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	05/21/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure inventions were implmented to safeguard, protect, and prevent the elopement (an instance where a resident leaves the facility without authorization and/or necessary supervision) for 1 of 3 residents (Resident 1) reviewed for accidents and hazards. This deficient practice placed residents at risk for serious injury and the potential for future elopements.Findings included.Review of the facility policy titled Wandering and Elopements, revised in March 2019, showed residents who were identified as at risk for wandering or elopement would have strategies and interventions to maintain residents' safety on their care plan.Resident 1Review of the medical record showed Resident 1 admitted to the facility, on 01/08/2026, with diagnoses of severe dementia (a loss of memory, language, problem-solving, and other thinking abilities) with agitation (feeling of irritability or mental distress), anxiety (feeling of fear, dread, and uneasiness), and restlessness (the physical or mental inability to relax or sit still).Review of the Elopement Assessment, dated 01/12/2026, showed Resident 1 was a high risk for elopement due to wandering behaviors and cognitive impairment.Review of Resident 1's elopement care plan, initiated on 01/13/2026, showed interventions included placement of a Wander Guard (a device worn on the wrist that interacts with the Wander Guard alarm system installed at all exit doors to alert staff of a potential resident exiting the facility) on Resident 1 and for staff to check its functionality every shift.Review of the comprehensive assessment, dated 04/16/2026, showed Resident 1 had severe cognitive impairment, required set up for dressing, personal hygiene, toileting, eating, and was independent with ambulation.Review of the nursing Progress Note (PN), dated 05/09/2026 at 6:01 PM, showed Resident 1 had been wandering and exit seeking throughout the day, tried to follow families and go out while the door is open, and tried to go out multiple times (nursing assistants) NAs and nurses redirected them.Review of the facility's Incident Report Log for May 2026 showed Resident 1 had an incident of elopement on 05/09/2026 at 10:36 PM.Review of the facility investigation for the elopement incident on 05/09/2026 showed Resident 1 was last seen at 9:00 PM by evening shift staff and was noted to be unaccounted for by night shift staff at 10:30 PM. The investigation showed Resident 1 was located by local Law Enforcement (LE) walking east on Mountain View Avenue (the road the facility was located) and was returned to the facility at 11:01 PM.Review of the nursing PN, dated 05/09/2026 at 10:36 PM, showed Resident 1 was returned to the facility by local LE, was wet and cold, appeared (they) had fallen into a ditch, had a skin tear to right foot, and Wander Guard was in place to right arm and was functional.Review of the medical record, on 05/21/2026, showed Resident 1's Medication Administration Record (MARs) for May 2026 with documentation of their Wander Guard device as functioning and in place.On 05/21/2026 at 12:45 PM, an observation showed a drainage ditch that ran parallel to road between the facility parking lot and the sidewalk on Mountain View Avenue. The ditch had one-and-a-half feet of water and multiple areas of four-foot-tall grass-like brush growing in it.During an interview, on 05/21/2026 at 3:10 PM, Staff A, Administrator, stated the normal process was for the maintenance staff to test the Wander Guard alarms at all the exits weekly, but the Maintenance Director had been out on leave for the past four weeks. Staff A stated the facility had a temporary maintenance employee, but they were unsure if (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 - Minimal harm or potential for actual harm Residents Affected - Few	they had been doing the tests prior to the incident on 05/09/2026.During an interview, on 05/21/2026 at 3:30 PM, Staff B, Director of Nursing, stated staff were alerted to the front door frequently throughout the day due to several residents with Wander Guard devices wandering near the front door and the adjacent visiting area. Staff B stated it would have been difficult for staff to see if Resident 1 had exited the front doors or was in the parking lot due to the time of night the 05/09/2026 incident occurred.During an interview, on 05/21/2026 at 4:15 PM, Staff C, Registered Nurse (RN), stated they worked the night shift on 05/09/2026. Staff C stated the Wander Guard alarm at the front door would alarm frequently throughout the day when residents with Wander Guard devices came close to the doors. Staff C stated they were present when Resident 1 was discovered to be missing and there were no Wander Guard alarms activated at any of the facility exits. During a concurrent observation and interview, on 05/21/2026 at 4:30 PM, Staff B, Director of Nursing, demonstrated the Wander Guard system at all five facility exits, the notification panels in the East, West, South hallways and at the Nurse's Station. Staff B showed the Wander Guard exit door testing log for December 2024 and January 2025 and stated it was an example of the tool the Maintenance Director documented their weekly testing on. Staff B stated they were trying to locate the most current testing logs but had not found them yet. Current testing logs were not provided by the facility.Refence: WAC 388-97-1060 (3)(g)