

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Mountain View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46998</p> <p>Based on observation, interview, and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for 1 of 7 (Resident #2) residents reviewed for abuse.</p> <p>The facility failed to immediately suspend LVN A after Resident #2 reported that one nurse matched the description provided by the Resident #2.</p> <p>This failure could place residents at risk of abuse by not immediately following the facility abuse policy and procedure manual of taking the necessary measures to protect residents from harm during and following an abuse, neglect, exploitation, mistreatment of resident's investigation.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet dated 04/24/25, revealed, admission on 05/21/24 and re-admission on 01/02/25 to the facility. Resident #2 was a [AGE] year-old male diagnosed with pulmonary hypertension (high blood pressure that affects the arteries in the lungs and the right side of the heart) and Cor Pulmonale (right-side heart failure that occurs when a lung condition forces the right side of your heart to work harder to pump blood into the lungs), and Syncope and collapse (terms that refer to a sudden loss of consciousness).</p> <p>Record review of Resident #2's admission MDS dated [DATE], revealed, a moderately impaired cognition BIMS score of 11 to be able to recall or make daily decisions. Activities of daily living noted to be dependent on toileting, shower, putting on footwear, and lower dressing.</p> <p>Record review of Resident #2's care plan dated 01/03/25, revealed, congestive heart failure. Report to the charge nurse any new or increased swelling, breathing problems, change in skin color, or increased difficulty performing tasks. Had a history of being resistive to care. Allow the resident to make decisions about treatment regime, to provide sense of control.</p> <p>Record review of Resident #2's Progress Notes dated 01/02/25 to 01/21/25, revealed, there was no mention of Resident #2 being unresponsive and a sternum rub being given to Resident #2. It was mentioned in the progress note, Allegation of abuse-alleged that one week ago, a night nurse hit him on his chest and was aggressive. Resident #2 described this person as a fat and chubby Hispanic male with a beard and hat. Claims he complained to someone last week but doesn't remember to whom. Resident #2 did not allow a skin assessment and stated he had nothing and does not want nothing.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Grievance generated by Ex-Administrator dated 01/14/25, revealed, Allegation of abuse - alleged that one week ago, a night nurse hit him on his chest and was aggressive. He described this person as a fat, chubby, Hispanic male with a beard and hat.</p> <p>Record review of facility State Report dated 01/21/25, revealed, Description of the Allegation, Alleged that one week ago a night nurse hit him on his chest and was aggressive. He described this person as fat and chubby Hispanic male with a beard and hat.</p> <p>Investigation Summary - There was no nurses who fit the description mentioned.</p> <p>Provider Action Taken Post-Investigation - LVN A was removed from his care to avoid any issues.</p> <p>During an interview on 04/23/25 at 1:13 PM, with CNA C, she stated she had gone with the DON to question Resident #2 with unrelated questions to the incident. CNA C stated that was when she first heard of the night male nurse hitting him on his chest. CNA C stated LVN A does have a beard, was [NAME], did wear caps, and was a male night nurse.</p> <p>During an interview on 04/23/25 at 1:56 PM, with RN B, he stated there was a male nurse that was chubby, wore hats, and had a beard who was LVN A. RN B stated he had been trained on abuse, neglect, and exploitation. RN B stated if there was an alleged perpetrator that AP would have to be suspended until the investigation was over.</p> <p>During an interview on 04/23/25 at 3:38 PM, with the DON, she stated on 01/14/25, she was questioning Resident #2 regarding a different matter unrelated to the incident when Resident #2 mentioned to her that a male night nurse that was chubby, had beard, and wears a hat had hit him a week ago in the night. The DON stated LVN A did have a beard, sometimes wear a hat, was Hispanic, and was not chubby but [NAME]. The DON stated the previous Ex-Administrator had conducted the investigation and did not know why she did not suspend LVN A. The DON stated LVN A had claimed that when he was conducting his rounds, he noted Resident #2 to be unresponsive and did a sternum rub (a painful stimulus technique used to assess a patient's responsiveness when they are unresponsive to verbal or other stimuli) in which Resident #2 responded. The DON stated Resident #2 had a history of singable episodes (distinct periods or incidents of a patient's health experience that are significant enough to be marked or identified separately) of being unresponsive and it was within LVN A's scope to use the sternum rub to get a response. The DON stated on the state report submitted to state agency she did not know it was mentioned why LVN A was removed from Resident #2's care to avoid any issues. The DON stated on the grievance and on the state report it did not mention LVN A being identified as the alleged perpetrator and suspended pending investigation. The DON stated if there was an incident with an alleged perpetrator it would be expected for the facility to follow its procedures and protocols to suspend the employee pending the outcome of the investigation. The DON stated this was to protect the resident and prevent any further abuse.</p> <p>During an investigation on 04/23/25 at 11:21 PM, with LVN D, she stated LVN A does have beard, was [NAME], and used surgical caps. LVN D stated LVN A had used a sternum rub on Resident #2 because he was unresponsive. LVN D stated the purpose of the sternum rub was to wake up the resident(s) or make them respond.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/25 at 9:37 AM, with LVN A, he stated Resident #2 had a history of passing out. LVN A stated he went into Resident #2's room and tapped his shoulder and was calling out to him and did not respond. LVN A stated as per his nursing training he used the sternum rub on Resident #2. LVN A stated Resident #2 was asking him why he hit him and explained to him he did not and educated him on why he used a sternum rub because he was unresponsive. LVN A stated he did have a beard, does wear surgical hat(s) and sometimes a regular cap to work. LVN A stated he was suspended for approximately 3 days until he received a phone call (did not recall who called him) letting him know the outcome of the investigation but did not remember what days. LVN A stated when went back to work he was told he could not work with Resident #2 and was given another resident.</p> <p>Observation and interview on 04/24/25 at 10:30 AM, with HR, who was observed going through LVN A's employee hard copy file and then going over to her computer looking through her e-mails and records for LVA A. HR stated LVN A was suspended due to the incident of Resident #2 claiming there was a male night nurse that had hit him on his chest. HR stated she had looked at LVN A's employee hard copy file and did not see any suspension letter for 01/01/25-01/31/25 nor could not find an e-mail or records submitted to corporate that LVN A was on suspension pending investigation. HR stated LVN A worked every day and only had one day off a week and does not show him been out for 3 days for suspension on the timesheets. HR stated she had been trained on abuse and neglect and knew that they had to remove LVN A and place him on suspension for the safety of the resident(s). HR stated the risk would depend on the allegation.</p> <p>During an interview on 04/24/25 at 3:17 PM, with the Ex-Administrator, she stated it was reported to her that Resident #2 alleged that a Hispanic male night nurse with a beard, who was chubby, and wore hats had hit him on the chest. The Ex-Administrator stated Resident #2 was having episodes of fainting and being non-responsive. The Ex-Administrator stated she had identified LVN A as matching the description of the alleged perpetrator and removed him. The Ex-Administrator stated she did not remember if LVN A was suspended but did not work the whole week (01/14/24-01/17/25) because he was the weekend nurse. The Ex-Administrator stated HR would have the documentation of suspension as they are to report it up to corporate. The Ex-Administrator stated during the course of the investigation a committee making up corporate and facility staff recommended not to suspend LVN A due to him doing a medical intervention on Resident #2. The Ex-Administrator stated post-investigation LVN A was not allowed to provide care for Resident #2. The Ex-Administrator stated as soon as she received report of alleged abuse as per facility protocol upon identifying the alleged perpetrator; the alleged perpetrator should have been suspended and in this case LVN A should have been suspended immediately. The Ex-Administrator stated the risk on not suspending the alleged perpetrator could be continued perpetrators if they intended to keep hurting residents.</p> <p>During an interview on 04/25/25 at 2:51 PM, with the Administrator, he stated if there was an incident with an alleged perpetrator then the process would be to suspend the alleged perpetrator if it was an employee pending the outcome of the investigation. The Administrator stated not suspending the alleged perpetrator could be the employee still coming into work and affecting the resident(s). The Administrator stated risk could be harm of the resident(s) and the abuse could still be happening.</p> <p>Record review of the facility Abuse/Neglect Policy dated 09/09/24, revealed, The resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide and ensure the promotion and protection of resident rights. It was each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse and situations that may constitute abuse or neglect to any resident in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Investigation - with an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee(s) will immediately be suspended pending an investigation. The employee will have an opportunity to present a written statement to answer the allegation(s) of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The employee will have the opportunity to be advised of the outcome of the investigation in the determination of disciplinary action and or reinstatement.</p> <p>Protection - The facility will take necessary measure to protect residents and employees from harm during and following an abuse, neglect, and exploitation, mistreatment of residents or misappropriation of residents property investigation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46998</p> <p>Based on interview and record review the facility failed to ensure alleged violations involving abuse, neglect, exploitation, or mistreatment, including misappropriation were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (DON &amp; ADON) of 2 staff reviewed for reporting.</p> <p>The DON and ADON failed to immediately report to the Administrator that Resident #9 was missing \$50 so that the Administrator could report it to the state agency.</p> <p>This failure could place residents at risk for exploitation and/or misappropriation of property.</p> <p>Findings included:</p> <p>Record review of Resident # 9's face sheet dated 04/24/25, revealed, admission on 05/23/24 to the facility.</p> <p>Record review of Resident #9's facility history and physical dated 05/30/24, revealed, a [AGE] year-old male diagnosed with being legally blind, anxiety, and major depressive disorder.</p> <p>Record review of Resident #9's annual MDS dated [DATE], revealed, a moderate impaired cognition BIMS score of 8 to be able to recall and make daily decisions. Resident #9 had acute mental status changes to disorganized thinking and altered level of consciousness behavior that fluctuates (comes and goes). Resident #9's activities of daily living have him dependent (nursing staff does all the work to assist) on roll left/right in bed, sit to lying, lying to sitting on the bed, sit to stand, and chair/bed to chair transfers.</p> <p>Record review of Resident #9's care plan dated 06/25/24, positive for MI and PASRR positive. LA will be invited annually to the care plan meeting for the review of Specialized Services. Had impaired visual function. Resident #9 prefers to have their room and things arranged to their needs.</p> <p>During an interview on 04/24/25 at 11:46 AM, CNA F stated that last week on 01/17/25, Resident #9 told her he had \$115 in his wallet. CNA F stated that they both counted the money together and it was only \$84. CNA F stated that Resident #9 thought he had more but did not. CNA F stated she reported what happened to LVN E. CNA F stated she was off and did not come back to work till 04/22/25, and she then re-counted the money revealing only \$34 left. CNA F stated she went to report it to LVN E once again and the \$34 was given to LVN E.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/25 at 1:04 PM, with LVN E, she stated on 04/17/25, it was reported to her by CNA F that Resident #9 was alleging that he had \$115 in his wallet. LVN E stated that CNA F counted it with Resident #9 together and only had \$84 in total. LVN E stated on 04/22/25, CNA F came back to her and let her know that Resident #9 only had \$34. LVN E stated it was reported to the DON and ADON regarding the situation of missing money.</p> <p>During an interview on 04/24/24 at 1:43 PM, with SW, she stated she had seen Resident #9 and was informed that he had money in his drawer. The SW stated she spoke with CNA F who mentioned that Resident #9 had \$84. The SW stated LVN E had given the BOM Resident #9's money to keep it safe. The SW stated it had been reported to the DON and then DON informed her of the incident. The SW stated if any kind of abuse was reported to her she would immediately report it to her supervisor and the Administrator who was the Abuse Coordinator. The SW stated the risk of not reporting would be money continuing to be missing and the resident would lose trust in the facility.</p> <p>During an interview on 04/24/25 at 2:08 PM, with the DON, she stated the incident with Resident #9's missing money was reported to the ADON who then reported it to her last week (01/13/25-01/19/25) but could not remember the exact date. The DON stated she told the ADON to pass it along to the SW. The DON stated she reported it to the Administrator as well. The DON stated CNA F brought a statement that indicated that Resident #9 had 3 \$20s, 1 \$10, 2 \$5, and 4 \$4 equaling \$84 that he kept in his top dresser drawer. The DON stated it was not reported to the state agency and based on the facility Abuse Neglect policy it should have been reported to the state agency. The DON stated the purpose of reporting abuse, neglect, exploration, and misappropriation of property was very clear that one had to report any abuse, neglect, exploitation, or misappropriation of property to the Administrator and state agency. The DON stated this was to protect the resident(s) and not reporting abuse, neglect, exploitation, and misappropriation of property did not protect the resident(s). The DON stated the SW was conducting the investigation and looking into the matter.</p> <p>During an interview on 04/24/25 at 2:37 PM, with the ADON, she stated it was reported to her last week on 01/17/25 by CNA F that Resident #9 was claiming to have \$115 and when counted by CNA F he only had \$84. The ADON stated CNA F counted the money this week (01/20/25-01/24/25) with Resident #9 and he had \$34 in his 1st drawer. The ADON stated this alleged allegation was reported by CNA F and was reported to both her and the DON. The ADON stated the SW was already conducting the investigation but was not sure if it was reported to the state agency. The ADON stated as per facility abuse policy it should have been reported to the state agency.</p> <p>During an interview on 04/24/25 at 2:57 PM, with the Administrator he stated, he had just received the report of the missing money for Resident #9. The Administrator stated no one had reported to him that money was missing and if he had been notified, he would have immediately followed the facility abuse protocols and procedures. The Administrator stated it was expected for the DON and ADON to have reported it to him immediately. The Administrator stated when they did report it to him on 04/24/25, they had given him the wrong name of the alleged victim. The Administrator stated it should have been reported to the state agency. The Administrator stated the purpose of reporting was for resident rights in which they have the right to be free from abuse, neglect, and exploitation and to protect the resident(s) from abuse. The Administrator stated the risk could be further abuse or exploited and the facility follow the resident rights which it could be harmful to the residents. The Administrator stated he was going to re-in-service the staff on abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>		

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