

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Mountain View of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Mountain View Dr Eureka, MT 59917	
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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769 Based on interview and record review, the facility failed to ensure a staff member that was hired as a medication aide was certified or licensed. This deficient practice had the potential to affect all residents in the facility receiving medications, to include 1 (#2) resident. Findings include: During an interview on [DATE] at 2:46 p.m., staff member C stated during the time when staff member E was hired the previous DON had checked licensing and certifications for new hires. Staff member E had a certified medical assistant certificate but not a medication aide license. During an interview on [DATE] at 2:57 p.m., staff member B stated she audited nursing staff licensing in February 2024 and discovered staff member E did not have a medication technician license or certificate. During an interview on [DATE] at 9:54 a.m., staff member A stated the previous DON confused medication aide with medical assistant certification when staff member E was hired. A review of an Offer of employment, document dated [DATE], addressed to staff member E, and signed by staff member A, showed: Dear [Staff member E]: on behalf of [Company name], I am pleased to offer you a position as a Certified Medical Assistant with a start date of [DATE]. A review of staff member E's timecards showed, she worked as a medication aide for approximately 102 shifts from [DATE] to February 8, 2024. A review of resident #2's MAR in the facility's EHR showed for the month of [DATE], staff member E administered medications approximately 69 times to resident #2. A review of the facility policy titled, New Licensed Employee Policy, with a release date of [DATE], showed: POLICY [Facility Name] ensures that all employees who apply for a licensed position are qualified to work the required field of practice and have a valid and active license in the State of Montana. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Mountain View of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Mountain View Dr Eureka, MT 59917	
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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility document titled, New Hire Checklist, with a revised date of ,d+[DATE], for staff member E, with a start date of [DATE], showed, a check box for Check Licenses/CPR (RN, LPN, PT, OT, SLP, CNA) not checked. A review of a facility policy titled, Medication Aide - Certified in Skilled Nursing Facility, with a revision date of [DATE], showed: . POLICY Certified Medication Aide (CMA), Medication Assistant - Certified (MA-C), Certified Medication Technician (CMT), Medication Aide I & II (MA I & II) may be used in accordance with the Nursing Board Standards of Practice of the state in which the aide practices. Definitions: Certified medication aides are nursing assistants who have been certified by the Board of Nursing in the state in which they practice. Their main function is to administer routine oral medications and perform other clinical duties in which they have been trained and demonstrate competency. PROCEDURE 1. Certified medication aides are to meet the following requirements unless otherwise specified by state regulation: . a. Successfully completed an approved state medication aide program or national council of state boards of nursing curriculum. b. Passed the state medication aide certification exam approved by the national council of state boards of nursing or other nationally recognized testing organization that provides testing for certified medication aides. c. Become certified by the state board of nursing as a CMA, MA-C, CMT, or equivalent. Based on the investigation, the facility acted timely by identifying the deficient practice, and had corrected the deficiency on [DATE]. The facility reported the incident as required by the Centers for Medicare and Medicaid.		