STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to ensure a resident was free from neglect for 1 of 3 residents (Resident 1), reviewed for neglect, when they failed to perform consistent skin assessments as ordered and failed to obtain and implement wound treatment orders when Resident 1 developed a new skin concern. Resident 1 experienced harm when they developed a necrotic (death of tissue) area to the right foot and fifth (little) toe which required hospitalization and surgical intervention of a partial amputation of the right foot (side of foot) including the little toe. Findings included . Review of the facility's policy dated 08/2024, titled, Abuse -screening, training, identification, investigation, reporting and protection, showed the definition for neglect is the failure to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015, showed neglect may result from an inaction by an individual or entity with a duty of care for nursing home residents, including the failure to provide goods and services necessary to avoid physical harm. Review of the facility's policy, dated 09/2020, titled, Skin at Risk/Skin Breakdown showed a full body skin evaluation was completed weekly by the licensed nurse. Completion of the skin audit was to be documented. Review of Lippincott Manual of Nursing Practice, Eleventh Edition, showed signs of necrotic tissue in wounds clinically manifest with increased pain, redness, swelling, and warmth to the area, development of bullae (fluid filled sac or lesion), drainage and foul odor. <Resident 1> Review of Resident 1's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include a fractured right hip, right side hemiplegia/hemiparesis (partial and complete loss of strength to one side of the body) and need for assistance with personal care. Review of the resident's comprehensive assessment dated [DATE] showed the resident's cognition was severely impaired. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's physician's orders showed the resident had an order dated 09/13/2024, for weekly skin checks every day on Fridays. Review of a nursing progress note, dated 11/07/2024, showed the resident had two new lesions to the outside of the right foot which involved the little toe. Review of a Wound Consultant progress note, dated 11/21/2024, showed wound had closed but remained high risk with direction for nursing to continue the daily wound dressing for extra protection. Review of the nursing progress note, dated 01/19/2025 at 3:30 PM, showed Staff E, Licensed Practical Nurse (LPN), was notified by Staff J, Restorative Assistant (RA), of Resident 1's right foot having a strong, foul odor. Staff E assessed Resident 1's outer right foot to have loose and removed skin, black colored tissue in the wound bed, the little toe (closest to the wound) was dark in color, and the wound had a foul odor. Staff E transferred Resident 1 to a local hospital for evaluation and treatment. During an interview, on 01/22/2025 at 3:04 PM, Staff D, Resident Care Manager (RCM), stated they completed weekly skin assessments on the residents, and the last time they assessed Resident 1's right foot was on 01/05/2025 (14 days prior to significant change). Staff D stated Resident 1 had a callous (a hard, thickened area on skin) to the outer portion of their right foot near the little toe and the surrounding skin was intact. Staff D stated the floor nurses were responsible for completing weekly skin assessments on the residents, and that they tried to routinely monitor pressure wounds and surgical incisions. During an interview on 01/22/2025 at 4:58 PM, Staff O, LPN, stated they worked with Resident 1 on 01/14/2025 and completed the dressing change to their outer right foot. Staff O stated they noted a small open area that was bleeding but the area looked at its baseline otherwise. Staff O stated they did not notify anyone or document the change in skin integrity. During an interview, on 01/22/2025 at 2:30 PM, Staff E, LPN, stated the last time they assessed Resident 1's right foot wounds was on 01/11/2025 (eight days prior to significant change), the area was at baseline with no open areas, and a protective dressing was applied as ordered. Staff E stated when they worked with Resident 1 on 01/15/2025, Resident 1 had refused the dressing change to their right foot due to significant pain and discomfort to the right foot. During an interview, on 01/23/2025 at 12:27 PM, Staff L, Nursing Assistant (NA), stated they worked with Resident 1 on 01/17/2025 and noticed when they assisted the resident to get dressed, the resident's right foot had re-opened. Staff L stated the right foot was swollen, red and warm and they notified Staff F who applied a new dressing. During an interview, on 01/22/2025 at 1:46 PM, Staff F, LPN, stated they worked with Resident 1 on 01/17/2025 and completed the dressing change to their outer right foot. Staff F stated they observed dried serosanguinous [contains both blood and serum (the liquid part of blood)] fluid on the old dressing and a small slit where the drainage was coming from. Staff F stated resident weekly skin assessments were completed by the RCMs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mountain View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E Mountain View Ellensburg, WA 98926	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 01/23/2025 at 10:47 AM, Staff H, LPN, stated they usually worked double shifts (two consecutive shifts to equal 16 hours) on the weekends, and they worked with Resident 1 on 01/18/2025 during the day shift (6:00 AM to 2:00 PM). Staff H stated they passed medications for the assigned hall, and did not complete any treatments or dressing changes. Staff H stated the treatments were completed Monday through Friday as they did not have a treatment nurse on the weekends. Staff H stated Resident 1 had a dressing to their right foot, but they never saw the wound. Staff H stated they recalled Resident 1 complained of pain to their right foot during the shift, and the NAs repositioned the resident frequently to keep them comfortable. During an interview, on 01/22/2025 at 2:16 PM, Staff J, RA, stated they worked with Resident 1 on 01/19/2025, after breakfast in their room. Staff J stated Resident 1's right foot did not have a dressing or a sock on it and they observed a bad sore on the outer part of the foot. Staff J stated the wound was on the outer part of the right foot, including the little toe, was dark in color, and there was a foul odor coming from it. Staff J stated they reported it to Staff E. During an interview, on 01/22/2025 at 12:47 PM, a Collateral Contact (CC) at the local hospital stated they had received Resident 1 from the facility, but they had transferred Resident 1 to a hospital in Seattle for further evaluation and treatment by a Podiatrist (medical specialist who help with problems that affect the feet and lower legs). The CC stated the local hospital physician was concerned about potential osteomyelitis (a bone infection that causes inflammation and swelling in the bone) in Resident 1's right foot. During an interview, on 01/23/2025 at 12:57 PM, Staff C, Assistant Director of Nursing (ADNS), stated their investigation regarding the change in condition to Resident 1's right foot showed Staff F assessed the wound on 01/17/2025 to be open, macerated (a breaking down of the skin resulting from prolonged exposure to moisture), and had a piece of loose skin. Staff C stated it did not appear Staff F documented the change to Resident 1's right foot wound nor notify the physician. During an interview, on 01/23/2025 at 4:19 PM, Staff A, Administrator, and Staff B, Regional Nurse, stated that there is indeed a deficiency in the assessment of the resident. During an interview on 01/27/2025 at 10:16 AM, Resident 1's RR, stated Resident 1 was in the hospital and had a partial amputation of their right foot on 01/25/2025. Reference: WAC 388-97-0640(1)