STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555162	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	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)
F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that rehabilitation services were rendered in accordance with federal regulations for one of two sampled residents (Resident 48), when Resident 48 received physical therapy (PT- a treatment focused on improving movement, mobility, and physical function) and occupational therapy (OT- a therapy aimed at helping individuals perform daily activities and improve functional independence) services without a physician's order. This failure had the potential to result in uncoordinated and ineffective care, which could negatively impact Resident 48's rehabilitation and overall treatment plan. Findings: During a review of Resident 48's admission Record (clinical record with demographic information), the admission Record indicated, Resident 48 was readmitted to the facility on [DATE], with diagnoses of acute pulmonary edema (condition where fluid suddenly builds up in the lungs, making it difficult to breathe), and muscle weakness. During an observation on June 3, 2025, at 12:48 PM in the gym (Rehabilitation Room), the physical therapist assistant (PTA) assisted Resident 48 with sitting to standing transfers. The PTA provided verbal instructions, guiding Resident 48 through the movement. Resident 48 was able to stand and maintain balance while holding both hands on the front-wheeled walker (FWW, a mobility aid with two wheels designed to provide support and stability while walking). During an observation on June 5, 2025, at 10:18 AM at the gym, the occupational therapist assistant (OTA) guided Resident 48 through two sets of 10 exercises, raising both arms up and down. The OTA provided verbal instructions throughout the session. Resident 48 successfully completed the exercises. During a concurrent record review and interview on June 5, 2025, at 1:00 PM, the Director of Rehab (DOR), the DOR reviewed the PT and OT evaluation and treatment plan, which indicated, . Certification period [a designated timeframe during which a healthcare service or treatment is authorized and meets regulatory or professional standards] of 5/12/25 [May 12, 2025] - 6/10/25 [June 10, 2025] . The DOR confirmed that Resident 48 is currently receiving PT and OT services. (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 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 48's clinical records of active physician orders was conducted. There was no documented evidence of a physician's order for PT or OT treatment. Additionally, there was no documented evidence that a physician had been notified of Resident 48's PT and OT services. (Resident 48 received PT and OT services for 25 days without a physician's order or oversight). During an interview on June 5, 2025, at 1:30 PM with the Director of Nurses (DON), the DON stated that he was not aware of the regulation requiring the facility to obtain a physician's order for PT and OT services and treatment. The DON further stated the facility's usual practice is to treat the evaluation and plan of treatment as a physician's order. Furthermore, the DON acknowledged that the facility does not have a formal policy or procedure outlining this process.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to safeguard residents' confidential information for one of three sampled residents (Resident 50) when Licensed Vocational Nurse (LVN 4) left the computer screen containing Resident 50's medical information unattended and visible to others on June 4, 2025. This failure resulted in Resident 50's clinical records to be exposed to anyone and had the potential for an unauthorized person to access the information. Findings: During a review of Resident 50's admission Record (patient demographics), the admission Record indicated Resident 50 was admitted to the facility on [DATE], with diagnoses that included, fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), cardiomegaly (a condition where the heart is larger than normal), acute respiratory failure with hypoxia (a condition where the respiratory system fails to adequately oxygenate the blood). During an observation on June 4, 2025, at 6:08 AM, LVN 4 entered room [ROOM NUMBER] to administer medication to a resident in bed C, leaving the computer screen up and unattended, in the hallway, with Resident 50's information visible to others. During an interview on June 4, 2025, at 6:15 AM, with LVN 4, LVN 4 stated, I usually minimize or close the screen, I've been a nurse for ten years, so I've picked up a lot of bad habits. You caught me on that. During an interview with Registered Nurse Supervisor (RN), on June 4, 2025, at 7:38 AM, the RN stated her expectation is when staff need to walk away from the computer, staff must either change the screen or close the computer screen. During a concurrent interview and record review with the Director of Nursing (DON) on June 4, 2025, at 8:40 AM, the DON reviewed the facility's policy and procedures (P&P) titled Safeguarding of Resident Identifiable Information, revised December 19, 2022, the P&P indicated, It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records . 7. Computer screens showing clinical record information may not be left unattended and readily observable or accessible by other residents or visitors. The DON acknowledged LVN 4, Should not have done that, and the policy was not followed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a sanitary and safe environment for one of three residents (Resident 2) on enhanced barrier precaution (EBP - Enhanced Barrier Precautions, infection control measures, specifically focused on reducing the spread of multidrug-resistant organisms (MDROs)) when a License Vocational Nurse (LVN 3) did not perform hand hygiene after contact with Resident 2's foley catheter (a thin, flexible tube used to drain urine from the bladder). This failure had the potential for cross contamination and infection (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) which can jeopardize the health and safety of Resident 2. Findings: During a review of Resident 2's admission Record (contains patient demographics), the admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included hypertension (elevated blood pressure), type 2 diabetes mellitus with hyperglycemia (a condition where body cannot produce enough insulin), chronic obstructive pulmonary disease (COPD- a group of lung diseases characterized by airflow obstruction and limited lung capacity) , protein-calorie malnutrition (a condition characterized by a deficiency of both protein and energy) dysphagia, oropharyngeal phase (difficult swallowing). During an observation on June 2, 2025, at 10:40 AM, with LVN 3, in Resident 2's room, there was sign at the door that indicated Resident 2 was on EBP. LVN 3 was wearing gloves and touching Resident 2's foley catheter tube and bag. LVN 3 then removed the gloves and handshake Resident 2, then walked out of the room without performing hand hygiene towards the nurse's station. During an interview on June 2, 2025, at 10:47 AM, with the LVN 3, LVN 3 stated, Oh sorry, next time, I will sanitize my hands. The LVN 3 acknowledged the resident is in EBP. During a concurrent interview and record review with Infection Preventionist (IP), on June 3, 2025, at 2:45 PM, the IP reviewed the facility's policy and procedure (P&P), titled Enhanced Barrier Precautions, revised on March 10, 2025. The P&P indicated 4. High-contact resident care activities include: . g. Device care or use: .urinary catheters. The IP stated, for resident on EBP the expectation is for staff to perform hand hygiene after touching foley catheter and after removing gloves. The IP further stated when residents had foley, staff needs to wear appropriate PPE (PPE- personal protective equipment such as gloves and gown) and wash hands. During a concurrent interview and record review with the Director of Nursing (DON) on June 3, 2025, at 4:31 PM, The DON reviewed the facility's policy and procedure (P&P) titled Hand hygiene, revised on December 12, 2022. The P&P indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The DON stated his expectation is for staff to wear appropriate PPE and to wash hands.