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	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison 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 - Immediate jeopardy to resident health or safety 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. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs for 1 of 7 residents (Resident #1) reviewed for care plans.The facility failed to implement Resident #1's comprehensive person-centered care plan for repositioning assistance by two staff members. On 11/11/25, CNA A repositioned the resident alone. During the process, the resident rolled off the bed and struck his head on the suctioning machine suffering from a brain bleed, sustaining a 2 cm laceration above the right eyebrow, orbital fracture, and sinus fracture. The noncompliance was identified as PNC. The IJ began on 11/11/25 and ended 11/11/25. The facility had corrected the noncompliance before the investigation began. This failure places the resident at risk of inappropriate repositioning with resulting injury. The findings included:Record review of Resident #1's face sheet dated 11/13/25 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's History and Physical dated 6/3/25 revealed a [AGE] year-old male with a history of long-standing alcohol use disorder, alcoholic encephalopathy (Brain damage and confusion caused by long-term heavy alcohol use), and chronic complications including cirrhosis (Severe scarring of the liver that prevents it from working properly), pancreatitis (Long-term inflammation and damage of the pancreas that affects digestion and causes pain), GI bleed (gastrointestinal bleed, bleeding somewhere in the stomach or intestines), and hypertension (High blood pressure). He was admitted to skilled nursing for medical management, nutrition, and ADL support following a seizure due to alcohol intoxication (A condition where a person has repeated seizures and being severely impaired or poisoned by drinking too much alcohol), acute respiratory failure (a serious condition where the lungs cannot provide enough oxygen to the body), and anoxic brain injury (brain damage caused by lack of oxygen) requiring tracheostomy (A breathing tube placed through the neck into the windpipe) and gastrostomy placement (A feeding tube placed directly into the stomach through the abdomen). Resident #1 was nonverbal and unable to follow commands. He required total care and repositioning every two hours. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 0, indicating his cognition was severely impaired. Under section GG0115 for Functional Limitation in Range of Motion, Resident #1's MDS revealed he was impaired in his upper and lower extremities. Resident #1 was totally dependent on staff for all activities due to vegetative state. Record review of Resident #1's care plan dated 9/24/25 revealed focus area for ADLs stating he had a Self-Care Performance Deficit Limited Mobility, had a diagnosis of anoxic brain injury. It stated that Resident #1 was totally dependent (meaning the helper or staff does all of the effort and the resident does none of the effort to complete the activity and the assistance of two or more helpers is required for the resident to complete the activity) on staff for bathing, bed mobility, requiring two staff for assistance.Record review of Resident #1's progress notes dated 11/11/25 at 7:14 AM by LVN B stated CNA A assisted the resident with ADLs (assistance with daily personal care). The resident was positioned on his left side. CNA A attempted to stabilize the resident by holding his RUE (right upper extremity - right arm) to prevent a fall; however, the resident fell from the bed to the floor, landing face-down on a floor mat. The resident was observed with a laceration (skin cut) to the right eyebrow. The resident was assessed and assisted back to bed by nursing staff and CNA A. The wound was cleansed with NS solution (sterile saline solution) and sterile strips (adhesive wound closure strips) were applied. Hospice was notified and the resident was transferred to the emergency room for further evaluation.Record review of Resident #1's progress notes dated 11/11/25 at 2:02 PM by the DON stated that An in-person conference was held with the resident's family members. Present were the Facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). The purpose of the meeting was to discuss the resident's recent fall that occurred during care, which resulted in an orbital fracture (broken bone around the eye socket) and brain bleed (bleeding in the brain), as confirmed by the attending physician. The Medical Director anticipated the resident's discharge back to the facility with an expected return date of 11/11/25. The family was informed that a self-report to the state had been initiated and that the facility was conducting a thorough internal investigation to identify contributing factors and implement appropriate corrective measures, to include clinical staff in servicing.The resident's care plan was updated to include bed bolsters (supportive cushions placed on the bed) and enhanced safety interventions during care to minimize the risk of future falls. Record review of Resident #1's

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infections for 1 of 2 (Resident #2) residents reviewed for quality of care.The facility failed on 11/17/2025 to ensure the pressure ulcer on Resident #2's right glute was covered with a dressing as ordered.This deficient practice could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds. The findings included: Record review of Resident #2's face sheet dated 11/17/25 revealed a [AGE] year-old male with an admission date of 1/5/25.Record review of Resident #2's History and Physical dated 6/19/25 revealed the resident had a diagnosis of chronic right gluteal pressure ulcer (an injury to the skin and underlying tissue over the buttocks (gluteal area) caused by prolonged pressure, friction, shear, or moisture that reduces blood flow to the area, leading to tissue damage), iron deficiency and anemia. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 2 indicating the resident was severely cognitively impaired. Under section M Skin Conditions, the MDS revealed the resident needed a Pressure Reducing device for bed, requiring pressure ulcer/injury care, application of nonsurgical dressings, Applications of ointments/medications.Record review of Resident #2's care plan dated 09/02/2025 revealed Resident #2 had a pressure ulcer or a potential for pressure ulcer development. The care plan revealed the resident needed to have intact skin, free of redness, blister or discoloration and asked for staff interventions which included administration of medications as needed, administering treatments as ordered and monitoring effectiveness by replacing loose or missing dressings.In an observation on 11/17/25 at 11:46 AM, LVN J and CNA K turned Resident #2. CNA K removed the brief, and a thick white substance was observed on the resident's buttocks and directly on the pressure injury. The wound had no dressing in place. In an interview 11/17/25 at 11:52 AM, CNA J stated she did not report the absence of the wound dressing. She stated staff were trained to immediately report missing dressings. In an interview on 11/17/25 at 11:54 AM, CNA K confirmed she noticed the dressing was missing earlier in the shift and did not notify nursing staff. She stated staff were trained to report missing dressings for any resident with pressure ulcers.In an interview on 11/17/25 at 12:28 PM, the DON stated wounds without dressings increased infection risk and delayed healing. The DON stated it was unacceptable for the resident not to have a dressing on his pressure ulcer as ordered in his care plan. The DON stated checking that dressings were in place as ordered was the responsibility of the wound care nurse. The DON stated that if any LVN or CNA noticed the wound had no dressing, it had to be reported immediately to the wound care nurse.Record review of the facility's policy titled Pressure Injury: Prevention, Assessment and Treatment read in part: Staff will maintain skin integrity, implement turning schedules, maintain hygiene, assess skin routinely and report abnormalities to nursing staff to prevent skin breakdown, promote healing, and prevent infection.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 (Resident #1) of 7 residents reviewed for accidents and supervision. Resident #1 required two-person assistance for peri care and repositioning. On 11/11/25, CNA A repositioned the resident alone. During the process, the resident rolled off the bed and struck his head on the suctioning machine, causing for him to suffer a brain bleed, sustaining a 2 cm laceration above the right eyebrow, orbital fracture, and sinus fracture. The noncompliance was identified as PNC. The IJ began on 11/11/25 and ended 11/11/25. The facility had corrected the noncompliance before the survey began.These failures placed residents at risk of injuries, hospitalization, and death. The findings included:Record review of Resident #1's face sheet dated 11/13/25 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's History and Physical dated 6/3/25 revealed a [AGE] year-old male with a history of long-standing alcohol use disorder, alcoholic encephalopathy (Brain damage and confusion caused by long-term heavy alcohol use), and chronic complications including cirrhosis (Severe scarring of the liver that prevents it from working properly), pancreatitis (Long-term inflammation and damage of the pancreas that affects digestion and causes pain), GI bleed (gastrointestinal bleed, bleeding somewhere in the stomach or intestines), and hypertension (High blood pressure). He was admitted to skilled nursing for medical management, nutrition, and ADL support following a seizure due to alcohol intoxication (A condition where a person has repeated seizures and being severely impaired or poisoned by drinking too much alcohol), acute respiratory failure (a serious condition where the lungs cannot provide enough oxygen to the body), and anoxic brain injury (brain damage caused by lack of oxygen) requiring tracheostomy (A breathing tube placed through the neck into the windpipe) and gastrostomy placement (A feeding tube placed directly into the stomach through the abdomen). Resident #1 was nonverbal and unable to follow commands. He required total care and repositioning every two hours. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 0, indicating his cognition was severely impaired. Under section GG0115 for Functional Limitation in Range of Motion, Resident #1's MDS revealed he was impaired in his upper and lower extremities. Resident #1 was totally dependent on staff for all activities due to vegetative state. Record review of Resident #1's care plan dated 9/24/25 revealed focus area for ADLs stating he had a Self-Care Performance Deficit Limited Mobility, had a diagnosis of anoxic brain injury. It stated that Resident #1 was totally dependent (meaning the helper or staff does all of the effort and the resident does none of the effort to complete the activity and the assistance of two or more helpers is required for the resident to complete the activity) on staff for bathing, bed mobility, requiring two staff for assistance.Record review of Resident #1's progress notes dated 11/11/25 at 7:14 AM by LVN B stated CNA A assisted the resident with ADLs (assistance with daily personal care). The resident was positioned on his left side. CNA A attempted to stabilize the resident by holding his RUE (right upper extremity - right arm) to prevent a fall; however, the resident fell from the bed to the floor, landing face-down on a floor mat. The resident was observed with a laceration (skin cut) to the right eyebrow. The resident was assessed and assisted back to bed by nursing staff and CNA A. The wound was cleansed with NS solution (sterile saline solution) and sterile strips (adhesive wound closure strips) were applied. Hospice was notified and the resident was transferred to the emergency room for further evaluation.Record review of Resident #1's progress notes dated 11/11/25 at 2:02 PM by the DON stated that An in-person conference was held with the resident's family members. Present were the Facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). The purpose of the meeting was to discuss the resident's recent fall that occurred during care, which resulted in an orbital fracture (broken bone around the eye socket) and brain bleed (bleeding in the brain), as confirmed by the attending physician. The Medical Director anticipated the resident's discharge back to the facility with an expected return date of 11/11/25. The family was informed that a self-report to the state had been initiated and that the facility was conducting a thorough internal investigation to identify contributing factors and implement appropriate corrective measures, to include clinical staff in servicing.The resident's care plan was updated to include bed bolsters (supportive cushions placed on the bed) and enhanced safety interventions during care to minimize the risk of future falls. Record review of Resident #1's progress notes dated 11/11/25 at 8:11 PM by LVN P revealed Resident #1 returned to the facility from the hospital via EMS (Emergency Medical Services - ambulance transport)

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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	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #2) of 2 residents reviewed for infection prevention and control. LVN J and CNA K failed on 11/17/25 to use PPE (special equipment that protects the wearer's body from infection) during wound care for Resident #2 as the resident was on EBP.LVN J and CNA K failed on 11/17/25 to wash their hands prior to having contact with the resident. These failures could place residents at risk of infections, cross contamination, secondary infections, tissue breakdown, and communicable diseases. Findings include:Record review of Resident #2's face sheet dated 11/17/25 revealed a [AGE] year-old male with an admission date of 1/5/25.Record review of Resident #2's History and Physical dated 6/19/25 revealed the resident had a diagnosis of chronic right gluteal pressure ulcer (an injury to the skin and underlying tissue over the buttocks (gluteal area) caused by prolonged pressure, friction, shear, or moisture that reduces blood flow to the area, leading to tissue damage), iron deficiency and anemia. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 2 indicating the resident was severely cognitively impaired. Under section M Skin Conditions, the MDS revealed the resident needed a Pressure Reducing device for bed, requiring pressure ulcer/injury care, application of nonsurgical dressings, Applications of ointments/medications.Record review of Resident #2's care plan dated 09/02/2025 revealed Resident #2 had a pressure ulcer or a potential for pressure ulcer development. The care plan revealed the resident needed to have intact skin, free of redness, blister or discoloration and asked for staff interventions which included administration of medications as needed, administering treatments as ordered and monitoring effectiveness by replacing loose or missing dressings.In an observation and interview on 11/17/25 at 11:44 AM, LVN J was observed entering Resident #2's room where an Enhanced Barrier Precautions (EBP) sign was posted. She did not perform hand hygiene and did not put on a gown or gloves before making physical contact with the resident. In an observation on 11/17/25 at 11:46 AM, LVN J and CNA K turned Resident #2. Both failed to wash hands prior to care and did not put on isolation gowns. CNA K removed the brief, and a thick white substance was observed on the resident's buttocks and directly on the pressure injury. During the observation, a second stage II ulcer was identified on the right buttock measuring approximately 2 cm x 0.5 cm with visible granulation tissue (new healthy tissue that forms in a wound as it heals).In an interview on 11/17/25 at 11:52 AM, LVN J, said there is no reason why we did not use a gown when having close contact with the resident according to the EBP precautions posted by the entrance to the resident's room. She said CNA K was assigned to Resident #2 during the morning shift, and she had not reported to her or the nurses that the resident did not have the wound dressing on the left buttock to protect the wound from contamination since the resident was incontinent of bowel and bladder. LVN J said the CNAs had been trained by the DON to immediately report to the licensed staff when the residents did not have the wound dressing according to physician's order to promote healing and prevent cross-contamination of the wounds. In an interview on 11/17/25 at 11:54 AM, CNA K said she was assigned to Resident #2. She said staff had been trained on EBP and were trained to use gloves and gowns when having close contact with the residents that have wounds to prevent cross contamination of their uniforms and prevent the spread of infection. She said, I do not know why I did not use a gown today according to the EBP precautions posted by the entrance to the resident's room.In an interview on 11/17/25 at 12:28 PM, the DON stated the EBP sign should be posted by the entrance to the resident rooms for those residents that have wounds . She said the staff should use a gown and gloves when having direct contact with the residents to prevent cross contamination and spread of infection. The DON stated she was unsure when staff were last trained on EBP.In an interview on 11/17/25 at 1:35 PM, the Doctor stated if the facility had posted an EBP sign by a resident's door, the staff had to follow the facility's recommendations and that the probable negative outcome would be spreading of infection and cross contamination to other residents in the facility if staff were not wearing their PPE. In an interview on 11/17/25 at 2:13 PM, the Administrator stated if there was a sign posted by the door of a resident stating that there were enhanced barrier precautions, the expectation was for the staff to follow that procedure and for them to wear those barriers. The Administrator said by staff not following these protocols there was a risk of spreading infection to other residents in the facility when staff went into different rooms. The Administrator