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	11/20/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure appropriate care and services were provided to maintain Range of Motion (ROM) for 3 of 3 residents (Residents 1, 3, and 2) reviewed for Restorative Nursing programs. The lack of consistent processes in place for implementation of splints and providing ROM services placed residents at risk for not maintaining ROM in the affected areas of contractures (tightening of tendons and muscle), decreased function and pain.Findings included .Resident 1 Review of the medical record showed the resident was admitted to the facility with diagnoses including history of a stroke (blood flow to a part of the brain is interrupted) with paralysis (loss or impairment of voluntary movement) on the left side and heart failure. Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and was dependent on staff for dressing, grooming and mobility. During an observation on 09/29/2025 at 1:17 PM, Resident 1 was in the dining room sitting in their wheelchair. The resident's left arm was hanging limply in their lap and their fingers were bent tightly against their palm in a fixed position. Resident 1 had a splint positioned upside down on their hand with the blue foam designed to keep the palm and fingers separated was on top of the resident's hand and not in their palm. Review of Resident 1's Kardex for September 2025 (a care plan used by Nursing Assistants [NAs] to give care directives for residents), showed the resident had a Restorative Nursing program which included ROM to be completed daily on their left arm and hand (there were no directives or information on the use of the blue splint which had been observed positioned incorrectly in their hand). Review of the daily signatures which indicated completion of the ROM program showed 14 missed days on 09/04/2025, 09/05/2025, 09/07/2025, 09/08/2025, 09/14/2025, 09/15/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/21/2025. 09/22/2025, 09/26/2025, 09/28/2025, and 09/29/2025. Resident 3Review of the medical record showed the resident was admitted to the facility with diagnoses which included history of a stroke with paralysis on the left side of their body, diabetes (too much sugar in the blood) and dementia (cognitive loss). Review of the comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and was dependent on staff for dressing, grooming, mobility and required a mechanical lift for transfers. During an observation on 09/30/2025 at 12:51 PM, Resident 3 was resting in bed. The resident's left hand was bent tightly against their palm in a fixed position. Staff B, NA, attempted to open the resident's hand, however it was position firmly against their palm, and the resident was uncooperative with Staff B attempting to open their hand. Staff B further stated the Restorative Nursing Assistant (RNA) was responsible for Resident 3's ROM program. Review of Resident 3's September 2025 Kardex showed they had a daily ROM program related to their left sided paralysis. Review of the daily signatures to signify the program had been completed showed 14 out of 30 days on 09/04/2025, 09/05/2025. 09/07/2025, 09/08/2025, 09/14/2025, 09/15/2025. 09/16/2025 09/17/2025, 09/18/2025, 09/21/2025, 09/22/2025, 09/26/2025, 09/28/2025 and 09/29/2025 the ROM program had not been signed as completed. Resident 2Review of the resident's medical record showed they were admitted to the facility with diagnoses which included a history of a stroke with left side paralysis and dysphagia (difficulty swallowing). Review of the comprehensive assessment dated [DATE] showed the resident had impaired cognition and was dependent on staff for grooming, eating, dressing, mobility and transfers. Review of the residents September 2025 Kardex showed they had a daily ROM and left-hand splinting program to prevent stiffness and contractures. Further review of the programs showed 14 of 30 days without signatures to indicate completion of the programs on 09/04/2025, 09/05/2025. 09/07/2025, 09/08/2025, 09/14/2025, 09/15/2025. 09/16/2025 09/17/2025, 09/18/2025, 09/21/2025, 09/22/2025, 09/26/2025, 09/28/2025 and 09/29/2025. During an interview on 09/29/2025 at 10:30 AM, a Collateral Contact stated Resident 2's left hand splint was often dirty and the palm of their had had an odor related lack of care to the area. Review of Resident 2's September 2025 Kardex showed the resident had a restorative nursing program which included ROM to the left arm and hand, and a splinting program to include placing the resident's hand and placing a soft splint on daily in the morning and removing it at bedtime to replace it with a full splint with finger separators worn at night. Further review of the record showed the restorative nursing programs were not completed on 09/04/2025, 09/05/2025. 09/07/2025, 09/08/2025, 09/14/2025, 09/15/2025, 09/16/2025, 09/17/2025, 09/18/2025, 09/21/2025, 09/22/2025, 09/26/2025, 09/28/2025 and 09/29/2025 (14 out of 30 days were missed). During an interview on 09/30/2025 at 1:24 PM, Staff B, RNA, stated I do my best to get them done. Staff B stated

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure cleaning, disinfecting and/or storing of oxygen care equipment was maintained in a manner to prevent infectious diseases for 3 of 5 residents (Residents 4, 5 and 6) reviewed for cleanliness of oxygen concentrator (a device that pulls air out of the environment and concentrates into oxygen) filters and storage of oxygen tubing when not in use. This failure placed residents at risk for infectious disease transmission and illness in their respiratory system (lungs). Findings included .Resident 4Review of Resident 4's medical record showed they were admitted to the facility with diagnoses including obstructive sleep apnea (repeated episodes of upper airway obstruction during sleep) and dementia (ongoing cognitive decline). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively impaired and was dependent on staff for grooming, dressing, transfers and mobility. Review of Resident 4's physicians order for September 2025 showed the resident's oxygen concentrator filters were to be changed or cleaned weekly per the facility protocol. During a concurrent observation and interview on 09/29/2025 at 12:59 PM, Staff A, Director of Nursing, entered Resident 4's room. The resident was lying in bed with their oxygen concentrator running. The oxygen was being administered to the resident by a nasal cannula (a small tube with two prongs which connects to the oxygen concentrator and is placed in the resident's nose). Observation of the concentrator's filter showed a thick layer of dust, dirt and hair on the surface of the filter. Staff A removed the filter and attempted to clean it however was unable to remove the debris and stated, this should have been replaced. Staff B further stated the oxygen filter was supposed to be cleaned or changed weekly per the oxygen use protocol which included the tubing and with a plastic bag hanging on the concentrator to store the tubing when not in use. Resident 5Review of Resident 5's medical record showed they were admitted with diagnoses including chronic obstructive pulmonary disease (a lung condition which causes restricted airflow and difficulty breathing) and congestive heart failure (when the heart cannot pump enough blood to meet the needs of the body). Review of the resident's comprehensive assessment dated [DATE] showed the resident had cognitive impairment and was dependent on staff for dressing, grooming, toileting and mobility. Review of the September 2025 physician orders showed they were required to have their oxygen concentrator filter changed/cleaned weekly and their oxygen tubing changed weekly per the facility protocol. During an observation on 09/29/2025 at 1:25 PM, showed Resident 5 in bed with their oxygen concentrator running. The resident's nasal cannula and tubing were positioned under their back on the bed and not in their nose delivering oxygen. There was no plastic bag to secure the tubing when it was not in use. A continued observation of the resident's oxygen equipment showed the oxygen concentrator filter had a thick layer of dust and dirt on the surface of the filter. Resident 6Review of Resident 6's medical record showed they were admitted with diagnoses including a history of pulmonary embolism (a blood clot in the lungs) and respiratory failure. Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance for dressing, grooming and transfers. Review of the September 2025 physician orders showed the resident used oxygen and required their oxygen equipment replaced weekly and stored appropriately. During observations on 09/29/2025 at 12:40 PM and 3:30 PM showed the resident's oxygen tubing connected to the room concentrator lying on the floor with the nasal cannula under the bed. There was no plastic bag to store the tubing to keep it from getting contaminated when placed on the resident, when in bed. During a follow up interview on 09/30/2025 at 12:40 PM, Staff A, stated their expectation was for the nurses to store the resident's oxygen tubing securely in a plastic bag to protect it from getting contaminated when not in use. Additionally, Staff A stated the expectation was for licensed nurses to clean or change the oxygen concentrator filters weekly as this was the facility's standard protocol for oxygen use. Reference WAC 388-97-1320(1)(a)