STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CARE CENTER	**601 ADAMS BOULEVARD , BOULDER CITY, Nevada, 89005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on September 11, 2025, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483, Requirements for Long-Term Care Facilities. The census at the time of the survey was 75. There was one complaint investigated: Complaint 2613517 was investigated. No regulatory deficiencies were identified. The investigation included: Observation of grooming and physical appearance for residents, staff-resident interactions, provision of care, medication administration, call light response, infection control practices, staffing schedules, work orders and a tour of the facility. Interviews were conducted with residents, certified nursing assistants, licensed nurses, housekeepers, and assistant administrator. Document review included facility policies and procedures, training documentation, resident room rounds and infection control precautions. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal or civil investigation, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy of this report for your records.	F0000		

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 reverse for further 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