

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Mountain View Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>45939</p> <p>Based on interview and record review, the facility failed to ensure residents were free of chemical restraints for 1 of 3 residents (Resident 5) reviewed for unnecessary medications. This deficient practice placed residents at risk of experiencing unnecessary side effects such as sedation, decline in physical functioning, and placed residents at risk of experiencing an undignified life.</p> <p>Findings included .</p> <p>Review of the facility policy Psychotropic Medication Use, revised February 2025, showed psychotropic medications were any medication that affected brain activity related to mental processes and behavior, and these medications were .never used to sedate or alter a resident's behavior for discipline or for the convenience of staff. Further review showed residents' medical record should show specific behaviors to monitor for, potential triggers for these behaviors, and non-pharmacological interventions to try for soothing before as needed psychotropic medication were administered.</p> <p><Resident 5></p> <p>Review of the medical record showed Resident 5 admitted to the facility, on 04/15/2025, with diagnoses of dementia (a disease that causes loss of memory, language, problem-solving and other thinking abilities), diabetes (a disease that affects the body's ability to process sugar in the blood), sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep), and anxiety (a mood disorder causing the feeling of fear, dread, and uneasiness). Review of the comprehensive assessment, dated 04/21/2025, showed Resident 5 had severe cognitive impairment and required the assistance of two people for transfers, toileting, bathing, and personal cares.</p> <p>Review of Resident 5's care plan, dated 04/15/2025, showed no care plan specific to behavior management, Identified Target Behaviors (ITBs), or individualized interventions.</p> <p>Review of the medical record showed there were no behavior monitors for Resident 5 in April 2025.</p> <p>Review of Resident 5's April 2025 Medication Administration Record (MAR), showed the following psychotropic medication orders:</p> <p>Donepezil (a medication used to treat dementia) 10 milligram [(mg) a unit of measure] by mouth at bedtime</p> <p>(continued on next page)</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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Escitalopram (a medication used to treat depression-a mood disorder that causes sadness and impacts the way a person thinks, feels, and behaves) 20 mg by mouth daily</p> <p>Quetiapine (a medication used to treat mood disorders by balancing brain chemicals) 25 mg by mouth daily in the morning and 50 mg by mouth at bedtime</p> <p>Hydroxyzine (an allergy medication used to treat anxiety due to its sedating and calming effects) 25 mg by mouth four times daily as needed for anxiety</p> <p>Lorazepam (a medication used to provide short term relief of anxiety symptoms) one mg by mouth twice a day as needed for anxiety.</p> <p>Review of the nursing progress note (PN), dated 04/22/2025 at 1:32 AM, showed Staff D, Registered Nurse (RN), documented at 12:30 AM (Resident 5) became agitated (visibly upset or restless) in bed and wanted to get up.</p> <p>Review of the nursing PN, dated 04/22/2025 at 2:24 AM, showed Staff D obtained a telephone order to administer lorazepam two mg subcutaneously [(SQ) an injection given in the fatty tissue, just under the skin] and it was administered to the right thigh.</p> <p>During an interview, on 05/05/2025 at 2:40 PM, Staff D stated, during the night of 04/22/2025, Resident 5 was yelling out loudly and slapping their hands on bedside table. Staff D stated they attempted to administer lorazepam by mouth to Resident 5 for agitation, but Resident 5 refused all attempts. Staff D stated they called the on-call medical provider, described the situation, and received the order to administer lorazepam two-mg as an injection. Staff D stated they administered the injection to Resident 5 and confirmed that Resident 5 was not given the option to refuse. Staff D stated Resident 5 needed the anti-anxiety medication to calm down and quit disrupting all the other residents.</p> <p>During an interview, on 05/05/2025 at 3:15 PM, a Resident Representative (RR) for Resident 5 stated they were not informed of the new order for injectable lorazepam prior to its administration, and they would not have given consent for the medication to be administered as an injectable.</p> <p>During an interview, on 05/05/2025 at 3:45 PM, Staff B, Director of Nursing, stated administering a psychotropic medication to a resident without consent from the resident and/or their representative made the administration a chemical restraint. Staff B stated they expected the Licensed Nurses (LNs) to know what a chemical restraint was and to question any order to administer one.</p> <p>Reference: WAC 388-97-0620 (1)(a)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>45939</p> <p>Based on interview and record review, the facility failed to ensure the components for identification and reporting abuse/neglect from their abuse prohibition policy were implemented for 1 of 5 residents (Resident 5) reviewed for abuse and neglect. This deficient practice placed residents at an increased risk for unidentified abuse and neglect and unmet care needs.</p> <p>Findings included .</p> <p>Review of the facility policy, Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection, dated 08/01/2024, showed facility staff was expected to be able to identify abuse and neglect of residents and were mandated to report these incidents to the State Agency (SA). Further review of the facility policy showed the facility identified unauthorized chemical restraints as a form of abuse with the example . [(psychotropic) a substance that affects the mind or brain, causing changes in thinking, feeling, or perception] medication is administered in order to prevent a resident from displaying behaviors . or for staff convenience resulting in a changed behavior requiring a lesser amount of effort or care.</p> <p><Resident 5></p> <p>Review of the medical record showed Resident 5 admitted to the facility, on 04/15/2025, with diagnoses of dementia (a disease that causes loss of memory, language, problem-solving and other thinking abilities), diabetes (a disease that affects the body's ability to process sugar in the blood), sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep), and anxiety (a mood disorder causing the feeling of fear, dread, and uneasiness). Review of the comprehensive assessment, dated 04/21/2025, showed Resident 5 had severe cognitive impairment and required the assistance of two people for transfers, toileting, bathing, and personal cares.</p> <p>Review of the facility investigation log showed Resident 5 had a medication error incident on 04/22/2025 at 1:00 AM.</p> <p>Review of the nursing PN, dated 04/22/2025 at 1:22 PM, showed Staff C, Assistant Director of Nursing, documented Resident 5's Representative (RR) came to the facility and had Resident 5 discharged Against Medical Advice (AMA) due to being .unhappy (Resident 5) is having other doctors order meds.</p> <p>Review of the medication error investigation summary, dated 04/25/2025, showed Staff D documented the administration of the injected medication incorrectly, and the cause of the medication error was determined to be a .transcription error.</p> <p>During an interview, on 05/02/2025 at 1:20 PM, Staff C stated there was a meeting that included Staff A, Administrator, Staff C, and RR for Resident 5 on the afternoon of 04/22/2025. Staff C stated during the meeting, the RR listed out a number of complaints regarding the care and services provided for Resident 5 during their stay including concerns regarding medication administration, behavior management, diabetes management, activities accommodation, and medical provider oversight. Staff C stated they addressed all the concerns and provided the RR with education regarding facility policies and procedures. Staff C stated the RR proceeded to have Resident 5 discharged AMA.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 05/02/2025 at 2:30 PM, Staff C stated they completed the 04/22/2025 medication error investigation for Resident 5 and determined it was not abuse and it was not reportable to the SA because there was no negative effect to the resident and there was no significant risk for harm. Staff C stated they identified the concerns expressed by Resident 5's Representative as education opportunities and did not consider them allegations of abuse or neglect.</p> <p>During an interview, on 05/05/2025 at 3:45 PM, Staff B, Director of Nursing, stated the administration of psychotropic medications as an injectable was a chemical restraint and form of abuse.</p> <p>During an interview, on 05/05/2025 at 4:30 PM, Staff A, Administrator, confirmed they were aware of the medication error and the concerns expressed by Resident 5's Representative. Staff A stated these incidents were not identified as potential abuse or neglect or reported to the SA.</p> <p>Reference: WAC 388-97-0640 (2)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45939</p> <p>Based on interview and record review, the facility failed to report allegations of potential abuse and/or neglect to the State Agency (SA) as required for 1 of 5 residents (Resident 5) reviewed for abuse and neglect. This deficient practice placed residents at risk for unidentified abuse/neglect.</p> <p>Findings included .</p> <p>Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, showed all reports of abuse and neglect .are reported to local, state and federal agencies (as required by current regulations) .</p> <p><Resident 5></p> <p>Review of the medical record showed Resident 5 admitted to the facility, on 04/15/2025, with diagnoses of dementia (a disease that causes loss of memory, language, problem-solving and other thinking abilities), diabetes (a disease that affects the body's ability to process sugar in the blood), sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep), and anxiety (a mood disorder causing the feeling of fear, dread, and uneasiness). Review of the comprehensive assessment, dated 04/21/2025, showed Resident 5 had severe cognitive impairment and required the assistance of two people for transfers, toileting, bathing, and personal cares.</p> <p>Review of the facility investigation log showed Resident 5 had a medication error incident on 04/22/2025 at 1:00 AM.</p> <p>Review the nursing progress note (PN), dated 04/22/2025 at 1:22 PM, Staff C, Assistant Director of Nursing, documented Resident 5 discharged Against Medical Advice [(AMA) resident discharging despite medical professionals advice to continue stay at the facility] when their Resident Representative (RR) came to the facility to express dissatisfaction with other medical providers making changes to Resident 5's medications (in reference to the medication error earlier in the day).</p> <p>Review of the medication error investigation, dated 04/25/2025, showed Staff D, Registered Nurse (RN), obtained an order to administer a psychotropic [(anti-anxiety) a substance that affects the mind or brain, causing changes in thinking, feeling, or perception] medication as an injection when Resident 5 refused to take the medication in pill form. The investigation summary concluded the error was transcription related due to Staff D failing to enter the new order correctly into the electronic health record.</p> <p>During an interview, on 05/02/2025 at 1:20 PM, Staff C stated they met with the RR for Resident 5 on 04/22/2025 along with Staff A, Administrator, and discussed several complaints regarding the care and services provided to Resident 5. Staff C stated the complaints included concerns regarding insulin administration, medical provider oversight, medication management, and daily activities. Staff C stated they addressed the complaints as education opportunities for the RR, and confirmed an allegation of abuse/neglect was not generated or reported from the expressed complaints.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 05/02/2025 at 2:30 PM, Staff C stated the medication error with Resident 5 on 04/22/2025 was a transcription error, showed no negative effect to Resident 5, and they determined it was not reportable to the SA.</p> <p>During an interview, on 05/05/2025 at 3:45 PM, Staff B, Director of Nursing, stated the administration of psychotropic medications in injectable form was a chemical restraint which was a form of abuse. Staff B confirmed the medication error for Resident 5 should have been reported to the SA.</p> <p>During an interview, on 05/05/2025 at 4:30 PM, Staff A confirmed they were aware of the medication error for Resident 5 and the complaints expressed by their RR. Staff A stated the incidents were not reported to the SA.</p> <p>Reference: WAC 388-97-0640 (5)(a)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45939</p> <p>Based on interview and record review, the facility failed to ensure medication administration practices were maintained in accordance with professional standards of nursing practice for 1 of 3 residents (Resident 5) reviewed for medication administration. This deficient practice resulted in Resident 5 receiving a chemical restraint and placed other residents at risk for receiving unnecessary medications.</p> <p>Findings included .</p> <p>Review of Lippincott Manual of Nursing Practice 10th edition, defined the following ethical areas:</p> <p>Informed consent was the patient's right to accept or decline treatment provided by the nurse, and in circumstances where the patient was incapable of fully understanding the treatment components, informed consent must be obtained through a responsible person such as a decision maker or guardian.</p> <p>Accountability required the professional nurse to be proactive and take all appropriate measures to ensure their professional practice was not lacking, remiss, or deficient in any area or way.</p> <p>Review of the facility policy, Psychotropic Medication Use, revised February 2025, showed psychotropic medications were any medication that affected brain activity related to mental processes and behavior, and clinical rationale for use of these medications or a change in the medication regime was to be documented in the medical record. The policy showed the .documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful ., and prior to initiating a change in any psychotropic medication, the resident and/or their representative had the right to accept or decline the treatment.</p> <p><Resident 5></p> <p>Review of the medical record showed Resident 5 admitted to the facility, on 04/15/2025, with diagnoses of dementia (a disease that causes loss of memory, language, problem-solving and other thinking abilities), diabetes (a disease that affects the body's ability to process sugar in the blood), sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep), and anxiety (a mood disorder causing the feeling of fear, dread, and uneasiness). Review of the comprehensive assessment, dated 04/21/2025, showed Resident 5 had severe cognitive impairment and required the assistance of two people for transfers, toileting, bathing, and personal cares.</p> <p>Review of Resident 5's Medication Administration Record (MAR) for April 2025 showed an order for lorazepam (a medication used to provide short term relief of anxiety symptoms) one milligram [(mg) a unit of measure] by mouth twice a day as needed for anxiety.</p> <p>Review of the nursing progress note (PN), dated 04/22/2025 at 1:32 AM, showed Staff D, Registered Nurse (RN), documented at 12:30 AM (Resident 5) became agitated (visibly upset or restless) in bed and wanted to get up.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing PN, dated 04/22/2025 at 2:24 AM, showed Staff D obtained a telephone order to administer lorazepam two mg subcutaneously [(SQ) an injection given in the fatty tissue, just under the skin] and it was administered to the right thigh.</p> <p>Further review of the medical record showed no documentation of non-pharmacological interventions attempted to address Resident 5's exhibited behaviors or attempts to offer lorazepam in pill form.</p> <p>During an interview, on 05/05/2025 at 2:40 PM, Staff D stated Resident 5 was displaying loud and disruptive behaviors and refused to take (their) meds. Staff D stated they called the on-call provider to get an order for the medication to be given as an injectable, and confirmed Resident 5 was not able to refuse receiving the medication because the doctor ordered (them) to have it.</p> <p>During an interview, on 05/05/2025 at 3:15 PM, a Resident Representative (RR) for Resident 5 stated they were not given the opportunity to accept or decline the change in medication administration route prior to Resident 5 receiving the medication. The RR stated they would not have consented to the lorazepam being administered as an injectable because (Resident 5) normally had no problem taking pills .an injection was not necessary.</p> <p>During an interview, on 05/05/2025 at 3:45 PM, Staff B, Director of Nursing, stated administering a psychotropic medication in a manner that disallowed a resident to refuse was not a standard of nursing practice and was considered a chemical restraint.</p> <p>Reference: WAC 388-97-1620 (2)(b)(i)(ii)</p>		