

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Mountain View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 27555 Rimrock Road Barstow, CA 92311	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observation, interview, and record review, the facility failed to ensure the post fall protocol was implemented in accordance with the facility 's policy and procedure for one of three residents (Resident 1) reviewed for falls, when the Interdisciplinary Team (IDT (a group of healthcare professionals from different disciplines working towards a common goal for a resident) did not conduct a review of Resident 1 's fall which occurred on October 23, 2024.</p> <p>This failure had the potential for Resident 1 to be at risk of further falls which could increase Resident 1 's risk of injuries.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record (a document that gives a summary of resident's information), indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that include Muscle weakness, abnormalities of gait and mobility, repeated falls.</p> <p>During an observation and interview on October 28, 2024, at 12:56 PM with Resident 1, in Resident 1 's room, Resident 1 was eating in bed, with the head of the bed elevated. Resident 1 stated she fell recently but could not remember how she fell , she further stated she believes she got stiches on her head from the fall.</p> <p>During a review of a facility provided document titled Change of Condition/Fall, it indicated Resident 1 had a fall incident on October 23, 2024.</p> <p>During an interview on October 28, 2024, at 2:25 PM with the Director of Nursing (DON 1), the DON 1 stated resident 1 fall was unwitnessed, and the interdisciplinary team failed to assess after Resident 1 fall.</p> <p>During a review of facility Policy and Procedure (P&P) titled, Fall Prevention Program dated 12/19/2022 indicated, .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . 3 The nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk .</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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