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	11/03/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess/reassess and provide adequate supervision and safety monitoring for 1 of 3 residents (Resident 1) reviewed for accidents. Resident 1, who had moderately impaired cognition and lacked safety awareness, experienced harm when they exited the facility unsupervised, was subsequently found by a bystander outside the facility, lying on the ground and sustained a head injury, left elbow fracture, and multiple bruises that required a hospital evaluation and intervention. Findings included .Review of a policy revised on March 2019 titled, Wandering and Elopement, showed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety.Review of Resident 1's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include a broken right shoulder, anxiety (a feeling of worry, nervousness, or unease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive decline. The resident's comprehensive assessment dated [DATE], showed Resident 1's cognition was moderately impaired and required one-to-two-person assistance with activities of daily living ([ADLs] self-care tasks people do every day).Review of Resident 1's progress notes dated 09/10/2025 through 10/21/2025 showed: 09/10/2025 titled admission summary showed the resident had confusion and moments of hallucinations (a sensory experience where someone perceives something that isn't there) during the evening hours. 09/30/2025 at 6:41 PM, Resident 1 had refused cares. 10/02/2025 at 10:32 AM showed Resident 1 had exhibited anxiety behaviors. 10/18/2024 at 7:17 PM, showed Resident 1 had demonstrated exit seeking behavior, anxiety, and wanting to go home. Further review showed a physician's order dated10/18/2025 for lorazepam (antianxiety medication) 0.5mg for anxiety. 10/18/2025 showed at 7:19 PM the resident was placed on a 1:1 supervision (one caregiver provides undivided attention and support to a single individual). Further review showed the 1:1 supervision was provided by staff until family arrived at 7:30 PM to sit with Resident 1. The 1:1 supervision was re-initiated at 10:00 PM on 10/18/2025 when family had left and the resident continued to exhibit exit seeking behaviors. Staff G, Registered Nurse (RN), stated Resident 1 was taken off the 1:1 supervision when they had calmed down the morning of 10/19/2025. 10/19/2025 at 12:51 PM showed Resident 1 was drowsy and continued with confusion frequently asking, where am I? 10/21/2025 at 10:43 AM, showed Resident 1 had increased confusion, walking into the hallways and looking for their family who were not in the facility.Review of Resident 1's elopement risk assessment dated [DATE] showed Resident 1 was at a low risk for elopement. Further review showed there were no updated elopement risk assessments or care plan updates completed for Resident 1 related to their change in behaviors. Review of the facility's incident report dated 10/24/2025 showed Resident 1 was last seen by night shift staff at approximately 4:30 AM on 10/24/2025, and again when Resident 1 had exited the facility by way of the window in their room into the back courtyard at approximately 6:15 AM. The resident was found by staff from a neighboring facility (Assisted Living Facility, ALF); the ALF staff stated the resident was peeking through their windows, so they came out to help the resident. The ALF staff stated Resident 1 was very agitated and would not let anyone assist them. The nursing home facility staff noticed the resident was out of the facility at 6:40 AM and found the resident at the ALF with scrapes to their knees and complaints of pain to their back and arm. Staff placed a blanket on the resident, called 911 and sent Resident 1 to the local hospital for evaluation and treatment related to the residents increased pain, agitation and anxiety.During an interview on 10/29/2025 at 12:24 PM Resident 1's collateral contact (CC) stated they had received a call from the facility on 10/24/2025 at about 6:45 AM. The CC stated they were asked if they had dropped Resident 1 off the day before after their outing (10/23/2025). The CC stated that they had not, their niece had dropped off the resident the prior evening. The CC stated the facility informed them that they were unable to locate the resident The CC stated they had to call the facility back for an update and were told Resident 1 was found lying on their back outside. The CC stated the facility had called an ambulance to send the resident to the ER. The CC stated when they arrived at the hospital Resident 1 had a goose egg above the left eye and had pajamas on with no socks or shoes. The CC stated Resident 1 had scrapes to their that were new. The CC further stated Resident 1 had sustained a hairline fracture to their left elbow, a head injury, and was concerned about the lack of supervision and care not provided for Resident 1. Review of the