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	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. The failure to consistently monitor kitchen refrigerator temperatures for 2 of 2 kitchen refrigerators, and the failure to ensure undated/expired foods were discarded for 1 of 1 nutritional refrigerator (resident snack refrigerator), placed residents at risk for ingestion of contaminated food or beverages, cross contamination, and potential of food borne illness. Findings included . Review of the Washington State Retail Food Code dated January 18th, 2023, showed Food must be protected from contamination by preparing and storing food as follows: In a clean, dry location, where it is not exposed to splash, dust, or other contamination. Records must be monitored to verify that the critical limits required for food safety are being met. Normal refrigerator temperature requirements are 41 degrees Fahrenheit to 45 degrees Fahrenheit. Review of the facility policy dated 08/01/2025, titled Resident Food from Outside Source showed Refrigerated food items from an outside source will be stored with the following information on it: Date product was brought in the facility Name of product Resident name and room number Refrigerated foods that are unlabeled or undated, when noted will be discarded. During observation and concurrent interview on 02/17/2026 at 9:32 AM, Staff U, Dietary Manager, acknowledged the inconsistent temperatures logged on the kitchen refrigerators. Staff U stated they had implemented a sign as a reminder for staff but can see they were still having trouble. During an observation on 02/18/2026 at 11:58 AM, the nutritional refrigerator located in the south hall contained unlabeled and expired foods. One opened jar of Tostito cheese with no date when opened, the manufacturers dated had been rubbed off. One opened jar of Marmalade jam, no open date on the jar. One large Ziplock bag that contained a peanut butter sandwich, ensure and cup of canned fruit in a bowl there were no dates on the contents in the bag or on the bag.ˆOne piece of a store-bought carrot cake with expiration/sell-by date of 1/23/26 (26 days past the sell-by date). During an observation and concurrent interview on 02/19/2026 at 8:40 AM, Staff V, Cook, stated they were aware the refrigerator logs had multiple days of no monitoring and they tried to remember to check the temperatures daily. Staff V stated it was important to monitor all temperatures to ensure the integrity of the food. Staff V stated as far as they know the kitchen staff were not responsible for cleaning that nutritional fridge. Staff V stated kitchen staff refill the nutritional refrigerator with the snacks. During an observation on 02/22/2026 at 3:12 PM, the nutritional refrigerator located in the south hall contained unlabeled and expired foods. One opened jar of Tostito cheese with no date when opened, the manufacturers dated had been rubbed off. One opened jar of Marmalade jam, no open date on the jar. One large Ziplock bag that contained a peanut butter sandwich, ensure and cup of canned fruit in a bowl there were no dates on the contents in the bag or on the bag.ˆOne piece of a store-bought carrot cake with expiration/sell-by date of 01/23/2026 (30 days past the sell-by date). ˆˆ During an interview on 02/22/2026 at 3:44 PM Staff A, Regional Nurse, stated that there was an expectation for the kitchen staff to ensure the nutritional fridge was stocked and cleaned. Staff A stated the food items were everyone's responsibility to ensure dates and names were placed on the food item to ensure staff were aware of when the items were brought into the facility.ˆ Reference: WAC 388-97-1100 (3)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 implement components of their infection prevention and control precautions regarding, A) the water management program (WMP) control measures (actions or steps taken), identified to reduce the potential growth/spread of Legionella (a bacteria that can cause a severe respiratory disease) in water, when not within acceptable ranges for 1 of 1 WMP reviewed for infection control and, B) respiratory devices were not cleaned/disinfected for 1 of 3 Residents (Resident 30), reviewed for respiratory care. This failure placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included .Review of the facility's policy titled, Legionella WMP, reviewed November 2025, showed that proactive steps were established to provide an .infection-free environments for their residents, staff and visitors . The policy showed the facility would identify water system areas/situation at risk or that could lead to legionella growth like, water storage tanks/filters, tubs, medical devices, presence of biofilm (a community of bacteria that stick together and to a surface forming a protective layer), water temperatures, areas of water stagnation (water that stops flowing for an extended period) or infrequently used equipment, ice machines, and ensure specific measures for maintenance/monitoring was completed. The WMP showed the monitoring of control measures were to be completed; monthly flushing of the hot water heaters and weekly temperature monitoring, monthly cleaning/disinfecting of ice machine with visual inspections for biofilm growth, flushing/cleaning/disinfecting of unused sinks/shower heads every 30 days for areas of water stagnation, cleaning/inspection of a resident Whirlpool bathtub when used, and weekly water temperatures throughout the facility. Additionally, the WMP showed that when control measures were not met for the facility's ice machine, the equipment would be taken .out of service, emptied and sanitized before returning back to service, and the facility's WMP was based on the Center for Disease Control and Prevention (CDC) toolkit. Review of the CDC toolkit titled, Developing a WMP to Reduce Legionella Growth and Spread in Buildings, updated 09/30/2025, showed a facility's WMP should identify areas or devices in the building where Legionella might grow or spread to people so the risk can be reduced. The toolkit showed that parts of a building water system that were a risk for spreading contaminated water included water storage tanks, water heaters, shower heads/hoses, ice machines, and infrequently used equipment like eye wash stations. Additionally, the toolkit showed that water stagnation encouraged biofilm growth, which can protect Legionella from heat/disinfectants and was common in water devices that went unused or infrequently used. Review of the control measures documentation presented by Staff C, Maintenance Director, on 02/20/2026 showed, The ice machine cleaning/disinfecting log had been completed monthly for every month in the year 2025, January 2026 and last completed on 02/10/2026. Additionally, the log showed that a deep cleaning of the ice machine was performed on 06/09/2025 and 12/11/2025. No documentation of monthly flushing of the facility's hot water heaters nor weekly monitoring of temperatures. No documentation for flushing, cleaning or monitoring of the facility's unused sink eye washing stations or whirlpool bath tube had been completed. Temperatures throughout different rooms in the facility had been completed weekly for January 2026 through February 2026, but no documentation showed for February 2025 through December 2025. During observations on 02/18/2026 at 11:58 AM and 02/19/2026 at 3:23 PM, showed multiple eye washing stations throughout the facility that had dirty, stained, partially broken labels with the last inspection date of May 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/19/2026 at 7:35 AM, Staff C, stated they were responsible for cleaning the one ice machine in the facility which was completed monthly and a deep clean was completed two times a year. Observations of the ice machine on 02/19/2026 at 1:48 PM, located in the east hallways dining room showed, that under the main lid of the ice bin was a slimy/wet, spotty, blackish/brown substance, resembling mold, interconnected in patches and noted on the underside of the ice bin's, white/plastic storage retainer plate (to secure or hold different items in place) which span five to six inches (a unit of measure) long by one to two inches wide. Additionally, the ice machine water filter was labeled with the date last changed of 03/24/2025. During an interview on 02/19/2026 at 1:52 PM, Staff C showed the control measures documentation and stated the ice machine was deep cleaned two times a year by the company that serviced the machine and that was also when the ice machines filter would be changed. Staff C stated they were the only staff in the facility that cleaned/disinfected the one ice machine. During a concurrent observation and interview on 02/19/2026 at 1:56 PM, Staff C and the surveyor observed the ice machine located on the east hallway. Staff C stated their process for cleaning and maintaining the ice machine was to check the digital display on the machine for errors, take out the ice from inside the bin and would then place the machine on an internal cycle that cleaned and disinfected itself, which was what Staff C completed on 02/10/2026. Staff C opened the ice machine's storage bins lid and noted the blackish/brown substance and stated the substance was not on the upper storage retainer plate before and that it needed to be .cleaned out . Staff C stated the blackish substance should not be there and that it might be in other parts of the ice machine which would require the staff to take off the upper panel of the ice machine to see. Additionally, after observing the ice machine water filters date of 03/24/2025 written on the filter, Staff C stated they were unaware of the filter not being changed for 10 months and 26 days and the company that serviced the ice machine should have changed it out the filter two times since that date, .they missed changing it out. After observing the ice machines current state, Staff C stated, I don't think that it's serious enough to shut it down, but would reassess after opening the ice machines top hatch further to see if more of the slimy blackish/brown substance was in that section of the ice machine as well. During an interview on 02/19/2026 at 2:12 PM, Staff W, Nursing Assistant (NA), stated they had just started their NA evening shift at 2:00 PM, and the facility had one ice machine in the east hallway dining room which was utilized to fill up other ice chest/coolers on each of the hallways throughout the facility. Additionally, Staff W stated the ice within the coolers was changed once every shift or three times a day. During a concurrent observation of the ice machine and interview on 02/19/2026 at 2:25 PM, Staff A, Regional Nurse, the brown slimy substance had the potential to be biofilm growth, the ice machine was not clean and needed to be disinfected. Staff A stated the facilities WMP legionella control measures would not be within acceptable ranges due to the current state of the ice machine and that Staff C should have taken the machine out of service so that residents were not served ice that could be contaminated. Staff A stated the correct process was not followed. During an interview on 02/19/2026 at 2:54 PM, Staff C stated they did not have documentation of the facility control measures for flushing/temperature monitoring of the hot water heaters, the flushing, cleaning/monitoring of unused sink eye washing stations or whirlpool bathtub, nor logs of the temperatures throughout the facility for 2025. Staff C stated they were aware of the eye washing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stations not being monitored or inspected since May 2024. Staff C stated the WMP control measures were not being monitored per the facility's process. Respiratory Devices Resident 30Review of the medical record showed Resident 30 admitted to the facility on [DATE] with diagnoses to include heart failure, obstructive sleep apnea (a chronic disorder where throat muscles relax excessively during sleep, causing the airway to close and breathing to repeatedly stop and start), and the need of assistance with personal care. The 01/11/2026 comprehensive assessment showed Resident 30's cognition was intact, they required a continuous positive airway pressure machine (CPAP, a machine that delivers pressurized air to keep the airway open when asleep by use of mask, and tubing) and required substantial assistance of one staff member for upper body dressing. During an observation and concurrent interview on 02/18/2026 at 11:00 AM, a CPAP machine was sitting on the right side of the Resident 30 on their nightstand. The undated mask and tubing were laid across the nightstand on top of the residents clothing, lotion and paperwork. Resident 30 stated they had not seen staff clean their mask or machine, but that the nurses on shift would place water in the machine before giving the mask to them when using their CPAP while. Review of the physician orders dated 07/05/2025, showed nursing staff were to Clean CPAP mask, tubing, and machine with soap & water, every week. Once a day every Thursday for weekly cleaning and to Check CPAP tubing daily prior to administration for damage/non-function. During an observation and concurrent interview on 02/22/2026 at 3:04 PM, Resident 30 was lying in bed watching television, their CPAP mask and tubing on the floor. The resident stated they have not had a change of mask or tubing; they were unsure if staff had cleaned the reservoir of the machine. During an interview and concurrent observation on 02/22/2026 at 3:12 PM, Staff H, Licensed Practical Nurse (LPN), acknowledged that Resident 30's CPAP mask was on the floor and stated the resident CPAP mask should not be on the floor. Staff H stated Resident 30's CPAP mask and tubing should be cleaned and, in a bag, when not in use to keep it clean for the resident's next use. Staff H stated the assigned nurse would place the CPAP mask on for the resident when they want to sleep, that nursing assistants do not place the masks. During an interview on 02/22/2026 at 3:44 PM, Staff A, Regional Nurse, stated the expectations were care be done for all residents, physician orders and resident care plans be followed. Reference: WAC 388-97-1320(1)(a)(2)(b)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review the facility failed to implement their abuse/neglect policies and procedures to identify allegations of neglect filed as grievances for 10 of 44 grievances from 12/01/2025 to 02/23/2026) reviewed for neglect allegations. The facility did not provide a thorough investigation into the allegations of neglect to determine if further action to protect the residents was required. The lack of recognizing allegations of neglect and taking appropriate action placed residents at risk for a deterioration in their physical and or mental health. Findings included. Review of Nursing Home Guidelines Prevention and protection, Incident Identification, Investigation, and Reporting The Purple Book dated October 2015 (sixth edition), showed the definition of neglect as; an individual or entity with a duty of care fails to provide goods and services that maintain resident's physical and mental health. Record review of the facility grievances from 12/01/2025 to 02/23/2026 showed ten grievances that were not identified as allegations of neglect and not provided a thorough investigation or follow up if indicated as required. 12/2/2025 Resident with risk of skin breakdown, was ignored by staff after requesting assistance for incontinent care. 12/2/2025 The resident was soaked through clothing with a puddle of urine under their wheelchair. Requested assistance four to five times but no assistance was given. 12/15/2025 A resident received no meal when going to dialysis. 12/16/2025 The facility neglected to get the resident to their surgical appointment which resulted in having to wait an additional three months to have surgery. 12/23/2025 Resident's husband requested help as wife was incontinent and did not receive timely assistance. 01/19/2026 Resident did not receive meal tray on four occasions. 01/31/2026 Concerns reported with frequency of wound care and handling of wound care supplies. 02/06/2026 Meal not sent with dialysis resident. 02/09/2026 Resident did not receive lunch meal and does not get assistance from staff with eating. 02/19/2026 resident wanted to get up for meal staff stated would return and assist them however never returned, resident remained in bed. During an interview on 02/18/2026 at 5:15 PM, Staff E, Social Services Director, stated they were the Grievance Officer and after reviewing the initial grievance would be sent to the appropriate department for follow up as indicated. Staff E further stated if the allegation was related to abuse or neglect, the process was to forward to the Director of Nursing to complete an investigation. In an interview on 02/20/2026 at 1:40 PM, Staff A, Regional Nurse, reviewed the grievances and stated the facility should have recognized the grievances as allegations of neglect. The expectation was to escalate allegations made on grievances to an incident investigation. Reference WAC 388-97-0540(2)(a)(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure investigations were completed and/or thorough for 3 of 5 residents (Resident 22, 4, and 52) reviewed abuse. The failure to initiate and complete thorough investigations placed residents at risk for unidentified accidents, abuse/neglect and serious injuries. ˆ Findings include . Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), all incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. A thorough investigation was a systematic collection of a review of evidence/information that describes and explains an event or a series of events to determine what occurred and make necessary changes to a resident's plan of care and services to prevent recurrence. The investigation should include the who, what, when, why and how, of the incident and establish a reasonable cause within 24 hours of the incident. Additionally, evidence of the investigation must be readily available to state licensing and certification staff and others according to their authority. ˆ Resident 22 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include dementia with agitation, anxiety, insomnia and need for assistance with personal care. The 12/18/2025 comprehensive assessment showed Resident 22 had moderately impaired cognition and required supervision/touch assistance of one staff member for walking distances of 10 feet (ft.) to 150 ft. During an observation on 02/19/2026 at 1:16 PM, Resident 22 was walking independently, to the East hallway and entered room [ROOM NUMBER]. ˆ During an observation on 02/20/2026 at 12:13 PM, Resident 22 was independently walking down the [NAME] hallway looking for their gold cup; the resident stated someone had taken it.ˆStaff J, Activities Director, offered to assist the resident and redirected them back to their room to find their cup. During an observation on 02/22/2026 at 3:07 PM, Resident 22 was sitting on a chair in the East hallway drinking from a covered cup. The resident stated they were doing well, but the person next to them was crazy and getting on their nerves. There was no other resident sitting next to Resident 22. During an interview on 02/22/2026 at 3:09 PM, Staff H, Licensed Practical Nurse, stated the resident had a history of delusions, always wandering and required supervision. Review of the facility's reporting log dated January 2026, showed Resident 22 was involved in a resident-to-resident altercation on 01/16/2026. Resident 22 entered room [ROOM NUMBER], Resident 52 grabbed Resident 22 by the wrist and escorted them out of their room into the East hallway, holding onto the resident until an unnamed staff member intervened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities investigation involving Resident 22 in a resident-to-resident altercation dated 01/16/2026 showed no witness statements to reflect a thorough investigation. Resident 4 Review of the resident's medical record showed they were admitted to the facility with diagnoses which included, diabetes (too much sugar in the blood), recent below the knee amputation and pulmonary fibrosis (scaring of lung tissue which makes it difficult to breathe). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact, had no memory deficits. The resident required total assist for showering and substantial staff assistance for transfers, mobility and dressing. During an interview on 02/17/2026 at 2:43 PM, Resident 4 stated they had a fall on Saturday 02/14/2026. The resident explained staff had assisted them to their wheelchair and placed them too close to the edge of the seat which caused them to slide out and onto the floor. The resident further stated they had not had a fall in a long time and wondered why no one had come to talk to them about the fall so they could tell them what had happened. Resident 4 stated they felt the nursing assistant who had transferred them to their wheelchair needed more training. Record review of a facility incident report dated 02/14/2026 at 1:10 PM documented the resident had slid out of their wheelchair while trying to maneuver in their room. The etiology of the fall was documented as related to the resident's behaviors of wandering and impulsiveness. Continued review of Resident 4's fall incident report showed no interviews with witnesses, or the resident. The resident's wheelchair was not assessed to ensure it was functioning properly and in good working order. Additionally, the residents' environment was not assessed for possible hazards that could be modified and mitigate the risk of additional falls. Review of Resident 4's progress notes from 02/14/2026 to 02/22/2026 showed no documentation of follow up on the fall or monitoring of the resident for possible residual injuries. Review of the care plan dated 11/10/2025 showed no documentation that the resident exhibited wandering or impulsive behavers as identified risks for the fall. During an interview on 02/20/2026 at 11:10 AM, Staff A, Regional Nurse stated that Resident' 4's incident report was not complete or thorough as it had no witness statements and did not adequately establish the cause of the fall. Staff A stated there should also have been alert charting in the resident's progress notes to monitor for further injuries after the fall. Resident 52 Review of the medical record showed the resident was admitted to the facility with diagnoses including heart failure and dementia (a decline in mental ability severe enough to interfere with daily life). The 12/21/2025 comprehensive assessment showed Resident 52's cognition was moderately impaired and required the assistance of one staff member for Activities of Daily Living (ADLs). Further review showed Resident 52 had no behavioral symptoms directed toward others. Review of the facility's reporting log, dated January 2026, showed Resident 52 was involved in a resident-to-resident altercation with Resident 22 on 01/16/2026. After Resident 22 entered room (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[ROOM NUMBER], Resident 52 grabbed Resident 22 by the wrist and escorted them out of their room into the East hallway. When an unnamed staff member intervened, Resident 52 attempted to bend the unnamed staff members wrist and threatened to punch them in the face. Review of the facility investigation of a resident-to-resident altercation involving resident 52, dated 01/16/2026 showed no evidence of a thorough investigation. The investigation lacked witness statements from staff members and interviews with other residents to determine the circumstances surrounding the incident. During an interview and observation on 02/19/2026 at 4:20 PM, Staff D, Resident Case Manager, stated they were unsure of any witness statements, and would have to speak to the Director of Nursing Services (DNS). Staff D stated the DNS or the Social Services Director (SSD) completed the investigations and would obtain witness statements for investigations. During an observation and interview on 02/20/2026 at 11:42 AM, Staff A, Regional Nurse, reviewed the facility incident report and acknowledged the investigation report as incomplete without witness statements. Reference: WAC 388-97-0640 (6)(a)(b)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of competent nursing staff to provide care and services for 4 of 4 residents (Residents 5, 2, 3, and 35) as evidenced by failures related to Resident Rights, Activities of Daily Living (ADLs), Quality of Care, and Prevention or Decrease in Range of Motion. Additionally, reports in the facility grievance logbook showed allegations of neglect in care and staff interviews provided additional evidence of insufficient staff. This failure placed residents at risk of not having their needs met and potential/actual negative outcomes to their physical and mental health. Review of the 2025 Facility Assessment, updated 01/13/2026, showed on Section A. Function and Mobility for Activities of Daily Living (ADL) excluding bathing which required assistance was 87% of the facility residents. Additionally, ADLs excluding bathing for residents who required maximal assistance of two plus staff was 45.8% of facility residents. Residents that required mobility assistance with contractures (a permanent shortening of the muscle or tendons that leads to stiffness and limits movement of a joint or body part.)F 550 Resident Rights related to Dignity The facility failed to provide an environment that enhanced and prompted a dignified lifestyle. Resident 5 On 02/19/2026 from 2:35 PM to 3:38 PM Resident 5 did not receive timely care for a bowel incontinence episode for 63 minutes despite having their call light on and requesting assistance multiple times. The resident was informed by staff that they had to wait until staff were available to assist them. Resident 5 stated they were embarrassed and upset at having to wait so long for assistance. F 677 Activities of Daily Living Care for Dependent Residents The facility failed to provide care for residents that required assistance in nail care and oral care. Resident 2 On 02/17/2026 at 10:48 AM Resident 2 was observed to have long yellowish jagged fingernails on their left hand. The lack of nail care resulted in harm to the resident's left hand as the un-cut fingernails dug into their left thumb causing injuries to the area. Resident 3 During an observation on 02/18/2026 at 9:07 AM, showed the resident in their room in bed. Their bottom teeth were yellow with a brownish grime substance on them. Additionally, they had foul smelling breath and dried cracked lips. Follow up observations on 02/19/2026 at 8:43 AM, 02/19/2026 at 2:09 PM and 02/22/2026 at 9:28 AM showed the resident with yellow teeth, dry cracked lips and foul breath. During an interview on 02/18/2026 at 9:30 AM an Anonymous Staff stated they did not have time to perform oral care for the residents. F 684 Quality of Care the facility failed to provide care that met professional standards. Resident 35 An observation on 02/18/2026 showed Resident 35 sitting in their wheelchair and their left fourth finger was bent at the knuckle in a fixed position. Review of the record showed the resident had experienced a fall on 07/28/2025 at 12:10 PM which resulted in a fracture to the left fourth finger. A splint was ordered on 08/01/2025 pending follow up with orthopedics. Review of Resident 35's medication administration record showed from 08/01/2025 to 08/26/2025 the resident?s left fourth finger was not put in a splint as ordered. Record review of clinic notes from an orthopedic clinic showed the resident's finger was healed in a tilted fixed state and would require surgery to correct. Additionally, the note showed the resident should have been seen earlier at the clinic as the outcome of surgery to fix the resident's finger could have been avoided. F 688 Prevent/Decrease in Range of Motion (ROM)/Mobility The facility failed to ensure staff provided care and services to maintain ROM and prevent contracture. Resident 2 In an observation on 02/17/2026 at 10:48 AM showed the resident lying in bed with their left hand in a clutched fixed position. It was also noted to have a strong odor related to the skin-on-skin contact of the fingers on the palm of the hand. Review of the care plan dated 12/04/2025 showed the resident was not receiving interventions to their left hand with no restorative nursing for splinting or range of motion program to avoid further decline in left hand mobility and worsening contractures. Grievance Logbook Record review of the facility grievance logbook showed five grievances filed by residents and families related to not receiving timely assistance to meet their basic care needs. 12/2/2025 Resident with (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of skin breakdown, was ignored by staff after requesting assistance for incontinent care. 12/2/2025 The resident was soaked through clothing with a puddle of urine under their wheelchair. Requested assistance four to five times but no assistance was given. 12/23/2025 Resident's husband requested help as wife was incontinent and did not receive timely assistance. 02/09/2026 Resident did not receive lunch meal and did not get assistance from staff with eating. 02/19/2026 resident wanted to get up for meal staff stated would return and assist them however never returned, resident remained in bed. Staff Interviews During an interview on 02/18/2026 at 11:47 AM with an anonymous caregiver stated there was not enough staff to provide even basic care for the residents. The caregiver further stated they had reported their concerns related to inadequate staffing however nothing gets done about it. During an interview on 02/22/2026 at 10:06 AM, Staff Z, Nursing Assistant, stated they were alone on the East Hall from 6:00 AM to 8:00 AM because we do not have enough staffing. Saff Z stated they were supposed to provide quality care to the residents but were not able to, related to a pattern of not having sufficient staffing. It is not fair to . the residents. Record review of the day shift daily staffing sheet for the East Hall on 02/22/2026 showed Staff Z had worked alone from 8:00 AM to 10:00 AM and was responsible for providing care to 23 residents. Reference WAC 388-97-1080(1), 1090(1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable and sanitary environment was maintained for 8 of 12 resident rooms (Rooms 3, 4, 5, 6, 9, 18, 21 and 25), 1 of 1 utility room (East hallway) and 1 of 1 kitchen reviewed for environment. This failure placed the residents at risk for potential accidents and not feeling safe/secure with their environment. Findings included . Rooms room [ROOM NUMBER]: observation on 02/23/2026 at 11:15 AM, showed the bathroom door had an area measuring 2 1/2 feet (a unit of measure) by 10 inches (a unit of measure) where the paneling had been removed, exposing bare wood. room [ROOM NUMBER]: observation on 02/17/2026 at 10:27 AM, showed a five-foot scratch extending down the wall to the left of the entry. Multiple areas of paint were missing, and the drywall was exposed. room [ROOM NUMBER]: observation on 02/17/2026 at 10:27 AM, showed a six-foot area of the wall to the left of the entrance missing paint. A metal plate located mid-wall near the floor was pulled away from the surface, leaving sharp edges exposed. The bathroom walls were observed with missing chunks of drywall, exposing the underlying structure. room [ROOM NUMBER] (Bed A): observation on 02/23/2026 at 11:15 AM, showed multiple deep scratches and chipped paint on the wall adjacent to the left side of the bed, leaving the drywall exposed. The bathroom wall surrounding the grab bar was observed with large sections of missing drywall. room [ROOM NUMBER]: observations on 02/17/2026 at 10:55 AM and on 12/18/2026 at 1:13 PM, showed a metal plate located mid-wall near the floor with the corners pulled away from the wall, leaving sharp edges exposed. room [ROOM NUMBER] (Bed B): observation on 02/17/2026 at 1:43 PM, showed a wall on the right side of Bed B had chipped paint, multiple deep gouges with drywall exposed. room [ROOM NUMBER]: observation on 02/17/2026 at 2:34 PM, showed a metal plate located mid-wall near the floor with the corners pulled away from the wall, leaving sharp edges exposed room [ROOM NUMBER] (Bed A): observation on 02/17/2026 at 3:27 PM, showed the room door with multiple scratches leaving splintered wood pieces on the front and back of the door. Closet A had no closet door, clothing protruding out of the closet. The back wall by Bed A had multiple chips of paint and exposed drywall. Utility Room (East Hall) Observation on 02/17/2026 at 10:58 AM, Showed multiple dirty commodes stored from the entry to the back of the room, leaving insufficient space to walk or maneuver. Multiple basins containing yellow and brown substances were observed on the counters and within both the clean and dirty sides of the sinks. The area surrounding the sink faucets were covered in yellow and brownish (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substances and there was a strong odor of urine. Kitchen During observation and concurrent interview on 02/17/2026 at 9:32 AM, Staff Dietary Manager, acknowledged the ceiling pipes, and the osculating fan had built up of black dirt and dust. Staff U stated they had cleaned the fan the week prior. Staff U stated they were unsure when the last time the ceiling pipes and floors were cleaned. Staff U stated they had stepped into the position three months prior and that kitchen staff completed routine cleaning, but understood maintenance completed the deep cleaning of the kitchen. During an observation and concurrent interview on 02/19/2026 at 12:00 PM, Staff Y, Registered Dietician, acknowledged the kitchen floors dark black/brown grout and missing floor tiles that exposed the concrete underneath. Staff Y stated with the management turnover they were not sure when the kitchen floors were last cleaned. Staff Y stated the flooring had been missing for two years; maintenance began to work on it then stopped, and unsure why. During an interview and concurrent observation on 02/20/2026 at 2:18 PM, Staff C, Maintenance Director, stated they did rounds of the facility and checked on the rooms weekly. Staff C stated all staff communicated any needed repairs for resident rooms verbally and used TELS (an electronic facility system designed for maintenance request). Staff C acknowledged the metal plates and stated they were working on a request to have them removed from the rooms. Staff C stated they did not have a repair schedule for the residents' rooms as it was difficult with a high census. Staff C stated they had no schedule to clean the ceiling pipes/ vents nor the deep cleaning of kitchen floors, as maintenance department was not responsible. During an interview on 02/22/2026 at 3:44 PM, Staff A, Regional Nurse, stated they were aware of the environmental issues of the building. Staff C stated maintenance was also aware and would be working on the facility. Staff A stated the deep cleaning of the kitchen was the responsibility of the maintenance department. Reference: WAC 388-97-3220 (1)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who required assistance with incontinence received timely care to maintain their dignity for 1 of 2 residents (Resident 11) reviewed for dignity. Resident 11 requested assistance with an incontinence episode however staff told them they would have to wait until other staff were available to help them. This failure placed the resident at risk for unmet care needs, embarrassment, potential skin injuries and a deterioration in their quality of life. Findings included . Record review of a facility document given to residents on admission to the facility titled [NAME] Specific Residents Rights stated, the nursing home must protect the rights of the resident to have a dignified existence and promote and protect their rights. Resident 11Review of the resident's medical record showed the resident was admitted to the facility with diagnoses which included heart failure (the heart is unable to keep up with needs of the body), chronic obstructed pulmonary disease (an incurable lung disease that causes breathing difficulty) and diabetes (high blood sugar). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact, was incontinent of bowel and bladder, and required total assistance for incontinent care. During an observation and concurrent interview on 02/22/2026 at 2:35 PM showed Resident 11's call light on over the door of their room. The resident stated they needed assistance as they had a bowel movement and had been waiting for a while. On 02/22/2026 at 2:38 PM Resident 11's concern and request for assistance was reported to Staff N, Licensed Practical Nurse, who was standing in the hall at a medication cart several doors down from Resident 11's room. Staff N stated they would take care of it. During an observation on 02/22/2026 at 2:58 PM showed Resident 11's call light still on. Resident 11 stated that Staff L, Nursing Assistant (NA), came into the room and told them they would have to wait for assistance until other staff were available to help them. During an observation 02/22/2026 at 3:38 PM, showed Staff L, going into the resident's room with Staff M, NA, to assist Resident 11 with their bowel incontinence care (63 minutes after the resident had requested help). During a interview on 02/22/2026 at 3:52 PM, Resident 11 stated they felt very embarrassed and upset because they had to wait so long for incontinent care. In an interview on 02/23/2026 at 10:20 AM, Staff B, Director of Nursing Services, stated it was not appropriate for staff to have left Resident 11 laying in their bowel movement. Additionally, Staff B stated their expectation was for staff to assist residents with incontinent care in a timely manner. Reference WAC 388-97-0180(1)-(4)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide required liability notices for 1 of 3 residents (Resident 78) reviewed for liability notices. Failure of the facility to issue a Notification of Medicare Non-Coverage [NOMNC] or Advanced Beneficiary Notice [ABN] (required notifications informing Medicare beneficiaries that their covered services will be terminated and providing information on their appeal rights) before discharge from the facility placed Resident 78 at risk for not fully understanding their Medicare benefits and appeal rights. Findings included. Resident 78Review of the resident's medical records showed they admitted to the facility on [DATE] with diagnosis of a surgical repair to their left lower leg. Review of the 09/19/2025 discharge assessment showed Resident 78's cognition was intact. Review of Resident 78's Medicare documentation showed Resident 78 was not issued NOMNC or ABN notifications prior to their discharge from covered services on 09/29/2025. During an interview on 02/20/2026 at 3:03 PM, Staff A, Regional Nurse, stated they reviewed Resident 78's medical records and the notifications had been missed all together, and not given to the resident prior to their discharge on [DATE]. Reference: WAC 388-97-0300 (1)(e)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident grievances were promptly followed up on by coming to a resolution of the grievance for 2 of 5 residents (Residents 5 and 4) reviewed for grievances. Additionally, the facility did not keep the residents updated on the progress of their grievances. This failure placed residents at risk for overall dissatisfaction with their lives and unresolved concerns. Findings included . Record review of a facility policy titled Grievances dated 08/2024 showed, each resident has the right to voice concerns/grievances. The facility will actively seek a resolution to concerns and keep residents updated on the progress. Resident 5 Review of the resident's medical record showed the resident was admitted to the facility with diagnoses which included heart failure (the heart can no longer keep up with the needs of the body), end stage renal disease with dialysis (the kidneys no longer work and require a machine to remove waste from the blood) and diabetes (too much sugar in the blood). Review of the comprehensive assessment dated [DATE] showed Resident 5 was cognitively intact and was dependent on staff for transfers and mobility. Additionally, the resident required substantial assistance for dressing and showers. During an interview on 02/17/2026 at 8:36 AM, Resident 5 stated they did not fill out grievances anymore because no one will follow up on them. The resident stated they had filed a grievance related to not getting enough food when traveling to and from dialysis. They were unable to receive services at the local center therefore had to travel a long way to an alternate center for dialysis services. The resident stated they got really hungry and had requested from the kitchen additional sandwiches to be sent with them instead of just one. Resident 5 stated after filling out the grievance they were approached by Staff B, Director of Nursing, and Staff U, Dietary Manager. Staff B and Staff U had informed them they would only get ?one sandwich, one fruit and one drink to take with them to dialysis.' The resident stated they would not let me explain or listen to me as to why they were requesting additional sandwiches because of the long ride to and from the dialysis center. Record review of a grievance form dated 02/06/2026 showed Resident 5 had filed a grievance related to not getting the sandwiches they had requested from the kitchen for when traveling to and from dialysis. The written follow-up, which was signed by Staff B and Staff U, stated ?met with resident and informed of what they can and can't have.' There was no resolution to Resident 5's concern and the outcome was documented as ?the resident will only receive one sandwich, fruit and a drink, when traveling to dialysis.' During a follow up interview on 02/19/2026 at 8:35 AM Resident 5 stated they did not feel their grievance had been resolved related to their request and were discouraged from filing any additional grievances. Resident 4 Record review of the resident's medical record showed they were admitted to the facility with diagnoses which included diabetes and pulmonary fibrosis (a disease of the lungs when the tissue becomes scarred and damaged). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact, required total assistance for toileting and showers with substantial assistance for dressing. In an interview on 02/17/2026 at 2:34 PM, Resident 4 stated they had filed a grievance related to their meal trays coming out later than usual. Resident 5 stated they had filed the grievance for the whole hall because it had affected all the residents on the south hall who ate in their rooms and some of them had a diagnosis of diabetes and needed to eat earlier to keep their blood sugars stable. The resident further stated it had upset them because no one had explained or asked any of the residents if they wanted a change in their mealtimes. Record review of a grievance form filed by Resident 4 on 12/13/2025 showed the in-room mealtimes had been changed and the residents were receiving their meals approximately one hour later than usual. The grievance form was signed by the dietary department stating ?nursing sets the order of the trays and nursing was responsible to follow up on the concern. Further review showed the form had no additional follow-up comments or actions by the nursing department. In an interview (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 02/22/2026 at 10:26 AM Resident 4 stated I still haven't heard anything back about my grievance on late mealtimes. During an interview on 02/20/2026 at 1:40 PM, Staff A, Regional Nurse, stated their expectation was for resident grievances to be appropriately followed up on to resident satisfaction and residents made aware of the outcome. WAC 388-97-0460(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic (drugs that change brain chemistry to alter a person's mood, thoughts, behavior, or perceptions) medications when they did not consistently attempt non-pharmacological (non-drug, strategies used first to manage mental health symptoms) interventions prior to medication use and failed to adhere to the 14-day limitation for PRN (as needed) psychotropic medications for 1 of 5 residents (Resident 35), reviewed for unnecessary medication. This failure placed residents at an increased risk for falls, medication-related adverse side effects, and unmet care needs. Findings included. Review of the policy titled, Psychotropic Medication, dated 08/01/2025, showed that non-pharmacological interventions would be attempted and documented prior to the use of any PRN psychotropic medication. Orders for such medications would expire in 14 days and would require an in-person assessment by a medical provider, along with supporting documentation, for the order to continue for an additional 14 days. Additionally, any continued use beyond that period would require a physician's justification for a specific timeframe. Review of the medical record showed the resident was admitted to the facility with diagnoses including Parkinson's disease (a condition where the brain gradually loses the ability to control movement properly), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities that were once enjoyable) and panic disorder (where a person experiences recurrent panic attacks) . The 01/03/2026 comprehensive assessment showed Resident 35's cognition was severely impaired and required the assistance of one-two staff members for Activities of Daily Living (ADLs). Further review showed Resident 35 received antianxiety (a class of drugs used to treat symptoms of anxiety, such as feelings of fear, dread and uneasiness) medication. Review of a physician's order dated 01/02/2026 showed an order for an antianxiety medication to be administered every 24 hours PRN. Review of an order dated 01/21/2026, 19 days after the initial antianxiety medication order, showed instructions to monitor behaviors and to attempt non-pharmacological interventions. Review of the January and February 2026 Medication Administration Records (MAR) showed the PRN antianxiety medication was administered on six occasions in January 2026 and six occasions in February 2026, for a total of 12 administrations with no documentation to indicate that non-pharmacological interventions were attempted or utilized prior to any of the 12 administrations. Review of the physician's orders dated 02/11/2026 showed that the PRN antianxiety medication remained active through February 2026. Further review showed the PRN order was written for 30 days and not limited to 14 days; additionally, there was no documented clinical rationale provided by the practitioner to extend the medication beyond the 14-day regulatory limit. During an interview on 02/22/206 at 12:22 PM, Staff A, Regional Nurse, stated they would expect to see documentation in the Medical Record regarding behaviors and non-pharmacological interventions, or at the very least, a resident's refusal of such interventions prior to the administration of a PRN psychotropic medication. Staff A further stated that for any PRN psychotropic medication lasting longer than 14 days, there should be clear documentation from the physician providing clinical justification for the medication and the extended duration. Reference WAC: 388-97-0620 (1)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent showers, incontinent care, oral care, and nail care for 2 of 5 residents (Residents 2 and 3) reviewed for activities of daily living (ADL). The failure to receive adequate showering and grooming care according to the residents' physician orders and care plan placed the residents at risk for unmet care needs, impaired skin integrity, and a potential decline in health. Findings included.Review of the facility's policy titled Activities of Daily Living (ADL), Supporting, revised date March 2018, showed appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, mobility, elimination, dining and communication. Resident 2 Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including stroke (a loss of blood flow to part of the brain), hemiplegia (severe or total loss of motor function on one side of the body) of the left side, dementia (loss of memory, thinking and the ability to perform daily activities), and need for assistance with personal care. Review of Resident 2's comprehensive assessment dated [DATE], showed the resident had severe cognitive impairment, and was dependent on staff for showering, grooming care, and transfers. Review of Resident 2's physician orders dated 11/19/2025 showed the Licensed Nurse was to check the resident's fingernails and toenails once a week on bath day, trim as needed. Further review of the physician orders showed Resident 2 had weekly skin checks. Review of the nurses' January 2026 treatment administration record (TAR, nurses' documentation of care and treatments given to residents) showed documentation on 01/07/2026, 01/14/2026, 01/21/2026 and 01/28/2026 Resident 2's nail trim was not needed, and they did not have any new skin impairment. Review of the nurses' February 2026 TAR showed documentation on 02/04/2026, 02/11/2026, and 02/18/2026 Resident 2's nail trim was not needed, and they did not have any new skin impairment. Review of Resident 2's January 2026 Nursing Assistant (NA) task flow sheet (nursing assistant documentation of care given to residents) showed the resident had received only one shower that was documented on 01/06/2026. Review of Resident 2's February 2026 task flow sheet showed the resident went six days without a shower. During an observation on 02/17/2026 at 10:48 AM, Resident 2 was lying in bed, kicking their legs up and down in the air, yelling out verbiage difficult to understand. The resident was unshaven with long chin hair; their left hand was in a clutched position. Resident 2 had a foul odor to their left hand; their fingernails were long, jagged, yellow in color. The resident's index and middle fingernails were imbedded (firmly and deeply in a surrounding mass) into their thumb with redness, and scabbing surrounding the fingernails in the thumb. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent observation on 02/19/2026 at 1:27 PM Staff P, NA, stated Resident 2 yelled out but had never been aggressive with staff. Staff P stated the resident was cooperative with their care. Staff P lifted the resident's left hand from underneath their blanket, the resident's left hand had a washcloth within their clutched fist. Resident 2 had long, yellow, jagged fingernails to their left hand, their index and middle fingernails were imbedded in their thumb. Staff P stated they were unsure how the washcloth was placed in the resident's left hand, that they had not been instructed to do that for the resident. During an observation and concurrent interview on 02/22/2026 at 10:36 AM, with Staff B, Director of Nursing Services (DNS), of Resident 2's left hand. The resident had a washcloth in their clutched fist; there was a foul odor as Staff B lifted their left hand up to assess it. Resident 2 had long fingernails, jagged, yellow in color that were imbedded into their thumb creating reddened indentations and abrasions. Resident 2 had moved to pull their hand away from Staff B with a grimace on their face when their fingernails were pulled out of their thumb. Staff B asked Resident 2 if they had pain when they removed their fingernails from their thumb, the resident had a blank stare and a frown on their face. Staff B lifted the resident's index and middle finger away from their thumb, there were two areas to the thumb. The first area near the second joint of the thumb had an open red area with scabs, the second area near the first joint of the thumb had redness and deep indentation. Staff B stated yes, the fingernails are causing those areas. Staff B stated the resident's fingernails needed to be trimmed, immediately grabbed supplies and trimmed the resident's fingernails. Resident 3 Review of the resident's medical record showed they were admitted to the facility with diagnoses which included history of a stroke (blood flow is cut off from a part of the brain), dementia and diabetes (high blood sugar). Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and required total assistance from staff for all daily care activities. Review of the resident's care plan dated 11/10/2025 showed the resident was to receive daily oral care including applying ointment to their mouth to avoid dry cracked lips. During an observation on 02/18/2026 at 9:07 AM, showed Resident 3 in bed lying on their back. Their lower teeth were yellow with brown colored grime on them, and their lips were dry and cracked. Additionally, their breath had a strong foul odor. In an interview on 02/18/2026 at 9:30 AM an anonymous nursing assistant (NA) stated they were often unable to brush the resident's teeth or provide oral care as they did not have time. During additional observations on 02/19/2026 at 8:43 AM, 02/20/2026 at 8:43 AM, 02/20/2026 at 2:09 PM and 02/22/2026 at 9:28 AM, showed the resident's bottom teeth were still yellow with brown grime, foul breath and dry cracked lips. During an interview on 02/22/2026 at 3:44 PM, Staff A, Regional Nurse, stated that the expectation of staff was that resident care was completed such as brushing teeth, bathing, nail care, and repositioning. Staff A stated the expectation was that nursing staff followed all physician orders and resident care plans. Reference: WAC 388-97-1060 (2) (C)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary care and services to maintain their highest practicable physical well-being in accordance with professional standards of care by failing to ensure proper immobilization, and failing to consistently follow physician's orders to oversee the healing process for 1 of 3 resident (Resident 35) reviewed for falls with injury. This failure placed Resident 35 at risk for further injury, impaired healing, and a decline in range of motion (ROM). Findings included. Review of the medical record showed the resident was admitted to the facility with diagnoses including Parkinson's disease (a condition where the brain gradually loses the ability to control movement properly). The 01/03/2026 comprehensive assessment showed Resident 35's cognition was severely impaired and required the assistance of one-two staff members for Activities of Daily Living. Further review of the comprehensive assessment showed Resident 35 had no impairment with their ROM to their upper extremity (hand). During an observation on 02/18/2026 at 9:21 AM, Resident 35 was seated in their wheelchair. Resident 35's left fourth finger was bent at the knuckle in a fixed position. When prompted, Resident 35 was unable to move the finger. During an interview on 02/18/2026 at 9:07 AM, Resident Representative (RR) stated Resident 35 had fallen from their bed, their left arm was trapped underneath them. The RR stated they had to request an x-ray related to Resident 35 complaining of pain to the left hand. The RR stated that Resident 35 sustained a fracture to their left ring finger. The RR further stated they noticed the finger was not healing correctly, which required them to contact the Orthopedic (a medical specialist who focuses on treating injuries of the musculoskeletal system) clinic to schedule an appointment and transport the resident there. The RR stated the Orthopedist was unable to fix the finger because it had healed incorrectly and would require surgery to repair. The RR further stated after discussion with family members they declined the surgery related to the risk factor. Additionally, the RR stated they had noticed a decline in Resident 35's functional ability to the left hand since the fall. Record review of a facility investigation dated 07/28/2025 at 12:10 PM, showed Resident 35 was found on the floor next to their bed lying on their left side. Review of a progress note dated 07/28/2025 at 7:49 PM, showed the provider was contacted to obtain an x-ray per the RR's request. The provider was also updated regarding the finger being swollen with purple discoloration. Order for x-ray was given. Review of a progress note dated 07/29/2025 showed the RR was notified of x-ray results that showed Resident 35's left fourth finger was fractured. Review of a progress note dated 07/31/2025 at 2:36 PM, showed Resident 35 would have a temporary splint placed until a new one arrived. Review of the physician visit dated 08/01/2025 showed an order for splint placement to left fourth finger. Review of the July and August 2025 Medication Administration record (MAR) showed an order to monitor placement of finger splint to left hand every shift. Further review of the MAR from 7/30/2025 to 8/26/2025 showed there were 21 shifts, the splint was not on Resident 35's left fourth finger. Additionally, there were six shifts where no charting was completed to verify placement of the splint. During an interview on 02/19/2026 at 10:54 AM, Staff S, Licensed Practical Nurse, stated they applied a makeshift splint on 07/28/2025. Staff S stated they ordered a splint online. Staff S reported that once the new splint arrived there were specific instructions for correct placement and the components required for use. Staff S stated the splint was frequently placed incorrectly and components required for the back of the finger went missing, rendering the splint ineffective even though nursing staff had been educated on proper placement. Staff S further stated they had updated Staff B, Director of Nursing Services (DNS), regarding these issues, specifically the inaccurate splinting and the finger becoming fixed in position. Review of an office clinical note dated 08/26/2025 (29 days after the fracture was identified) from Kittitas Orthopedics showed Resident 35's left hand had obvious significant deformity of the fourth finger. Further review showed the finger had healed angulated (something that is bent, tilted, or angled away from its normal straight line or position) following the fracture sustained from the 07/28/2025 fall. Additionally, the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orthopedist recommended Resident 35 undergo surgical intervention to correct the deformity. During an interview on 02/19/2026 at 1:41 PM, Collateral Contact (CC1) associated with Orthopedics provider, stated if Resident 35 had been seen earlier the finger would not have been fixed and possibly would not have required surgical intervention. During an interview on 02/22/2026 at 12:22 PM, Staff B, DNS, stated that the facility should try to find something appropriate for the fracture, notify the physician, and obtain an order to see a specialist to prevent the least amount of damage. Staff B stated Resident 35 should have been sent to Orthopedics to weigh the risks and benefits of treatment. Staff B further admitted that a timely consultation may have helped prevent the contracture. Reference WAC: 388-97-1060 (1)(3)(d)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure care and services were provided for 1 of 4 residents (Resident 2) reviewed for positioning. There were no assessments, specific interventions to mitigate the risk of contractures (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) or Restorative nursing for Range of Motion (ROM) services to prevent further decrease in range of motion and hand contracture. This failure placed the residents at risk for a decrease in mobility, development/worsening of contractures and inability to maintain their current level of functioning. Findings included. Resident 2 Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including hemiplegia (severe or total loss of motor function on one side of the body) of the left side, dementia (loss of memory, thinking and the ability to perform daily activities), and need for assistance with care. Review of Resident 2's comprehensive assessment dated [DATE], showed the resident had severe cognitive impairment, and functional limitation of the upper and lower extremity on one side. Review of Resident 2's care plan dated 12/04/2025, showed no care plan had been developed for Resident 2's left hemiplegia to prevent further decrease in ROM, mobility and /or development of contractures. During an observation on 02/17/2026 at 10:48 AM, Resident 2 was lying in bed, their left hand in a clutched position with nothing in their hand to prevent contact between skin and fingernails. There was a strong foul odor to Resident 2's left hand. During an interview and concurrent observation on 02/19/2026 at 1:27 PM, Staff P, Nursing Assistant (NA), stated Resident 2 was cooperative with their care. Staff P lifted the resident's left hand from underneath their blanket. Resident 2's left hand had a washcloth within their clutched fist. Staff P stated they were unsure how the washcloth was placed in the resident's left hand, that they had not been instructed to do that for the resident. In an interview on 02/19/2026 at 2:12 PM, Staff I, Restorative Nursing Assistant (RA), stated Resident 2 was on a restorative program for meals. Staff I stated they did not have a restorative program for ROM for Resident 2 nor placed a device on their left hand. In an interview on 02/20/2026 at 11:04 AM, Staff G, Director of Rehab, stated they wrote restorative programs for the facility residents. Staff G stated the restorative program was run by the nursing department and overseen by Staff B, Director of Nursing Services (DNS) and Staff D, Resident Care Manager (RCM). Staff G stated their tracking system had been streamlined on the computer and the orders for the residents' restorative programs went directly to the nursing department for processing. Staff G stated when they were alerted to a residents' decline in mobility/function, they address the resident's decline with the nursing department and obtain orders for evaluations. Staff G stated they reevaluated residents' when decline in mobility/function was identified. Staff G stated they would then re-write the restorative program after they evaluated the resident to address their needs. Staff G stated they were not aware that Resident 2 had a contracture and should have been notified by the nursing staff. In an interview on 02/20/2026 at 11:30 AM, Staff D, RCM stated they and the DNS oversaw the restorative program. Staff D stated they met once a month with the RA's who provided the program, discussed residents on the program, the refusals and resident who were unable to perform a certain task. Staff D stated for a contracture, first thing they would obtain was a referral for therapy to evaluate the resident. Staff D stated they were not aware of Resident 2's left hand contracture. Staff D reviewed the resident's care plan to verify the resident had a restorative program and acknowledged the resident did not have a care plan specifically for ROM to their left hand. In an interview on 02/22/2026 at 2:46 PM, Staff B, DNS, stated the RA program was new and just implemented a binder with all resident programs. Staff B acknowledged Resident 2 was on a RA program for meals but not range of motion. In an interview on 02/22/2026 at 3:44 PM, Staff A, Regional Nurse, stated the expectations were that staff follow the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans as they delivered the care as ordered, monitor the residents for decline/deficits and document all care done for all residents. Reference: WAC 388-97-1060 (3)(d) This a repeat citation

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure drugs and biologicals were stored, labeled, and monitored in accordance with professional standards. The facility failed to discard expired or improperly labeled medications on one of three medication carts (East medication cart) and failed to document twice-daily temperature monitoring for 1 of 1 medication refrigerator in medication storage room. These failures placed residents at risk for receiving compromised or ineffective medications and vaccines and negative health outcomes.Review of the Centers of Disease Control and Prevention guidance titled, Vaccine Storage and Handling, dated 04/03/2024, showed to ensure safety of vaccines, the refrigerator must have a reliable temperature monitoring device with the recommended use of a recording device called a digital date logger (DDL-a device that records temperatures at least every 30 minutes). The guidance further showed when a DDL was not used, the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. A review of the temperature logs from 02/01/2026 through 02/16/2026 showed the temperature was being checked once daily on the NOC (night) shift. At the time of the survey, the refrigerator contained the following improperly monitored biologicals: Three vials of Apisol (solution used for tuberculosis sensitivity test) Nine boxes of Fluzone Quadrivalent (a vaccination designed to protect you from the influenza virus), containing 10 single-dose vials per box (Totaling 90 doses). Two vials of Arexvy (a vaccination that helps your body's immune system learn how to fight off the Respiratory Syncytial Virus (RSV- a serious lung infection). During an interview on 02/22/2026 at 12:22 PM, Staff A, Regional Nurse, stated that per regulations, the medication refrigerator must be monitored twice daily if vaccinations are stored within it. Staff A acknowledged this monitoring was not being performed. East medication cart During an observation and concurrent interview on 02/22/2026 at 9:24 AM, with Staff N, Licensed Practical Nurse (LPN), stated they were unsure of when the medication cart had been last audited, they monitored the expiration dates when administering the medications. An observation of the East medication cart on 02/22/2026 at 9:24 AM, showed as follows: 1 bottle of Nitroglycerin (a medication used to treat chest pain) tabs the label was worn off, unable to determine who the medication was for, when it was delivered and when the medication expired. 2 Lantus (a brand of insulin used to control sugar in the blood) insulin pens without a date to show when the medication had been removed from the refrigerator and opened. 1 lispro (a brand of insulin used to control sugar in the blood) insulin pen without a date to show when the medication had been removed from the refrigerator and opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 box of Ferrous sulfate (iron supplement) with an expiration date of 12/2023, there was no label on the box to show who the medication it was, and within the box multiple cards of different medications such as 4 cards (32 tablets) of Ferrous fumarate (iron supplement) 324mg, 4 tablets on a card of anti-diarrhea 2mg, 2 cards (16 tablets) of guaifenesin (cough expectorant medication) 600mg/30mg, and 2 cards (16 tabs) of Ferrous Glutamate (iron supplement). During an interview on 02/22/2026 at 09:30 Staff N, LPN stated the insulin should be dated because the medications were only good for 28-30 days when out of the refrigerator. Staff N acknowledged the box was filled with different medications and stated they did not realize the box had all different medications within it and should be destroyed. During an interview on 02/22/2026 at 9:42 AM Staff B, Director of Nursing Services, stated their central supply staff completed audits on the medication carts, and the pharmacy had just audited the medications carts a month ago. Staff B stated the expectation was that the nurses review dates and ensure insulins are dated when opened. Reference: WAC 388-97-1300 (2)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure routine and timely dental services were provided and failed to follow through on practitioner-ordered referrals for 3 of 5 residents (Resident 52, 53 and 41) reviewed for dental care. This failure placed the residents at risk for dental pain, nutritional compromise and unmet dental needs. Findings included. Resident 52 Review of the medical record showed the resident was admitted to the facility with diagnoses including heart failure and dementia (a decline in brain functions severe enough to interfere with daily life). The 12/21/2025 comprehensive assessment showed Resident 52 cognition was moderately impaired and required the assistance of one staff member for Activities of Daily Living (ADL)s. During an interview on 02/17/2026 at 10:49 AM, Resident 52 stated they wanted to go to the dentist because they had one tooth in the back on the right side that was worn out. Resident 52 stated they had not seen a dentist since their admission to the facility on [DATE]. During an interview on 02/20/2026 at 10:05 AM, Staff D, Resident Case Manager (RCM), stated the correct process was for all residents to be added to the dental list (the facility's internal tracking system used to ensure all residents receive dental care) upon admission. Staff D stated Resident 52 had not been added to the dental list upon admission and had not seen a dentist while at the facility. Resident 53 Review of the medical record showed the resident was admitted to the facility with diagnoses including heart failure. The 12/21/2025 comprehensive assessment showed Resident 53 cognition was moderately impaired and required the assistance of one staff member for ADLs. Additionally, the assessment showed Resident 53 had upper dentures. Review of a dental encounter sheet dated 12/04/2025, showed a referral for new upper dentures. Review of a progress note dated 01/21/2026, showed Resident 53 returned from an appointment with the denturist with a request for additional paperwork to start the dentures. An observation and concurrent interview on 02/20/2026 at 2:15 PM, Resident 53 stated, I'm missing a whole side there and there, while pointing to missing teeth on both sides of their upper denture. Resident 53 stated the facility had told them they were getting them new dentures, but they had not heard anything since. Resident 53 further stated they were missing a front tooth, and it was hard for them to eat because the dentures were broken. Resident 53 stated, I was eating bacon this morning, and another piece fell off the denture. Resident 53 stated they were told by Staff D, RCM, that the facility did not have the referral and needed to get another one. Resident 53 further stated requesting dental care was a long process and they did not like missing a front tooth because it affected their appearance. During an interview on 02/20/2026 at 2:32 PM, Staff D stated they needed to fill out the paperwork they had on their desk. Staff D stated that as soon as they completed the paperwork, they could schedule the appointment for Resident 53. Staff D stated they had just received the paperwork and would have followed up sooner if they had been aware of it, but they did not know the paperwork was needed. Staff D further stated the facility did not have a set process for tracking such requests (two months and 18 days from the date of the initial referral request). Resident 41 Review of the medical record showed the resident was admitted to the facility with diagnoses including stroke (happens when the blood supply to part of the brain is suddenly blocked or a blood vessel in the brain bursts). The 1/13/2026 comprehensive assessment showed Resident 41's cognition was moderately impaired and required the assistance of one-two staff members for ADLs. Additionally, the assessment showed resident 41 was edentulous (without any natural teeth). Review of a dental encounter sheet dated 12/04/2025, showed abnormal findings on Resident 41's tongue and included an order for a referral to evaluate those findings, as well as an order for new upper and lower dentures. During an observation and concurrent interview on 02/20/2026 at 2:09 PM, Resident 41 was lying in bed and stated they had requested new dentures because their current ones were loose. Resident 41 demonstrated the looseness of the bottom denture, showing how they could move it around with their tongue. Resident 41 stated it was sometimes hard to chew. Resident 41 stated it (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been a long time since the dentist visited and they would like to receive the new dentures. Observation of Resident 41's tongue revealed a red, raised area on the left lateral border. During an interview on 02/20/2026 at 2:32 PM, Staff D, stated they were not aware of Resident 41's referral or the orders for new dentures from the 12/04/2025 dentist visit. Staff D stated they did not review the dental orders form that visit, even though the facility's practice was to review any such orders during the first week the dentist visits. Staff D stated the review of any new orders did not occur this time and acknowledged they did not complete it. During an interview on 02/22/2026 at 12:22 PM, Staff B, Director of Nursing Services, stated they would expect all dental visits to be followed up promptly and documented in the electronic health record with appropriate follow through. Staff B stated the process was not followed and the referrals were not completed in a timely manner. Staff B further stated they would expect all new admissions to be seen during the next scheduled dental visit and for all residents to be seen on a routine basis. Reference: WAC 388-97-1060 (1),(3)(j)(vii)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents/resident representatives (RR) were educated on the potential risk versus benefits when offering the pneumococcal and influenza immunization (specific vaccines that protects against pneumococcal bacteria and influenza viruses that can lead to lung, nose and throat infections) nor documentation that indicated vaccination were offered, accepted or refused for 2 of 5 residents (Resident 22 and 2) reviewed for immunizations with infection control. This failure placed residents at risk of exposure to contagious diseases without the knowledge of the risk/benefits in order to make an informed decision.Findings included .Review of the facility's policy titled, Influenza and Pneumococcal Immunizations, dated 08/01/2024, showed the facility would provide residents with the opportunity to accept or refuse the influenza and pneumococcal vaccines. The policy stated that a resident or RR would complete an immunization informed consent document, were to receive education regarding the benefits/potential side effects of the influenza/pneumococcal immunizations by facility staff and the acceptance or vaccine declinations would be documented in the resident medical record.Resident 22 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include dementia (a progressive disease that destroys the memory and other important mental functions) with agitation, anxiety and insomnia (a sleep disorder). The 12/16/2025 comprehensive assessment showed the resident had a moderately impaired cognition, was offered and declined the influenza/pneumococcal vaccines.Review of Resident 22's immunization informed consent document, dated 12/11/2025, showed the resident had been offered other for the type of immunization, but no documentation of which immunization was noted on the form. The consent document showed that Resident 22's RR had refused the other unknown immunization and was not educated on the potential risk versus benefits or possible side effects regarding both the influenza/pneumococcal immunizations.Resident 2Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including hemiplegia (severe or total loss of motor function on one side of the body) of the left side and dementia. The 11/23/2025 comprehensive assessment showed the resident had severe cognitive impairments, did not receive the influenza vaccine and was offered and declined the pneumococcal vaccine. Review of Resident 2's immunization informed consent document, dated 11/17/2025, showed the resident themselves had been offered and accepted/signed to receive the influenza immunization. The consent document showed that no education was completed on the potential risk versus benefits or possible side effects of the influenza immunization with the resident. Additionally, no documentation showed that Resident 2 or a RR had been offered nor educated on the potential risk versus benefits or possible side effects regarding the pneumococcal immunization.During an interview on 02/19/2026 at 12:42 PM, Staff R, Registered Nurse/Infection Preventionist, stated the process for immunization was to offer them to the resident/RR upon admission, obtain history of immunization already received by the resident and have the resident complete an immunization informed consent document which was transferred to an evaluation in the resident medical record. Staff R stated that if a resident was not cognitively intact in order to make the decision, a RR would complete the immunization consent document for the resident. Staff R stated the immunization consent document also showed the resident received education on the potential risk versus benefits or possible side effects regarding both the influenza/pneumococcal immunizations. After reviewing Resident 22's immunizations records, Staff R stated the resident and/or RR were not educated on the potential risk versus benefits or possible side effects regarding both the influenza/pneumococcal immunizations. When reviewing Resident 2's immunization records with the surveyor, Staff R stated they were aware of the resident's severely impaired cognition, and a RR should have completed immunization document and been educated on the influenza and pneumococcal immunizations. Staff R stated the correct process was not followed for offering, educating and documenting resident immunizations. Reference: WAC 388-97-1340(2)

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	02/23/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or resident representative (RR) were offered/educated on the COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death) immunization (a specific vaccine for the COVID-19 virus) benefits/risks and potential side effects for 2 of 5 sampled residents (Resident 22 and 2) reviewed for immunization status. This failure placed the resident and/or their representative at risk of making an uninformed decision and resident contracting the COVID-19 virus.Findings included .Review of the facility's policy titled, COVID-19, dated 08/01/2024, showed that facility residents were offered the recommended COVID-19 immunization upon admission to the facility. The policy stated that an immunization informed consent would be obtained and education regarding the benefits/potential side effects of the COVID-19 immunization. Additionally, facility staff document resident acceptance or declination of the immunization within the resident medical records.Resident 22 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include dementia (a progressive disease that destroys the memory and other important mental functions) with agitation, anxiety and insomnia (a sleep disorder). The 12/16/2025 comprehensive assessment showed the resident had a moderately impaired cognition and COVID-19 immunization status was not up to date (did not have the current recommended COVID-19 immunization).Review of Resident 22's immunization informed consent document, dated 12/11/2025, showed the resident had been offered other for the type of immunization and not the COVID-19 immunization. Additionally, the resident/RR was not educated on the potential risk versus benefits or possible side effects regarding the COVID-19 immunization.Resident 2Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including hemiplegia (severe or total loss of motor function on one side of the body) of the left side and dementia. The 11/23/2025 comprehensive assessment showed the resident had severe cognitive impairments, was not up to date with the COVID-19 immunization.Review of Resident 2's immunization informed consent document, dated 11/17/2025, showed the resident themselves had been offered and accepted/signed to receive the influenza immunization, but no documentation showed that Resident 2 or a RR had been offered nor educated on the potential risk versus benefits or possible side effects regarding the COVID-19 immunization.During an interview on 02/19/2026 at 12:42 PM, Staff R, Registered Nurse/Infection Preventionist, stated the process for immunization was to offer them to the resident/RR upon admission, obtain history of COVID-19 immunizations and complete an immunization informed consent document. Staff R stated the document would then be transcribed onto an electronic evaluation form in the resident medical record. Staff R stated that if a resident was not cognitively intact in order to make the decision a RR would have to complete the immunization consent document for the resident. Staff R stated the immunization consent document also showed the resident/RR receiving education on the potential risk versus benefits or possible side effects regarding both the influenza/pneumococcal immunizations. After reviewing Resident 22 and Resident 2's immunizations records, Staff R stated the residents and/or the RR were not offered nor educated on the potential risk versus benefits or possible side effects regarding the COVID-19 immunization. Staff R stated the correct process for Resident 22 and Resident 2 was not followed with offering, educating and documenting resident COVID-19 immunizations. Reference: WAC 388-97-1620(2)(b)(i)(ii)