down). Record review of Resident #5's quarterly MDS dated [DATE], revealed, a BIMS score of 10 which indicated a moderate cognition to be able to recall and make daily decisions. Resident #5's ADLs revealed a substantial/maximal assistance (the nursing staff does more than half the effort to assist the resident) for toileting, shower/bathe, and dressing lowering body. Resident #5 was partial/moderate assistance (nursing staff does less than half the work when assisting the resident) for sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident #5 was diagnosed with traumatic brain injury, schizophrenia, intervertebral disc degeneration in the lumbar region, low back pain, muscle wasting, muscle weakness, lack of coordination, repeated falls, and abnormalities of gait and mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's Physical Therapy Evaluation dated 05/01/24 - 06/29/24, revealed, baseline on 05/01/24 of max assistance with functional transfers. Patient referred to PT due to new onset of decreased in strength, decreased in functional mobility, decreased in transfers, reduced ability to safely ambulate, reduced balance, and decreased coordination indicating the need for physical therapy. Bed mobility was max, and transfers was max assistances (total dependence for nursing staff help). Impressions - presents with deficits in balance, truck control, right upper extremity weakness, and needs assistance for all bed mobility and transfers. Resident #5 was non-ambulatory and presents with poor safety awareness. Record review of Resident #5's Care Plan dated 06/05/24, revealed, ADLs self-care performance - transferring: requiring 2 staff, Hoyer (machine/device used to lift residents) for assistance. Care Plan dated 06/05/24, revealed, risk for falls - 1 staff to assist with transfers. The care plan had conflicting transfers. Record review of Resident #5's Fall-Risk assessment dated [DATE], revealed, has not had any falls within the last 3 months. Required use of an assistive device (i.e., cane, wheelchair, walker, furniture). Resident #5 had a score of 5. Record review of Resident #5's Event Note - Fall dated 06/24/24, revealed, Resident #5 had a fall in his room. It was coded for assisted. Resident #5 was not having any cognitive/behaviors at the time of the event. Resident #5 reported a fall to LVN B that happened the day prior (06/23/24). Resident statement related to event stated, Resident #5 was being transferred from the wheelchair to the bed and I had a fall to the floor when CNA C was helping me. Today my leg was really killing me. Record review of Resident #5's Progress Notes on 06/05/24, revealed there was no progress note on 06/23/24, for a fall for Resident #5. During an interview on 09/05/24 at 9:40 AM, with CNA E, she stated she had worked with Resident #5 but was moved to the 1st floor. CNA E stated Resident #5 was partial assistance and she would use the gait belt when transferring him. CNA E stated Resident #5 was at the facility for a fracture he had from a fall at home. CNA E stated since 05/2024 staff had been transferring him using the gait belt and used other forms of transfer. CNA E stated Resident #5 in the Kardex was a hoyer transfer. CNA E stated that LVN B, had told her that Resident #5 did not require the 2-person Hoyer lift anymore . During an interview on 09/05/24 at 9:59 AM, with the Regional MDS, she stated acute care plans were done and/or revised by the DON and the ADONs as needed. The Regional MDS stated Resident #5's care plan dated 06/05/24, before the incident on 06/23/24, revealed that Resident #5 was a 2-person hoyer transfer. Regional MDS stated the nursing staff should have and were expected to be doing a 2-person hoyer transfer for Resident #5. The Regional MDS stated it was expected for the nursing staff to be following the care plan. The Regional MDS stated the purpose of a care plan was to know how to take care of the resident. The Regional MDS stated the risk of not following the care plan could be a fall or fracture, especially for ADLs. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24 at 10:53 AM, with LVN B, she stated the DON or the ADONs would put the mode of transfer if it was updated in the care plan. LVN B stated if she were to update the mode of transfer, she would have placed it on the progress notes, MAR, and on the communication report. LVN B stated she had seen Resident #5 as a 2-person Hoyer transfer. LVN B stated the nursing staff was expected to be following the care plan if it stated Resident #5 was a 2-person Hoyer transfer. LVN B stated it was important because each care plan was personalized to meet the needs of each individual resident. LVN B stated the risk could be injury or death. LVN B stated changes on a resident should reflect what the new outcome would be for that resident. Observation and interview on 09/05/24 at 11:19 AM, the Regional MDS observed that there were two different modes of transfer for Resident #5. The Regional MDS stated that having two different transfers on a care plan would contradict itself and be a risk of injury. During an interview on 09/05/24 at 11:35 AM, with the DON, she stated the IDT, and the DON would catch any acute information and be placed in the care plan to ensure that the care plans were correct for the residents. The DON stated there could have been a risk as the care plan drives the care of the resident . The DON stated the risk would be injury to the resident. During an interview over the telephone on 09/05/24 at 1:13 PM, with LVN A, he stated he was not sure of Resident #5's mode of transfer but thought Resident #5 was a 2-person Hoyer lift transfer. LVN A stated if a care plan had two different transfers, then it would be conflicting. LVN A stated that nursing and therapy would be responsible for updating the care plan as needed. LVN A stated there could be a risk of injury. Record review of the facility comprehensive care planning policy not dated revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Record review of the facility Preventive Strategies to Reduce Fall Risk Policy dated 10/05/16, revealed, Policy: The goal of fall prevention strategies was to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. After risk was assessed, individualized nursing care plans will be implemented to prevent falls.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interviews and record review the facility failed to ensure that the residents environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 1 (Resident #5) of 5 residents reviewed for accidents. The facility failed to ensure that Resident #5 who was a two-person transfer was transferred as a two-person transfer with mechanical lift instead of a one-person transfer . CNA C failed to report Resident #5 had a fall resulting in pain to nursing when Resident #5 was guided down to the floor hitting his right knee and having his left leg extended. This failure could place residents at risk of falls or injuries. Findings included: Record review of Resident #5's face sheet dated 09/05/24, revealed, admission on 02/28/24 and re-admission on 06/26/24 to the facility. Resident #5 was a [AGE] year-old male diagnosed with history of other (healed) physical injury and trauma (a serious injury to the body), repeated falls, lack of coordination (due to a muscle control problem that causes an inability to coordinate movements), abnormalities of gait (change to your walking pattern) and mobility (a person is having difficulty walking and moving as they normally would), muscle wasting (decrease in size and wasting of muscle tissue), muscle weakness (difficulty rising from a chair, brushing your hair, lifting an object off a high shelf, or dropping thing), cervical disc degeneration (neck pain), and intervertebral disc degeneration (spinal disks wear down). Record review of Resident #5's quarterly MDS dated [DATE], revealed, a moderate cognition to be able to recall and make daily decisions BIMS score of 10. Resident #5's ADLs revealed a substantial/maximal assistance (the nursing staff does more than half the effort to assist the resident) for toileting, shower/bathe, and dressing lowering body. Resident #5 was partial/moderate assistance (nursing staff does less than half the work when assisting the resident) for sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident #5 was diagnosed with Traumatic Brain Injury, Schizophrenia, intervertebral disc degeneration in the lumbar region, low back pain, muscle wasting, muscle weakness, lack of coordination, repeated falls, and abnormalities of gait and mobility. Record review of Resident #5's Physical Therapy Evaluation dated 05/01/24-06/29/24, revealed, Baseline on 05/01/24 of Max assistance with functional transfers. Patient referred to PT due to new onset of decreased in strength, decreased in functional mobility, decreased in transfers, reduced ability to safely ambulate, reduced balance and decreased coordination indicating the need for physical therapy. Bed Mobility was Max and Transfers was Max assistances (total dependence for nursing staff help). Impressions - presents with deficits in balance, truck control, right upper extremity weakness and needs assistance for all bed mobility and transfers. Resident #5 was non-ambulatory and presents with poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's Treatment Encounter Note dated 06/21/24, revealed, transfer with minimum assistance. Record review of Resident #5's Care Plan dated 06/05/24, revealed, ADLs self-care performance - transferring: requiring 2 staff, hoyer (machine/device used to lift residents) for assistance. Care Plan dated 06/05/24, revealed, risk for falls - 1 staff to assist with transfers. The care plan had conflicting transfers. Record review of Resident #5's Fall-Risk assessment dated [DATE], revealed, has not had any falls within the last 3 months. Required use of an assistive device (i.e., cane, wheelchair, walker, furniture). Resident #5 had a score of 5. Record review of Resident #5's Event Note - Fall dated 06/24/24, revealed, Resident #5 had a fall in his room. It was coded for assisted. Resident #5 was not having any cognitive/behaviors at the time of the event. Resident #5 reported a fall to the LVN B that happened the day prior (06/23/24). Resident statement related to event stated, Resident #5 was being transferred from the wheelchair to the bed and I had a fall to the floor when CNA C was helping me. Today my leg was really killing me. Record review of Resident #5's Progress Notes on 06/05/24, revealed there was no progress note on 06/23/24, for a fall for Resident #5. Record review of the Administrator Statement dated 06/25/24 at 1:11 PM, revealed, Employee (CNA C) recalls on Sunday (06/23/24) at approximately 11 am CNA C assisted this resident (Resident #5) with transfers from bed to wheelchair as he was preparing to go on a smoke break. CNA C noted he was assistance with transfers. When attempting to transfer Resident #5 using the gait belt, his right leg accidentally got caught between the wheelchair and bed. CNA C was able to break the fall by holding onto him with the gait belt and transferred him back to bed. CNA C repositioned the wheelchair to the opposite direction and reattempted to transfer him from bed to the wheelchair. At no time did Resident #5 complain of pain or that he had fallen or hit himself. This was the reason the CNA C claimed she did not inform the nurse since there was no fall or incident to report. CNA C claimed that for the duration of the shift she decided to use the Hoyer instead just as a precaution and assisted the help of CNA D. Record review of Resident #5's hospital report dated 06/25/24, revealed, Patient arrived to emergency roiagnom on [DATE]. Resident #5 stated being dropped from transition from bed to wheelchair at facility on 06/23/24. Complains of hip pain and knee pain of a score of 6 out of 10. History of Present Illness: Subacute (Rather recent onset or somewhat rapid change) to chronic (persisting for a long time or constantly recurring) appearing ununited fracture of [NAME]-cervical (a fracture through the base of femoral neck at its junction with the intertrochanteric region), intertrochanteric (between the trochanters - which are bony protrusions on the femur (thighbone)) fracture of right femoral neck with mild distraction and angulation (an angular position, formation or shape). Old, healed fractures of superior and inferior right pubic rami. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was mild remodeling suggesting subacute to chronic age of the fracture and this may represent nonunion (When a broken bone fails to heal). Correlation (the statistical relationship between two entities or how two variables move in relation to one another) with age of injury/traumatic event was recommended. Bones are osteoporotic (a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes). During an interview on 09/05/24 at 9:40 AM, with CNA E, she stated she had worked with Resident #5 but was moved to the 1st floor. CNA E stated Resident #5 was partial assistance and she would use the gait belt when transferring him. CNA E stated Resident #5 was at the facility for a fracture he had from a fall at home. CNA E stated since 05/2024 staff had been transferring him using the gait belt and used other forms of transfer. CNA E stated Resident #5 in the Kardex was a Hoyer transfer. CNA E stated that LVN B, had told her that Resident #5 did not require the 2-person Hoyer lift anymore. During an interview on 09/05/24 at 9:59 AM, with the Regional MDS, she stated Resident #5 was to be a 2-person Hoyer transfer and based on the documentation it would be considered an improper transfer. During an interview on 09/05/24 at 10:53 AM, with LVN B, she stated Resident #5 was sent out to the hospital (06/25/24) for a fracture that happened on the weekend (06/23/24). LVN B stated Resident #5 had a fall on 06/23/24 and was sent out on 06/25/24. LVN B stated she thought one of the CNAs might have accidently dropped him or sat him down too hard on the bed. LVN B stated she would not be able to answer how the CNAs transferred him and was not always there. LVN B stated if the CNAs did not know how to transfer Resident #5 then they could always go to her. LVN B stated she did not remember telling anyone how Resident #5 was to be transferred. LVN B stated the CNAs had the Kardex (a nursing worksheet that includes a summary of patient information, such as prescribed medications, clinical follow-ups, and daily care schedules) to tell them the mode of transfer of a resident. LVN B stated she had not had any nursing staff come up to her and ask her what Resident #5's mode of transfer was. LVN B stated she was unaware how Resident #5 was being transferred as a 1-person transfer. LVN B stated not following the residents transfer or doing an improper transfer could be a risk of injury. During an interview on 09/05/24 at 11:35 AM, with the DON, she stated it was reported by CNA C that Resident #5 got hooked on the wheelchair at the front. The DON stated CNA C and Resident #5 lost their balance and Resident #5 went down to the floor and hit his bottom. The DON stated as Resident #5's foot got caught on the wheelchair he was being lowered to the ground and was complaining of leg pain. The DON stated LVN A should have assessed for any injury and level of pain, but it was not reported to him. The DON stated CNA C should have reported the fall to LVN A immediately. The DON stated the risk of not reporting was the facility could not do anything to assess the resident. The DON stated Resident #5 was assessed upon learning of the incident and sent out to the hospital. The DON stated CNA C was suspended pending the outcome of the investigation and all CNAs were given an in-service on reporting, abuse, neglect, and exploitation, and transfers. The DON stated CNA C had done an improper transfer and placed Resident #5 at risk of injury or pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24 at 1:13 PM, with LVN A, he stated he had worked the day of the incident (06/23/24) with CNA C. LVN A stated he had received a call from the DON asking about what had happened on Sunday (06/23/24) with Resident #5 having a fall. LVN A stated the DON had told him Resident #5 had voiced out that he had a fall when CNA C was transferring him. LVN A stated he was complaining of pain. LVN A stated he was unaware of a fall as CNA C nor other staff had mentioned that Resident #5 had a fall. LVN A stated it was expected of the facility staff to be reporting any falls that resident(s) might have. LVN A stated if someone falls that they were not to be picked up and a nurse needed to check the resident out before any lifting happened. LVN A stated there could be a risk of not doing the correct transfer on a resident and that could be injury. During an investigation on 09/05/24 at 1:40 PM - Resident #5 stated he always has pain. Resident#5 he stated he was transferred from the bed to the wheelchair. Resident #5 stated CNA C lost her grip and so did he. Resident #5 stated he fell with his left leg straight and his right knee bent and hit the floor. Resident #5 stated he had pain when he hit the floor. Resident #5 stated he had no history of falls and was told he had a right hip fracture. Resident #5 stated CNA C placed him back on the wheelchair. Resident #5 stated he had no more pain once on the wheelchair. Resident #5 stated he let the CNA C know that he was in pain. Resident #5 stated he had no futher pain until the following day on 06/24/24. Resident #5 stated he told the nurse the following day that he fell and had pain. Resident #5 stated he was given pain medication and felt a lot better. During an interview over telephone on 09/06/24 at 8:30 AM, with CNA C, she stated she tried transferring Resident #5 from his bed on 06/23/24 to the wheelchair so he could go on his smoke break. CNA C stated she lifted Resident #5 the 1st time without a gait belt and his right leg got stuck on the wheelchair. CNA C stated during the transfer Resident #5 was complaining about being in pain and she told him she would leave him on the bed. CNA C stated she placed Resident #5 back on the bed in which he stated he was fine. CNA C stated the 2nd time she was going to transfer Resident #5 she used the gait belt on him. CNA C stated she felt bad for not reporting the incident to LVN A. CNA C stated she had to report the incident and also because he complained of pain. CNA C stated not reporting could have been a risk of physical injury to the resident. CNA C stated in the facility Kardex system it showed the mode of transfer for Resident #5. CNA C stated Resident #5 was a 2-person Hoyer transfer. CNA C stated she had not done the correct transfer for Resident #5 as she needed another staff member and the Hoyer to transfer Resident #5. CNA C stated she had to transfer Resident #5 with two staff because he had a hurt leg and could hurt himself again. Record review of the facility Event reporting policy not dated provided by the DON on 09/06/24, revealed, that the facility accidents policy was the Event reporting policy. The policy did not relate to accidents and hazards. No other policy was brought forth prior to exit. The facility will complete an event report on variances that occur within the facility. Variances include falls, skin tears, bruises, lacerations, fractures, choking, burns, elopement, or behaviors that affect others. Interventions: Include and care plan any required interventions or supervision to help prevent further occurrence of the event. Record review of the facility Hydraulic Lift Policy not dated, revealed, The hydraulic lift was a mechanical device used to transfer a resident from and to the bed and chair. It was reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance. The resident will achieve safe transfer to bed or chair via mechanical lift device. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The caregiver will demonstrate safe and correct transfer of the resident to the bed or chair via the hydraulic lift. Record review of the facility Moving a Resident, Bed to Chair/chair to bed policy dated 2003, revealed, Purpose: The purpose of this procedure are to allow the resident to be out of his or her bed as much as possible and to provide for safe transferring of the resident. This procedure may require two person. If moving a resident from bed to chair: Position a gait belt around the resident's waist and clasp it. Make sure it was tight enough that only a slight hand movement will guide the patient, but not so tight that you cannot firmly grasp the belt without making the patient uncomfortable. Support the resident by placing a gait belt around the resident's waist for you to hold and steady the resident. Record review of the facility Preventive Strategies to Reduce Fall Risk Policy dated 10/05/16, revealed, Policy: The goal of fall prevention strategies was to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s).