STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health Services	5865 South Wasatch Drive Ogden, UT 84403

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 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility. Specifically, for 1 out of 3 sampled residents, a resident was not readmitted after being transferred to the hospital. Resident identifier: 1.Findings included:Resident 1 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, hypertensive heart and chronic kidney disease without heart failure, with state 5 chronic kidney disease, or end state renal disease, major depressive disorder, and anxiety disorder.Resident 1's medical record was reviewed.On 4/11/25 at 5:18 PM, a General Note documented . Resident was transported by a transport service around 1500 [3:00 PM], family was not present. Resident seems to know where she is at but not why she is alert and oriented x3 [person, place, and time]. Resident needs assistance with ADLs [activities of daily living] and transfers due to the risk for falls. Physician was notified and meds [medications] were brought in by hospice nurse.On 4/11/25 at 11:39 PM, a General Note documented a late entry Resident seen at the nurse's station very agitated and upset because she wants to go home. She purposely tipped over a chair at the nurse station out of anger. This nurse Tried to redirect and educate resident about safety of not doing that. Resident was taking [sic] to her room to get ready for bed. This nurse stepped out to get the CNA [Certified Nursing Assistant] to help with resident ADLs. While she was in there less than 5 minutes a loud repetitive banging was heard. Resident managed to get her W/C [wheelchair] foot Peddle's [sic] off and was hitting her side table with it. This nurse called Admin [Administrator] [name redacted] to report resident's behavior. While on the phone a CNA [name redacted] was able to retrieve the food peddle [sic] from the resident. She let go and he took it out of the room. [Name redacted] DON [Director of Nursing] was called and notified. This nurse was instructed to call the residents Hospice nurse. Hospice was called and [name redacted] and [name redated] was notified. Hospice nurse called the Dr [doctor] to get order for medication IM [intramuscular]. Several times DON and Hospice nurse was called and spoke with. Hospice nurse said she got order for Haldol IM but wasn't sure if it would be here before tomorrow. Resident settled down a bit but then said to this nurse and Both CNA at the nurse station 'Do you want to watch the picture show?' Not understanding what she meant, the resident threw the tissue box and then started to take things off the medication cart. At one point was touching the sharps container. Resident was pulled away from the med [medication] cart and CNA put med cart behind the dining room double doors. This nurse was on the phone with [name redacted] DON and instructed to call 911 to have the Resident sent to the emergency room to be evaluated and treated. [Name redacted] was going to call the Hospice nurse and inform her that we are sending resident out. This nurse called resident's SON [name redacted] tonotify [sic] him of resident's behavior that resident was being sent to [name of hospital redacted] for evaluation and treatment. Resident was picked up by EMS [Emergency Medical Services] and Report given.The April 2025 Medication Administration Record (MAR) was reviewed. On 4/11/25, resident 1 received an evening dose of lorazepam 0.5 milligrams (mg) and methadone 2.5 mg.On 4/11/25 at 12:45 PM, a physician's order documented Haloperidol Lactate Oral Concentrate 2 MG/ML [milliliter] (Haloperidol Lactate) Give 0.5 ml by mouth every 1 hours as needed for psychosis. It should be noted that there were no doses administered to resident 1 according to the MAR.On 4/11/25 at 1:00 PM, a physician's order documented LORazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 2 hours as needed for anxiety. It should be noted that there were no doses administered to resident 1 according to the MAR.The facility Transfer/Discharge Report documented that resident 1 was transferred to an acute care hospital on 4/12/25 at 1:00 AM.On 4/12/25 at 6:33 AM, a Police Department (PD) Incident Report documented Narrative [name of PD redacted] was called by [city name redacted] Fire who was having an issue with returning a medical patient from [name of hospital redacted] to [name of Long Term Care (LTC) facility redacted] after treatment. On arrival the doors were locked, [city name redacted] Fire had their patient in their ambulance for over an hour while they tried to find a resolution. We made several attempts by knocking or calling into the facility and staff refused to communicate. I was able to speak to the Director of Nursing for the facility and explain our concerns. She contacted the Director of the Facility as well as the Hospice Nurse for the patient who all responded to the situation. As a result I and the [city name redacted] Fire Department determined the best place for the patient is not at the facility at this time. She was transported back to [name of hospital redacted] By [name of city redacted] Fire and her Hospice Nurse notified so they can make other arrangements. This