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	05/01/2026

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 - Minimal harm or potential for 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** Based on interview and record review, the facility failed to protect the residents' right to be free of abuse for 1 of 3 residents (Resident 1) reviewed for abuse. This deficient practice placed residents at risk for physical injury, psychosocial distress, and feeling unsafe in their home.Findings included.Review of the facility policy, Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection, revised in January 2025, defined abuse as the willful infliction of injury to another person and defined willful as a deliberate action.Resident 1Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis or impaired ability to move) of the right side and Chronic Obstructive Pulmonary Disease [(COPD) a lung disease that makes it difficult to breathe due to damaged, inflamed, and narrowed airways]. Review of the comprehensive assessment, dated 02/10/2026, showed Resident 1 had moderate cognitive impairment and required the assistance of two people for bed mobility, dressing, and transfers.Resident 2Review of the medical record showed Resident 2 admitted to the facility on [DATE] with diagnoses of major depressive disorder (mental health condition characterized by persistent low mood and deep sadness), anxiety disorder (mental health condition characterized by excessive and uncontrollable fear or worry that interferes with daily life), and obsessive compulsive disorder (mental health condition characterized by repetitive intrusive thoughts and urges to repeat certain behaviors). Review of the comprehensive assessment, dated 02/01/2026, showed Resident 2 was cognitively intact and was independent with transfers and mobility using a wheelchair or walker.Review of the facility incident log showed a Resident-to-Resident altercation incident occurred, on 04/20/2026 at 6:55 PM, between Resident 1 and Resident 2 in room [ROOM NUMBER].Review of the facility investigation for the above incident showed Resident 1 and Resident 2 were roommates in room [ROOM NUMBER], and the altercation started with verbal aggression from Resident 2 toward Resident 1 due to Resident 1's television volume. The verbal altercation escalated, Resident 2 ambulated over to Resident 1 who was laying in their bed and physically hit Resident 1 in the mouth. The investigation showed staff intervened, separated the residents, assessed for injuries, and notified local law enforcement.During an interview, on 05/01/2026 at 1:50 PM, Resident 2 stated they recalled hitting Resident 1 in the mouth because Resident 1 was mouthing off and dared me to hit them. Resident 2 stated they knew hitting other people was wrong, but sometimes their (Resident 2's) anxiety caused them to react aggressively. Resident 2 stated they usually just yell when their anxiety was out of control, but this time they (Resident 2) reacted physically. Resident 2 stated they felt they would be less triggered now that they had a private room and more personal space from others.During an interview, on 05/01/2026 at 2:15 PM, Resident 1 stated they were watching television in their room on the day of the altercation when Resident 2 became agitated and was yelling about the volume. Resident 1 stated they got tired of listening to them holler and said they (Resident 2) should do something about it. Resident 1 stated they saw Resident 2 walk over to the side of their bed and then Resident 2 hit Resident 1 on the left side of the face. Resident 1 stated they did not trust Resident 2 and was glad they moved to another room.During an interview, on 05/01/2026 at 4:10 PM, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	05/01/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Staff B, Director of Nursing, stated Resident 2 had a history of verbal outbursts when they were triggered by a lack of control in a situation, but had not seen it become physical until now. Staff B stated Resident 2 had been out of the facility earlier in the day for a medical procedure and was likely overstimulated and easily triggered. Staff B stated Resident 2's behavior was not acceptable.During an interview, on 05/01/2026 at 4:40 PM, Staff A, Operations Manager, stated resident abuse of any kind was not acceptable. Reference: WAC 388-97-0640 (1)