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	07/02/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to conduct assessments that accurately reflected the resident's status for 1 of 4 residents (Residents #2) reviewed for resident assessments.The facility failed to ensure Resident #2's Annual MDS Assessment accurately reflected resident's behaviors exhibited ongoing basis when daily care was provided.The failure could place residents at risk of not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well-being.The findings included:Review of Resident #2's admission Record, dated 7/01/26, revealed she was an [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE].Review of Resident #2's History & Physical dated 12/22/25, revealed Major Depression (is a serious mood disorder causing persistent sadness, hopelessness and loss of interest in activities, significantly affecting daily life, sleep, appetite and concentration), Anxiety Disorder (mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), and Diabetes Mellitus with Neuropathy (is nerve damage caused by prolonged high blood sugar).Review of Resident #2's Annual MDS dated [DATE] revealed, unclear speech, usually understood, usually understands others; BIMs Score 03 (cognition severely impaired). No Behavioral symptoms. Overall Presence of Behavioral Symptoms reflected none. Active Diagnoses: Non-Alzheimer's Dementia Non-Alzheimer's Dementia (losing the thinking, memory, and social skills enough to mess up daily life), Anxiety Disorder(mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations) , Adjustment Disorder with Anxiety (a stress related mental health condition) and Depression (a serious mood disorder causing persistent sadness, loss of interest, and lack of motivation, affecting how the person feels, think, and act, differing from normal sadness by lasting long periods and interfering with daily life).Review of the CNA Documentation Record dated June 2026, only document 16 episodes of behaviors on 6/08/26, 06/10/276, 06/11/26, 06/12, and 06/29/26 on the evening shift but did not specify the behaviors exhibited by Resident #2 when daily care was provided. Review of the Nurses Medication Administration Record dated June 2026 did not have any documentation of the resident's behaviors reported by the CNAs when daily personal care was provided. Review of Resident #2's Care Plan reviewed on 6/23/26 revealed:-The care plan did not address Resident #2 2 resisted care, and screamed when touched to provide care, pushed and hit staff when attempts to change briefs and to turn and reposition in bed were, attempted to bite while being transferred from the bed to the wheelchair, cursed at and insulted the staff, called them whores and told them they were stupid when they attempted to provide daily care.-Adverse medication effect and behavior monitoring. Interventions: Continually monitor for behaviors and medication adverse and notify the MD, LVN or NP as required. In addition, note any behaviors and adverse effects on the weekly summary. Each shift, monitor for and report any potential side effects or behaviors in the kiosk. If noted, also verbally report to a licensed nurse. Monitoring an accurate documentation of the resident's response to any treatments (such as lab results, vital signs, progress notes, behavior flow sheets, medication administration records and the consultant pharmacist's drug regime review) is essential to evaluate the ongoing effectiveness benefits, as well as risk. For nonpharmacological approaches and (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications.During a telephone interview on 7/02/26 at 4:25 p.m. with Resident #2's family member revealed CNA K had asked the family members on 06/21/26 to come in the resident's room so they could see how Resident #2 screamed when touched to provide care, cursed, hit, resisted care, scratched and attempted to bite the staff when care was provided or being transferred from the bed to the wheelchair. The family member reported that the resident would call the staff whores and told them that they were stupid. One of the family members said she was the resident's care giver for Resident #2 while she was living at home and she exhibited the same behaviors at home when she attempted to assist her with her personal care and would throw them out of her house.During a telephone interview on 7/02/26 at 4:38 p.m. with CNA K revealed Resident #2 was oriented to person, recognized familiar faces, required total assistance of one person with ADLs. She said Resident #2 resisted care, and screamed when touched to provide care, pushed and hit staff when attempts to change briefs and to turn and reposition in bed were, attempted to bite while being transferred from the bed to the wheelchair, cursed at and insulted the staff, called them whores and told them they were stupid when they attempted to provide daily care. She said the resident's body was very stiff and the resident did not make any efforts to assist with personal care. She said the resident would yell loudly when they touched her to turn & reposition, change soiled briefs, during transfers, and when personal care was provided. During an interview and record review on 07/02/26 at 5:07 p.m. with RN MDS Nurse M revealed that she was not aware that Resident #2 had behaviors. She said she gathered information to complete the MDS assessment from IDT progress notes, and history and physical. She said that she did not interview the nursing staff when she completed MDS Assessment. She said that she did not review the CNAs documentation Care Reports or the Nurses Medication Administration Records for behaviors.During an interview on 7/02/26 at 5:21 p.m. the facility's Regional Compliance Nurse R said that the facility did not have a policy and procedure on Completing MDS assessment and they followed the Resident Assessment Instrument 3.0 Manual to complete MDS assessments. The Compliance Nurse said the nurses and CNAs were not documenting in Resident #2's clinical record that resident exhibited behaviors anytime that direct care was provided. She said the nursing staff had been trained to document the behaviors in the IDT Notes, Medication Administration Records and CNA Documentation Sheets. She said the MDS should conduct interviews with the nursing staff and other disciplines as needed when completing MDS assessments.During an interview on 7/02/26 at 7:13 p.m. with CNA O said he started working on 02/26/26 on the 2 PM to 10 PM shift and that the CNAs rotate assigned sections daily and was frequently assigned to care for Resident #2. He said Resident #2 was only oriented to person, was able to verbalize needs, required total assistance of one person with ADLs. He said Resident #2 would become anxious when daily care was provided and would bite, hit, cuss, and scream. He said the resident's body was very stiff and her back was not straight. He said the nurses were aware that Resident #2 exhibited these behaviors when daily care was provided.During an interview on 7/02/26 at 7:15 p.m. with LVN Charge Nurse P said on the 2 PM to 10 PM shift revealed Resident #2 was confused, required total assistance of one person with ADLS, incontinent of bowel & bladder, had on-going behaviors and would cuss, bite, hit, and resisted care. She said the resident did not like for the staff to touch her and screamed when moved to provide the needed personal care. She said that the CNAs reported to her that Resident #2 would become anxious when daily care was provided and would bite, hit, cuss, and scream. She said that she could not remember if she had documented the behaviors in the resident's clinical record. She said that they had been trained to document the behaviors in the Medication Administration Records on every shift.

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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** Based on interviews and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #1) reviewed for care plans. The facility failed to ensure behaviors were addressed in Resident #2's Care Plan. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included:Review of Resident #2's admission Record, dated 7/01/26, revealed she was an [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE].Review of Resident #2's History & Physical dated 12/22/25, revealed Major Depression (is a serious mood disorder causing persistent sadness, hopelessness and loss of interest in activities, significantly affecting daily life, sleep, appetite and concentration), Anxiety Disorder (mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), and Diabetes Mellitus with Neuropathy (nerve damaged caused by prolonged high blood sugar and high blood fats).Review of Resident #2's Annual MDS dated [DATE] revealed, unclear speech, usually understood, usually understands others; BIMs Score 03 (cognition severely impaired). No Behavioral symptoms. Overall Presence of Behavioral Symptoms none. Active Diagnoses: Non-Alzheimer's Dementia, Anxiety Disorder, Adjustment Disorder with Anxiety and Depression.Review of Resident #2's Care Plan reviewed on 6/23/26 revealed:-The care plan did not address Resident #2 2 resisted care, and screamed when touched to provide care, pushed and hit staff when attempts to change briefs and to turn and reposition in bed were, attempted to bite while being transferred from the bed to the wheelchair, cursed at and insulted the staff, called them whores and told them they were stupid when they attempted to provide daily care.-Adverse medication effect and behavior monitoring. Interventions: Continually monitor for behaviors and medication adverse and notify the MD, LVN or NP as required. In addition, note any behaviors and adverse effects on the weekly summary. Each shift, monitor for and report any potential side effects or behaviors in the kiosk. If noted, also verbally report to a licensed nurse. Monitoring an accurate documentation of the resident's response to any treatments (such as lab results, vital signs, progress notes, behavior flow sheets, medication administration records and the consultant pharmacist's drug regime review) is essential to evaluate the ongoing effectiveness benefits, as well as risk. For nonpharmacological approaches and medications.During a telephone interview on 7/02/26 at 4:25 p.m. with Resident #2's family member revealed CNA K had asked the family members on 06/21/26 to come in the resident's room so they could see how Resident #2 screamed when touched to provide care, cursed, hit, resisted care, scratched and attempted to bite the staff when care was provided or being transferred from the bed to the wheelchair. The family member reported that the resident would call the staff whores and told them that they were stupid. One of the family members said she was the resident's care giver for Resident #2 while she was living at home and she exhibited the same behaviors at home when she attempted to assist her with her personal care and would throw them out of her house.During a telephone interview on 7/02/26 at 4:38 p.m. with CNA K revealed Resident #2 was oriented to person, recognized familiar faces, required total assistance of one person with ADLs. She said Resident #2 resisted care, and screamed when touched to provide care, pushed and hit staff when attempts to change briefs and to turn and reposition in bed were, attempted to bite while being transferred from the bed to the wheelchair, cursed at and insulted the staff, called them whores and told them they were stupid when they attempted to provide daily care. She said the resident's body was very stiff and the resident did not make any efforts to assist with personal care. She said the resident would yell loudly when they touched her to turn & reposition, change soiled briefs, during transfers, and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when personal care was provided. During an interview and record review on 07/02/26 at 5:07 p.m. with RN MDS Nurse M revealed that she was not aware that Resident #2 had behaviors. She said she gathered information to complete the MDS assessment from IDT progress notes, and history and physical. She said that she did not interview the nursing staff when she completed MDS Assessment. She said that she did not review the CNAs documentation Care Reports or the Nurses Medication Administration Records for behaviors.During an interview on 7/02/26 at 5:21 p.m. the facility's Regional Compliance Nurse R said that the facility did not have a policy and procedure on Completing MDS assessment and they followed the Resident Assessment Instrument 3.0 Manual to complete MDS assessments. The Compliance Nurse said the nurses and CNAs were not documenting in Resident #2's clinical record that resident exhibited behaviors anytime that direct care was provided. She said the nursing staff had been trained to document the behaviors in the IDT Notes, Medication Administration Records and CNA Documentation Sheets. She said the MDS should conduct interviews with the nursing staff and other disciplines as needed when completing MDS assessments.During an interview on 7/02/26 at 7:13 p.m. with CNA O said he started working on 02/26/26 on the 2 PM to 10 PM shift and that the CNAs rotate assigned sections daily and was frequently assigned to care for Resident #2. He said Resident #2 was only oriented to person, was able to verbalize needs, required total assistance of one person with ADLs. He said Resident #2 would become anxious when daily care was provided and would bite, hit, cuss, and scream. He said the resident's body was very stiff and her back was not straight. He said the nurses were aware that Resident #2 exhibited these behaviors when daily care was provided.During an interview on 7/02/26 at 7:15 p.m. with LVN Charge Nurse P said on the 2 PM to 10 PM shift revealed Resident #2 was confused, required total assistance of one person with ADLS, incontinent of bowel & bladder, had on-going behaviors and would cuss, bite, hit, and resisted care. She said the resident did not like for the staff to touch her and screamed when moved to provide the needed personal care. She said that the CNAs reported to her that Resident #2 would become anxious when daily care was provided and would bite, hit, cuss, and scream. She said that she could not remember if she had documented the behaviors in the resident's clinical record. She said that they had been trained to document the behaviors in the Medication Administration Records on every shift.Review of facility's undated policy and procedure on Comprehensive Care Planning 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 time frames to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being. Each resident will have a person-centered, comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set to assess the resident's, clinical condition, cognitive and the functional status and use of services.

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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** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #4) reviewed for quality of care in that:The facility failed to ensure CNA I and CNA J correctly applied the gait belt to transfer Resident #4 from the wheelchair to the bed.The failure could put residents at risk of accidents and serious injuries which could result in a reduced quality of life.Findings included:Review of Resident #4's admission Record, dated 7/02/26, revealed she was an [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE].Review of Resident #4's History & Physical dated 3/16/26, revealed Debility and immobility. Mobility device wheelchair. Substantial/maximal assistance with Sit to lying, sit to stand, chair/bed-to-chair transfer; Non-Alzheimer's Dementia, CVA (a stroke, causing blood flow to part of the brain gets cut off, starving brain cells of oxygen and causing them to die), unsteadiness on feet, lack of coordination.Review of Resident #4's Quarterly MDS dated [DATE] revealed a BIMs Score of 03 (cognition severely impaired).Review of Resident #4's Care Plan reviewed on 4/20/26 revealed: Resident #4 has ADL Self-Care Deficit. Interventions: transfer requires assistance x 1 person.Review of the facility's In-Service Training Record dated 03/29/24 presented by the ADONs provided by the ADON B on 07/02/26 revealed: Topic: Transfer-Kardex must be followed for transfer. No training information was attached to the Training Record. During an observation and interview on 07/02/26 at 3:36 p.m. with CNA I and CNA J accompanied by LVN ADON B revealed Resident #4 was sitting in a wheelchair by the right side of the bed waiting to be transferred from the wheelchair to the bed. The CNAs said that they used a gait belt to transfer residents that did not need a mechanical device to transfer. CNA I, handed the gait belt to the CNA J who was standing directly in front of the resident. CNA J asked CNA I to show her how to buckle the gait belt prior to placing the gait belt on the resident. It was observed that the CNAs asked the resident to sit forward to place the gait belt. It was observed that CNA J who was standing directly in front of the resident placed the gait belt around the resident's upper back directly over the resident's breasts and the CNAs were getting ready to move the resident. The state surveyor stopped the CNAs from moving the resident and asked the CNAs how they had been trained to place the gait belt to transfer the resident. The CNAs said they had been trained to place the gait belt just above the hips. The CNAs loosened the gait belt and placed the gait belt just above Resident #4's hips and they demonstrated that the gait belt was tight enough to provide support but loose enough to fit two fingers between the belt and the resident's body. The CNAs locked the wheelchair brakes, asked the resident to sit upright with feet flat on the floor and assisted the resident to a standing position by firmly placing their hands under the gait belt. The CNAs guided the resident in a controlled pivot towards the edge of the bed, maintaining a firm grip on the gait belt until they sat the resident at the edge of the bed. One CNA placed her arm under the resident's head and the other arm under the resident's knees and slightly turned the resident to the side, lifted her legs and the other CNA assisted in positioning the resident to the middle of the bed. The CNAs said it was important to place the gait belt around the waist to prevent injury to the resident when moving the resident from the wheelchair to the bed. The CNAs said they could not remember the last time that they were trained on use of the gait belt.During an observation and interview on 07/02/26 at 3:50 p.m. with PTA S in the presence of RN Regional Compliance Nurse R demonstrated how they had trained the CNAs to do a transfer using a gait belt. He said the resident was seated upright in the wheelchair with feet flat and arms at their sides. It was observed that the gait [NAME] was placed around the staff member's waist over the clothing just above the hip bones. The buckle in front was secured. The gait belt was pulled snug enough to allow two fingers to fit between the belt and the staff member. The PTA placed the wheelchair close to the side of the bed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and locked the wheelchair brakes. He grasped the side of the gait belt withs his hands and assisted the staff member to a standing position and turned the staff member and sat the staff member at the edge of the bed. He placed a hand on the shoulder blade and with the other hand raised the legs and gently put the staff member in bed. The gait belt was removed. The RN Regional Compliance Nurse R said that the facility did not have a policy and procedure on the use of a gait belt. She said that she did not remember when the last time was the staff were trained on the use of the gait belts.Review of the facility's policy and procedure dated 2003 on Moving a Resident, Bed to chair/Chair to Bed revealed: This procedure may involve potential and/or direct exposure to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals. Purpose: The purpose of this procedure are to allow the resident to be out of his bed. Or her men as much as possible and to provide for safe transferring of the resident. Steps in the Procedure: this procedure may require 2 persons. Nor the height of the bed to the lowest position. If moving a resident from chair to bed. Place the chair stored. It touches the side of the bed and faces the foot of the bed. Have the chair on the resident strongest side. If transferring the resident from a wheelchair: Be sure the wheels are locked. Fold the footrest and or the leg rest out of the way. And place the residence feet Firmly on the floor. Turn the bed covers down. Instruct the resident to place both hands on the arms of the chair and waist and clasp it. Make sure it is 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. If the resident requires 2 persons. One on each side should grasp the gait belt and gently stand and turn the resident and sit him or her on the edge of the bed. Move the resident. Instruct their resident to raise his or her legs on the bed. Assist as necessary. Assist the resident to undress as necessary and remove the gate belt.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review the facility failed to ensure that it employed a qualified social worker on a full-time basis for one of one social worker positions reviewed for social services, in that: The facility, which was licensed for 187 beds, failed to employ a qualified social worker on a full-time basis since 05/30/2026.This failure put facility residents at risk of not having their psychosocial or discharge planning needs met. Findings included:Review of the Facility's Summary Report revealed the facility was licensed for 187 beds.During an interview and record review on 07/02/26 at 5:25 p.m. with the Administrator, revealed employee list provided to the surveyor on 07/01/26 by the Administrator revealed Social Worker R was listed as Social Worker unlicensed. He said he hired Social Worker R on 04/03/26, who was unlicensed, to assist the previously licensed Social Worker that had resigned on 05/30/26. He said he was in the process of interviewing potential applicants to hire a licensed Social Worker as soon as possible.Record review of the facility's undated policy Social Services revealed, the following is a non-exhaustive criterion that related to the job of a Social Worker, and it is consistent with the business needs of the facility. Knowledge Base: A bachelor's degree in social work or secondary education in social services and certification as a social worker may be substituted as appropriate. Social Worker Responsibilities: Purpose: To outline the role of the social worker in discharge planning to ensure safe transitions of care, regulatory compliance, and adequate coordination with residents, families, and the interdisciplinary team. Scope: This procedure applies to social workers managing the psychosocial and coordination aspects of resident discharges. Other duties as assigned.