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	01/08/2026

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

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 13 of 24 sampled residents, 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. Specifically, the facility failed to sanitize the blood glucose meters according to manufacturer requirements. This was determined to have resulted at an immediate jeopardy level. In addition, the facility had not updated their COVID-19 policy and procedures according to the latest guideline. Resident identifier: 1, 3, 6, 10, 11, 13, 14, 16, 22, 24, 35, 36 and 43. NOTICE On 1/7/26 at 2:30 PM, an Immediate Jeopardy was identified and notice was given verbally and in writing to the Administrator (ADM) and the Director of Nursing (DON) regarding the facility not sanitizing the blood glucose meters according to manufacturer requirements to prevent the transmission of bloodborne pathogens. On 1/8/26, the ADM provided a written abatement plan for the removal of the Immediate Jeopardy effective on 1/8/26 at 2:00 PM. The following is a summary of the plan: Correction of deficient practice: current glucometers that were in use were discarded immediately and replaced with new, sanitized devices. Systemic changes including the following: infection control policy and procedures, specifically Blood Sampling (Finger Sticks) Policy updated to include manufacturer recommendations for cleaning and disinfecting procedures. All nursing staff will be trained by the Director of Nursing on the updated policy for disinfecting the glucometer after each use to ensure Infection Prevention standards are being met. Nurses not available to sign the in-service book will have the new policy and procedure sent to them via text message and will respond that they understand the new process and will physically sign the in-service book for their next shift in the building. Staff training and education: all licensed nursing staff will receive immediate re-education on: infection control principles; blood and glucose monitoring procedures; and proper cleaning and disinfecting of glucometers. Staff competency evaluations were completed and documented. Audits to ensure compliance: Infection Preventionist or designee will conduct: weekly random audits for 5 weeks; monthly random audits thereafter; all results of audits will be reported to the Administrator and Quality Assurance and Performance Improvement (QAPI) team. (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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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Audits will include: observation of glucose testing and a review of cleaning and sanitizing practices. The Medical Director has been notified of the potential risk of exposure to other residents. The facility will continue to monitor for signs and symptoms of any new illness. The facility will follow recommendations from the Medical Director. The facility alleged abatement of the Immediate Jeopardy as of 1/8/26 at 2:00 PM. On 1/8/26, while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 1/8/26 at 2:00 PM. Findings included: IMMEDIATE JEOPARDY On 1/7/26 at 8:45 AM, an interview was conducted with LPN (Licensed Practical Nurse) 1. LPN 1 stated that each medication cart contained one [NAME] Quintet AC Glucose Meter, which was used for all blood glucose checks. LPN 1 reported disinfecting the blood glucose meter with alcohol prep pads before and after each use. An observation was made of the alcohol prep pad, which contained 70% isopropyl alcohol. No CaviWipes were observed on the south medication cart. On 1/7/26 at 1:13 PM, an interview was conducted with LPN 2. LPN 2 stated that each medication cart had one [NAME] Quintet AC Glucose Meter, which was used for all blood glucose checks. LPN 2 stated they disinfected the blood glucose meter with alcohol prep pads following each use. No CaviWipes were observed on the north medication cart. According to the [NAME] Quintet AC Glucose Meter Owner's Manual, Indirect transmission of Human Immunodeficiency (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) during the delivery of healthcare services has been increasingly reported. Persons using blood glucose monitoring systems have been identified as one risk group due to sharing.blood glucose meters. The manual further instructed The meter MUST be cleaned and disinfected after use on each patient. The following disinfecting wipe can be used to clean and disinfect the meter. CAVIWIPES DISINFECTING TOWELETTES (EPA# 46781-8) . It should be noted that according to the manufacturer's Safety Data Sheet, CaviWipes contained 17.20% of Isopropanol, 1 – 5% of 2-Butoxyethanol, and 0.28% of Benzethonium Chloride. The manual also stated the cleaning procedure is to remove dust, blood and body fluid from the surface and should be performed whenever the meter is visibly dirty. The disinfecting procedure is necessary to kill pathogens such as HIV, HBV and HCV on the device. The manual revealed the following cleaning and disinfecting procedures: Wipe the entire surface of the meter with CaviWipe thoroughly to clean any possible dirt dust, blood, and other body fluids, take another CaviWipe and wipe the meter thoroughly again, allow the surface to remain wet for 2 minutes, and allow to air dry. On 1/7/26 at 1:14 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a glucometer in each medication cart that was shared between residents. The DON stated the nurses used alcohol wipes to sanitize the glucometers after each use. The DON stated (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the facility did not have CaviWipes available because they had been flushed down the toilet and caused plumbing issues. The DON stated she used CaviWipes at the hospital and she liked them because of their drying time. The DON stated she was not aware of the manufacturer requirements to use CaviWipes to sanitize the glucometer. All diabetic residents' medical records were reviewed to determine who was receiving scheduled blood glucose checks and their diagnoses. There were 13 residents in the facility with orders for blood glucose checks. 1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included chronic HCV. It should be noted that HCV is a bloodborne pathogen. Resident 3's medical record was reviewed on 1/7/26. Resident 3 had physician's orders dated 3/26/23 for blood sugar checks twice daily. 2. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic viral Hepatitis C, type 2 diabetes mellitus, paranoid schizophrenia, and major depressive disorder. Resident 1's medical record was reviewed on 1/7/26. A physician's order dated 3/13/22 revealed blood sugar check every week on Wednesdays related to type 2 diabetes mellitus without complications. 3. Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus, takotsubo syndrome and schizoaffective disorder. Resident 14's medical record was reviewed on 1/7/26. A physician's order dated 2/9/2020 revealed to check blood glucose every evening related to type 2 diabetes mellitus. 4. Resident 10 was admitted to the facility on [DATE] with diagnoses which included Huntington's disease, type 2 diabetes mellitus and bipolar disorder. Resident 10's medical record was reviewed on 1/7/26. A physician's order dated 5/29/21 revealed to check blood sugars every week and notify the physician if less than 60 or over 400. The blood sugar was to be done every Friday. 5. Resident 11 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with hyperglycemia, Alzheimer's disease and muscle weakness. Resident 11's medical record was reviewed on 1/7/26. A physician's order dated 7/14/25 revealed to check blood sugars every morning related to type 2 diabetes with hyperglycemia. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician's order dated 8/19/22 revealed to check blood sugar before meals and at bed time. 13. Resident 36 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus and cerebral aneurysm. Resident 36's medical record was reviewed on 1/7/26. A physician's order dated 8/3/25 revealed blood sugar checks twice daily for blood sugar checks. POTENTIAL FOR HARM On 1/5/26, the infection control policy and procedure was requested during entrance. The following was provided with a revision date of August 2014: Coronavirus 2019, Prevention and Control Policy Statement This facility follows current guidelines and recommendations for the prevention and control of Coronavirus 2019 (COVID-19). Prevention: There are currently no vaccines to prevent COVID-19. On 1/8/26 at 1:30 PM, an interview was conducted with the DON. The DON stated there must be a more updated infection control policy and procedure because it had to have been updated after 2014. The DON stated this was not updated because there was a vaccine available. On 1/8/26 at 1:40 PM, an interview was conducted with the Administrator and the Business Office Manager (BOM) who stated there was a more updated policy and they were not sure where that one was. The DON was interviewed as well and stated that was the policy and procedure in the infection control binder.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, it was determined for 2 of 24 sampled residents, the facility did not develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, residents' care plans did not include hospice services, did not address inappropriate sexual behaviors in a timely manner, and were not updated with new interventions after falls. Resident identifiers: 6 and 25. Findings included: 1. Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, obsessive-compulsive disorder, dementia, and abnormalities of gait and mobility. Resident 25's medical record was reviewed on 1/5/26 through 1/8/26. Resident 25's care plan did not include hospice services:On 12/18/25, Resident 25 was admitted to hospice. No reference to hospice services could be located in resident 25's care plan. Resident 25's care plan was not updated in a timely manner after resident 25 displayed sexually inappropriate behaviors: A review of resident 25's progress notes revealed: On 11/25/25 at 5:48 PM, an encounter note documented The afternoon of 11/25/2025 the patient was unfortunately found in another patient's room trying to remove her pants. On 12/9/25 at 2:36 PM, a general note documented CNA states resident came out of his room and in the hallway attempted to pull down a female resident's pants. On 12/9/25, a care plan was initiated with the focus area: Inappropriate sexual behavior, including several associated interventions. [It should be noted that the care plan was not updated following the initial documented incident on 11/25/25, when Resident 25 was sexually inappropriate with another resident.] Resident 25's care plan was not updated after multiple falls: A review of the facility's incident reports revealed that resident 25 had fallen on 5/13/25, 7/3/25, 8/13/25, 9/9/25, and 10/26/25. On 6/3/25, a care plan was initiated with the focus area: Resident has had an actual fall/at risk for falls, including several associated interventions. [It should be noted that the care plan was updated 21 days after the fall on 5/13/25 and no interventions were initiated in a timely manner after the four subsequent falls.] On 1/8/26 at 1:34 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility had struggled to maintain updated resident care plans and that they were attempting to implement changes to improve the timeliness of updates. The DON stated that, in an effort to keep resident care plans updated, the Interdisciplinary Team (IDT) had recently begun to meet weekly to review resident care plans on a quarterly and as needed basis. The DON stated that ultimately she was responsible for ensuring that care plans were up to date. The DON stated that resident 25's quarterly care plan review was completed in December 2025. The DON stated that resident 25's care plan should have included hospice services, and that the missing information should have been noticed in the quarterly review. The DON stated that when a resident had a fall the care plan was reviewed to see interventions needed to be updated. The DON stated that she did not update Resident 25's care plan after the first sexually inappropriate incident, believing the behavior stemmed from a urinary tract infection and high ammonia levels, but she did update it after the second incident. 2. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 1 diabetes mellitus, dementia, mood disorder and psychotic disturbance. On 1/7/26 at 9:37 AM, an interview was conducted with resident 6. Resident 6 stated she had fallen 3 or 4 times and had not gotten hurt. Resident 6 stated someone did some exercises with her to help her get stronger after she had a fall. Resident 6 was not able to make full sentences during the interview. On 1/7/26 at 9:13 AM, an observation was made of resident 6. Resident 6 was observed in bed with her bed not in the lowest position to the ground. Resident 6's wheelchair was not next to her bed and was out of her reach. Resident 6's medical record was reviewed 1/5/26 through 1/8/26. Resident 6 fell on 4/1/25, 4/3/25, 4/21/25 and 6/17/25. There were no new (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions on the care plan. A care plan dated 8/5/25 revealed interventions to assess current abilities and risk factors for potential falls, assess residents as needed to prevent falls, follow facility protocol for post fall interventions, keep bed in low position for safety and keep the environment clear of obstructions. A care plan intervention dated 9/4/25 revealed to wear non-skid socks or shoes while ambulating/after a shower. Resident 6 fell on 9/16/25, 9/24/25, 11/6/25, 12/16/25 and 12/29/25 and there were no new interventions developed on the care plan. On 1/7/26 at 9:47 AM, an interview was conducted with the DON. The DON stated after a resident sustained a fall, the nurse assessed the resident by completing vital signs and neurological checks if the fall was unwitnessed. The DON stated there was a checklist that nurses used which helped determine the root cause, what happened, and how the fall could have been prevented. The DON stated the checklist was started about a month ago so she did not have one for resident 6. The DON stated there were no interventions developed after resident 6 fell on 9/16/25 because the resident did not make contact with the floor. The DON stated no new interventions were developed after the fall on 9/24/25. The DON stated after resident 6 fell on [DATE], the intervention was to provide therapy services and switch to using a wheelchair. The DON stated the intervention after resident 6's fall on 11/6/25 was to remind her to use her wheelchair. The DON stated she was not aware of new interventions after resident 6 fell on [DATE] but thought staff reminded her to use her call light. The DON stated after resident 6 fell on [DATE], the intervention was to have the bed lowered to the floor because it was too high. The DON stated she was not aware there was an intervention for a low bed dated 8/5/25. The DON stated staff were not following the care plan if that was an intervention before. The DON stated the intervention was to keep resident 6's bed in the lowest position, meant to have the bed in the lowest position closest to the floor. The DON stated interventions were initiated on 8/5/25 because she had performed a chart audit and put the interventions in that day.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, it was determined that the facility did not ensure that any individual working in the facility as a nurse aide for more than 4 months on a full time basis had completed a training and competency evaluation program approved by the State. Specifically, three nurse aides were found to have worked at the facility for more than 4 months without completing a training and competency evaluation program approved by the state. Staff identifiers: 1, 2 and 3.Findings Include: On 1/8/26, five employee files were reviewed. The files of staff members 1, 2, and 3 indicated that those three staff members had been working at the facility for more than 4 months without completing a state-approved nurse aide training and competency evaluation program. On 1/8/26, an interview was conducted with the Administrator. The Administrator stated that nurse aides working at the facility have 120 days to become certified nursing assistants. The administrator stated that new hires at the facility must prove that they were enrolled in a training program. To verify this, the Administrator stated he had new hires provide documentation or a receipt from their school stating that they were attending a training program. The administrator stated that Staff Member 1, Staff Member 2, and Staff Member 3, who had been working at the facility four longer than 4 months, must have dropped out of the programs that they had been enrolled in.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review the facility failed to follow their written policies and procedures for feedback, data collection systems, monitoring to develop and implement appropriate plans of action to correct identified deficiencies. Specifically, there were repeat deficiencies and infection control was not identified during the Quality Assurance and Performance improvement (QAPI). Resident identifier: 3. Findings included: On 1/7/26, it was identified that the facility was not sanitizing their blood glucose meters according to manufacturer requirements. This finding was identified at an Immediate Jeopardy level because a resident had a known blood borne pathogen. Deficiencies cited on the previous survey on 8/14/24 and recited during the current survey included F656, F689, F770 and F880. On 1/8/26 at 2:54 PM, an interview was conducted with the Administrator. The Administrator stated the facility had quarterly QAPI meetings with the physician, Director of Nursing (DON), Administrator, Business Office Manager, Dietary Manager and Activities Director. The Administrator stated the last QAPI was 12/30/25. The Administrator stated the DON provided infection control mapping of infections and the root cause was determined. The Administrator stated sanitizing of the blood glucose meters was not identified in the QAPI meeting. The Administrator stated incidents like falls were reviewed and residents who had frequent falls were reviewed. The Administrator stated resident 6 was not identified as having falls. The Administrator stated laboratory results in medical records were not identified as an issue. The QAPI plan provided by the facility was titled QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home The plan was not specific to the facility. In addition, the facility provided an outline for the QAPI meetings. This information did not provide policy and procedures on how to implement QAPI at the facility.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 5 of 5 sampled residents and 5 out of 5 sampled staff members, the facility did not develop and implement policies and procedures to ensure each resident and staff member were offered the COVID-19 vaccine unless the immunization was medically contraindicated or the resident or staff member had already been immunized. In addition, residents and staff were not educated regarding the benefits and risks and potential side effects of the vaccine prior to being offered. The resident's medical record and staff records did not include documentation education was provided regarding benefits and potential risk associated with the COVID-19 vaccine or if the residents refused or if the vaccine was medically contraindicated. Specifically, there was no documentation that residents and staff were educated and offered the COVID-19 vaccine. Resident identifiers: 1, 3, 6, 11 and 43. Staff identifiers: 4, 5, 6, 7, and 8. Findings included: Resident COVID-19 Immunizations 1. Resident 11 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, diabetes mellitus and anxiety. Resident 11's medical record was reviewed 1/5/26 through 1/8/26. Resident 11's immunizations tab of the electronic medical record was reviewed and revealed refused. Resident 11's paper medical record was reviewed and there was no information that COVID-19 vaccine was offered, education was provided, or that the vaccine had been refused. 2. Resident 43 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, diabetes mellitus and postprocedural kidney failure. Resident 43's medical record was reviewed 1/5/26 through 1/8/26. There was no information that COVID-19 vaccine was offered or if education was provided. 3. Resident 1 was admitted to the facility on [DATE] with diagnoses which included pulmonary obstructive disease, depression and paranoid schizophrenia. Resident 1's medical record was reviewed 1/5/26 through 1/8/26. There was no information that COVID-19 vaccine was offered or if education was provided. 4. Resident 3 was admitted to the facility on [DATE] with diagnoses which included dementia, major depressive disorder and polyneuropathy. Resident 3's medical record was reviewed 1/5/26 through 1/8/26. Resident 3's medical record revealed COVID-19 was provided 5/18/24. There was no information that COVID-19 vaccine was offered for 2025 or if education was provided. 5. Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 1 diabetes mellitus, dementia and psychotic disturbance. Resident 6's medical record was reviewed 1/5/26 through 1/8/26. Resident 6's medical record revealed COVID-19 was refused but there was no date of when it was refused. There was no information that COVID-19 education was provided. On 1/8/26 at 9:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated in October 2025, she reviewed all residents' COVID-19 vaccine status. The DON stated there was no documentation the COVID-19 vaccine was offered, if residents were provided education or whether residents refused or not. The DON stated resident 11, resident 43, resident 1, resident 3 and resident 6 did not have COVID-19 vaccine education provided. Staff COVID-19 Immunizations On 1/6/26, Staff Member (SM) 4, SM 5, SM 6, SM 7, and SM 8's employee files were reviewed. There was no information regarding COVID-19 vaccines being offered or education provided to the staff members. On 1/8/26 at 2:06 PM, an interview was conducted with the Business Office Manager (BOM) who stated the COVID-19 vaccine was offered and arranged to be done at the local pharmacy if a staff member wanted it. The BOM stated there was no information that staff were provided education of risks and benefits of the COVID-19 vaccine.

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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 it was determined, for 1 of 24 sampled residents, the facility did not provide supervision to prevent accidents. Specifically, a resident sustained falls with no interventions developed and interventions were not implemented per the care plan. Resident 6. Findings included:Resident 6 was admitted to the facility on [DATE] with diagnoses which included type 1 diabetes mellitus, dementia, mood disorder and psychotic disturbance. On 1/7/26 at 9:37 AM, an interview was conducted with resident 6. Resident 6 stated she had fallen 3 or 4 times and had not gotten hurt. Resident 6 stated someone did some exercises with her to help her get stronger after she had a fall. Resident 6 was not able to make full sentences during the interview. On 1/7/26 at 9:13 AM, an observation was made of resident 6. Resident 6 was observed in bed with her bed not in the lowest position to the ground. Resident 6's wheelchair was not next to her bed and was out of her reach. Resident 6's medical record was reviewed 1/5/26 through 1/8/26. On 4/1/25 at 5:58 PM, a nursing progress note revealed .tis [sic] AM [morning] until approx [approximately] she was leaning extremely to the left almost like she lost halt [sic] [NAME] [sic] body muscle control she was shaking so she ended [up] falling x 3 at approx 1015 [10:15 AM] and 1250 [12:50 PM] the second was not witness so neuros [neurological assessments] intitiated [sic] but thare [sic] WNL [within normal limits] but she was insistant [sic] on no help and yelled at me like it didnt sounde [sic] like her voice. so it wass [sic] hard to tell if if [sic] she is having neuro muscleskeletakl [sic] sypmtoms [sic] or like the message is not getti9ng [sic] from the brain to the muscles to perform functionno [sic] injuries noted md [Medical Doctor] aware he ordered some labs tomorrow, WCTM [Will continue to monitor] her father was attempted to be contacted but the voicemail is full. I was able to get in touch with her brother to inform of fall. On 4/3/25 at 9:37 AM, a nursing progress note revealed the nurse observed resident 6 fell at 10:15 AM. On 4/3/25 at 9:37 AM, a nursing progress note revealed resident 6 fell again around 12:40 AM while coming out of the bathroom, no one witnessed fall. The nurse in charge was notified and neuros were started. On 4/21/25 at 1:01 PM, a nursing progress note revealed resident 6 fell when leaving the restroom this morning. Neuros were started and there was concern with her right eye responding. The Nurse Practitioner assessed and suspected cataracts. On 6/17/25 at 1:21 AM, a nursing progress note revealed right after midnight rounds, a Certified Nursing Assistant (CNA) found resident 6 on the floor. The nurse went to resident 6's room and resident 6 was found in bed. The nurse documented the bed was lowered to the lowest position, and the call light was placed within reach after the fall. It should be noted there were no care plan interventions located after each of the above falls. A care plan dated 8/5/25 revealed interventions to assess current abilities and risk factors for potential falls, assess residents as needed to prevent falls, follow facility protocol for post fall interventions, keep bed in low position for safety and keep the environment clear of obstructions. A care plan intervention dated 9/4/25 revealed to wear non-skid socks or shoes while ambulating/after a shower. On 9/16/25 at 1:10 AM, a nursing progress note revealed that during med pass, it was reported that resident 6 was found between her chair and recliner. There was no physical contact with the floor. Upon assessment, resident 6 stated she had fallen. Call light was placed within reach and bed lowered for safety. On 9/24/25 at 1:06 AM, a nursing progress note revealed resident 6 had an unwitnessed fall on 9/23/25 at 1:30 AM.Call light with [sic] reach bed lowered to the ground for safety. Resident encouraged to call for assistance. On 10/30/25 at 1:48 PM, a nursing progress note revealed resident 6 had a fall in her room after lunch at 12:35 PM. Resident 6 slid out of her recliner onto the floor. Care plan interventions dated 10/30/25 included skilled or restorative therapies as ordered to increase range of motion and maintain abilities and use adaptive/safety equipment as necessary and ordered. On 11/6/25 at 12:43 PM, a nursing progress note revealed resident 6 stood up from her wheelchair without assistance while in the dining (continued on next page)

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	465086	A. Building B. Wing	01/08/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room and fell. Resident 6 was encouraged to ask for assistance before getting up from her wheelchair, bed, toilet, or any other transfer. On 12/16/25 at 3:41 PM, a nursing progress note revealed resident 6 was found on the floor by the bedside by the housekeeper. Resident 6 stated she fell while transferring from her bed to the wheelchair without assistance and hit her head on the floor. On 12/29/25 at 10:46 PM, a nursing progress note revealed resident 6 fell at 5:45 PM. CNA offered to get resident 6 ready for bed and resident 6 refused. Shortly after, resident 6 called out to CNA and the resident was found on the floor. Resident 6 stated she slipped while trying to get into bed. On 1/6/26 at 3:41 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated resident 6 had not had any falls recently. NA 1 stated she helped resident 6 with transferring because the resident liked to close her eyes. NA 1 stated she checked on resident 6 every hour but there was nothing to document that she had checked on the resident every hour. NA 1 stated most of resident 6's falls are when she tries to transfer herself. NA 1 stated resident 6's bed needed to be in the low position but was not aware of other interventions to prevent falls. On 1/7/26 at 9:33 AM, an interview was conducted with CNA 1. CNA 1 stated resident 6 had a lot of falls and staff tried to keep her wheelchair close to the bed and at equal height with the bed so she can transfer herself safely. CNA 1 stated CNA's also kept her within ear shot because she yells out. CNA 1 stated she had thought about a fall mat next to the bed but Honestly. there are not many [fall] preventions for her. On 1/7/26 at 9:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated after a resident sustained a fall, the nurse assessed the resident by completing vital signs and neurological checks if the fall was unwitnessed. The DON stated there was a checklist that nurses used which helped determine the root cause, what happened, and how the fall could have been prevented. The DON stated the checklist was started about a month ago so she did not have one for resident 6. The DON stated there were no interventions developed after resident 6 fell on 9/16/25 because the resident did not make contact with the floor. The DON stated no new interventions were developed after the fall on 9/24/25. The DON stated after resident 6 fell on [DATE], the intervention was to provide therapy services and switch to using a wheelchair. The DON stated the intervention after resident 6's fall on 11/6/25 was to remind her to use her wheelchair. The DON stated she was not aware of new interventions after resident 6 fell on [DATE] but thought staff reminded her to use her call light. The DON stated after resident 6 fell on [DATE], the intervention was to have the bed lowered to the floor because it was too high. The DON stated she was not aware there was an intervention for a low bed dated 8/5/25. The DON stated staff were not following the care plan if that was an intervention before. The DON stated the intervention of a low bed, meant to have the bed in the lowest position closest to the floor. The DON stated interventions were initiated on 8/5/25 because she had performed a chart audit and put the interventions in that day.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 24 sampled residents, the facility did not obtain laboratory services to meet the needs of its residents. Specifically, one resident did not receive laboratory (lab) services for A1C (glycohemoglobin) and lipid panel as ordered. Resident identifiers: 25. Findings included: Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, obsessive-compulsive disorder, dementia, and adult failure to thrive. Resident 25's medical record was reviewed on 1/5/26 through 1/8/26. An order for resident 25 was started on 7/12/25 for A1C and lipid panel annually. The results for the A1C and lipid panel could not be located in resident 25's medical record. On 1/8/26 at 9:35 AM an interview was conducted with Registered Nurse (RN) 1, who stated that she was unable to locate the results for the A1C and lipid panel that were ordered on 7/12/25. RN 1 stated that after a provider ordered a nonurgent lab a copy of the order was placed in the lab binder, and that the lab service referenced the binder to know what samples to obtain during their weekly visit. On 1/8/26 at 10:32 AM an interview was conducted with the Director of Nursing (DON). The DON stated that after a provider ordered a nonurgent lab a copy of the order was placed in the lab binder, and that the lab service referenced the binder to know what samples to obtain during their weekly visit. The DON stated that she was unable to locate the order for an A1C and lipid panel dated 7/12/25 in the lab binder. The DON stated that because the order was not in the lab binder the samples would not have been collected.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 2 of 24 sampled residents that the facility did not file in the resident's clinical record laboratory reports. Specifically, residents' laboratory (lab) results were not filed in their medical record. Resident identifiers: 25 and 43. Findings included: 1. Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, obsessive-compulsive disorder, dementia, and adult failure to thrive. Resident 25's medical record was reviewed on 1/5/26 through 1/8/26. A physician's order dated 6/18/25 at 4:00 PM revealed CBC (complete blood count), CMP (comprehensive metabolic panel), Depakote, and TSH (thyroid-stimulating hormone) Q6 months (every six months). A physician's order dated 11/25/25 at 4:00 PM revealed CBC, CMP, TSH with reflex T4 (thyroxine), ammonia, B12 (vitamin B12) and UA with micro and reflex to culture (urinalysis with microscopic examination and reflex to culture). get urine sample today and draw labs tomorrow. It should be noted that the lab results for the orders dated 6/18/25 and 11/25/25 could not be located in resident 25's medical record. On 1/8/26 at 9:35 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 was able to print the missing lab results associated with the order dated 11/25/25 on the lab service's online portal. RN 1 stated that lab results were placed in a resident's medical record after the physician reviewed and signed the results. On 1/8/26 at 10:32 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the lab records indicated that the samples associated with the order dated 6/18/25 were collected, but the results were not in resident 25's medical record. The DON stated that lab results were reviewed and signed by the physician, and then placed in a resident's medical record. 2. Resident 43 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, diabetes mellitus, generalized anxiety disorder and bacteremia. Resident 43's medical record was reviewed 1/5/26 through 1/8/26. A physician's order dated 12/10/25 revealed CBC w/differential, CMP, CRP (C-reactive protein) and CK (creatine kinase) every Wednesday. There were no results from 12/24/25 located in resident 43's medical record. On 1/8/26 at 9:25 AM, an interview was conducted with RN 1. RN 1 provided the lab values from 12/24/25. RN 1 stated she printed them from the online portal and they had not been signed by the physician and filed into the medical record. On 1/8/26 at 9:59 AM, an interview was conducted with the DON. The DON stated lab results were faxed to the facility and there were 2 fax machines. The DON stated the lab results were available on the online portal. The DON stated after the physician signed the lab results they were filed in the residents medical record. The DON was observed to look in resident 43's medical record and stated she was unable to find the lab draw from 12/24/25.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 24 sampled residents, the facility did not obtain the required information from hospice representatives and the facility did not communicate with the hospice representatives to coordinate hospice care. Specifically, the facility did not obtain the most recent hospice plan of care and the hospice election form for one resident. Additionally, that resident's plan of care did not include both the most recent hospice plan of care and a description of the services furnished by the Long Term Care facility. Resident identifiers: 25. Findings Included:1. Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia, obsessive-compulsive disorder, dementia, and adult failure to thrive. Resident 25's medical record was reviewed on 1/5/26 through 1/8/26. A physician order dated 12/18/25, revealed resident 25 was admitted to hospice. It should be noted that the hospice hospice plan of care and the hospice election form could not be located in resident 25's medical record. Furthermore, resident 25's plan of care did not contain the hospice plan of care and a description of the services furnished by the LTC facility. On 1/7/26 at 11:12 AM, an interview was conducted with the Director of Nursing (DON), who stated that the hospice physician certification and face to face visits were kept in resident medical records, along with contact information for the hospice personnel and the hospice's 24-hour on-call system. The DON stated that other documentation was requested from the hospice as needed. On 1/8/26 at 1:34 PM, a follow up interview was conducted with the DON. The DON confirmed that the facility had not received resident 25's hospice plan of care and hospice election forms, and that resident 25's plan of care did not contain the hospice plan of care and a description of the services furnished by the LTC facility. [Cross reference to F656.]

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review the facility did not post nursing staff information each day for public access. Specifically, there was no nurse staff positing from 1/5/26 through 1/7/26. Findings included: On 1/5/26, 1/6/26 and 1/7/26 there was no nurse staffing information observed to be posted for the public to access. On 1/7/26 at 8:38 AM, an interview was conducted with the Business Office Manager (BOM). The BOM stated the Director of Nursing (DON) posted the nurse staffing daily at the nurses station. The BOM was unable to find the posting. On 1/7/26 at 8:40 AM, an interview was conducted with the DON. The DON stated she did not post the nurse staffing for the public. The DON stated she had the postings in a binder in her office so she could audit them. The DON stated she had stopped posting the nursing information about 2 weeks ago. The DON stated it had been posted at the nurses station on a clip board before she took it down 2 weeks ago.