STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for 3 of 5 sampled residents (Resident 1, 2, and 3) reviewed for admission orders. Failure to implement and follow physician prescribed orders on admission to the facility placed residents at risk of medical complications and a decline in health status. Findings included . <RESIDENT> 1 Resident 1 was admitted to the facility on [DATE] with diagnosis of acute (comes on suddenly) and chronic (long term problem) respiratory failure (the respiratory system fails in one or both of its gas exchange functions), sleep apnea (condition where breathing stops during sleep) and lung disease. Review of the Skilled Nursing Facility (SNF) transfer orders, dated 04/01/2024, showed Resident 1 was to have bipap (machine that provides air pressure to lungs to help someone breath better) during the night and when napping. Review of Resident 1's facility admission orders showed no order for a bipap machine. Review of Resident 1's Treatment Administration Records (TAR) from 04/01/2024 - 04/10/2024, showed no use of a bipap machine. During an interview on 04/24/2024 at 12:11 PM, Resident 1 reported they brought a bipap machine with them to the facility when they admitted but the bipap mask was missing. Resident 1 stated the staff did nothing to obtain a mask for the first 10 days they were at the facility. During an interview on 05/03/2024 at 12:35 PM, Staff C, Resident Care Manager/Licensed Practical Nurse, stated when a resident admitted to the facility from the hospital, the facility used the SNF transfer Order document from the hospital and the admission nurse entered medications and treatment orders into the resident's electronic medical record from the document. Staff C reported the orders were then confirmed by another nurse. Staff C stated they were the second nurse that reviewed Resident 1's admission orders on 04/01/2024 but only checked the medications for accuracy and not the treatment orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/03/2024 at 1:37 PM, Staff B, Registered Nurse/Director of Nursing Services, stated that Resident 1's bipap orders were missed from their admission on 04/01/2024. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] with diagnosis to include orthostatic hypotension (dizziness or fainting when standing due to drop in blood pressure). Review of Resident 2's hospital discharge summary, dated 04/16/2024, showed they had fallen in the hospital and the cause was thought to be from orthostatic hypotension. The discharge summary showed physician orders for compression stockings (specialized socks that increase blood flow in the legs) and an abdominal binder (wide elastic band that encircles the waist and provides compression) to be worn when the resident was out of bed or working with therapies for the orthostatic hypotension. Review of Resident 2's admission orders to the facility, dated 04/16/2024, showed no order for the compression stockings or the abdominal binder. During a phone interview on 04/26/2024 at 12:11 PM, Collateral Contact 1 (CC1), Resident 2's family member, stated Resident 2 was to have an abdominal binder and wear compression stockings whenever they were standing. CC1 stated they had spoken to a therapist about the need for those items and the therapist had stated the aide would apply them. CC1 stated they had not seen Resident 2 wearing those items when they visited. Review of Resident 2's care plan, print date 05/03/2024, showed no documentation directing staff the abdominal binder or compression stockings were to be used when resident was out of bed or working with therapy. The care plan had a focus area for falls, initiated on 04/16/2024, but did not have orthostatic hypotension listed as a condition. Review of Resident 2's Kardex (care needs of the resident), print date 04/25/2024, showed no documentation the resident required an abdominal binder or compression stockings when out of bed or working with therapy. Review of Resident 2's physical therapy notes from 04/17/2024 - 04/20/2024 and occupational therapy notes from 04/17/2024- 04/22/2024, showed no documentation the abdominal binder or the compression socks were worn during therapy sessions. During an interview on 05/03/2024 at 12:35 PM, Staff C stated they had entered the orders for Resident 2. Staff C reviewed the admission orders for Resident 2 and stated that it did not look like the compression socks or abdominal binder had been entered on the physician orders, but they would investigate it. No further information was received. During an interview on 05/03/2024 at 1:37 PM, Staff B stated they were aware that Resident 2 had special compression socks but was not sure about the abdominal binder. Staff B was not able to provide documentation the staff had been applying the abdominal binder or the compression socks when out of bed as directed by the discharge summary. <RESIDENT 3> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 admitted to the facility on [DATE] with diagnosis to include orthostatic hypotension. Review of Resident 3's hospital discharge summary, dated 04/06/2024, showed physician orders for compression stockings and an abdominal binder were to be worn for orthostatic hypotension. Review of Resident 3's current physician orders, print date 04/26/2024, showed no order for compression stockings or an abdominal binder. Review of Resident 3's Kardex, print date 04/26/2024, showed no documentation that the resident required an abdominal binder or compression stockings. During an interview on 05/03/2024 at 1:37 PM, Staff C was notified of the discharge summary that showed Resident 3 was to have compression socks and an abdominal binder, and if they could find any documentation that the facility had been using them. No further information was received. Refer to WAC 388-97-1620 2(b)(ii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents (Residents 4, 2, and 5) reviewed for diabetes (disease where body does not use sugar effectively) remained free of significant medications errors related to the administration of insulin (high-risk medication for diabetes). Failure to administer insulin within the required time frame of one hour before/after the scheduled time parameter placed residents at risk of abnormal blood sugars (level of sugar in blood that is monitored for residents with diabetes). Findings included . Review of an undated facility policy titled, Medication Pass Times, showed medications ordered to be given before a meal should be administered 15 minutes to one hour before the scheduled mealtime. Review of the facility's mealtimes showed breakfast was to be served between 7:15 AM - 7:45 AM, lunch was to be served between 11:15 AM - 11:45 AM, and dinner was to be served between 4:15 PM - 5:00 PM. <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with a diagnosis of diabetes. Review of Resident 4's April's 2024 Medication Administration Records (MAR), showed an order for lispro (fast acting) insulin sliding scale (based on blood sugar) before meals and bedtime. From 04/01/2024 - 04/26/2026, they received 10 doses that were more than one hour after the scheduled time, including one dose documented as given over four hours late. Doses included: On 04/02/2024 the 4:30 PM dose was documented as given at 6:47 PM (two hours and 17 minutes late), On 04/02/2024 the 8:30 PM dose was documented as given at 10:08 PM, On 04/05/2024 the 4:30 PM dose was documented as given at 8:55 PM (four hours and 25 minutes late), On 04/08/2024 the 7:30 AM dose was documented as given at 9:04 AM, On 04/09/2024 the 8:30 PM dose was documented as given at 10:56 PM (two hours and 26 minutes late), On 04/10/2024 the 7:30 AM dose was documented as given at 9:33 AM (two hours and three minutes late), On 04/10/2024 the 4:30 PM dose was documented as given at 5:53 PM, On 04/10/2024 the 8:30 PM dose was documented as given at 10:34 PM (two hours and four minutes late), On 04/11/2024 the 4:30 PM dose was documented as given at 6:06 PM, and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2024 the 11:30 AM dose was documented as given at 1:11 PM, Review of Resident 4's April's 2024 MAR showed an order for glargine (long acting) insulin daily, scheduled at 7:00 AM. From 04/01/2024 - 04/26/2026, they received 12 doses that were more than one hour after the scheduled time. Doses included: On 04/02/2024 the 4:30 PM dose given at 6:47 PM (two hours and 17 minutes late), On 04/02/2024 the 8:30 PM dose given at 10:08 PM, On 04/05/2024 the 4:30 PM dose given at 8:55 PM (four hours and 25 minutes late), On 04/08/2024 the 7:30 AM dose given at 9:04 AM, On 04/09/2024 the 8:30 PM dose given at 10:56 PM (two hours and 26 minutes late), On 04/10/2024 the 7:30 AM dose given at 9:33 AM (two hours and three minutes late), On 04/10/2024 the 4:30 PM dose given at 5:53 PM, On 04/10/2024 the 8:30 PM dose given at 10:34 PM (two hours and four minutes late), On 04/11/2024 the 4:30 PM dose given at 6:06 PM, and On 04/25/2024 the 11:30 AM dose given at 1:11 PM, Review of Resident 4's April's 2024 MAR, showed an order for detemir (long acting) insulin at bedtime, scheduled at 8:00 PM. From 04/01/2024 - 04/25/2026, they received six doses that were more than one hour after the scheduled time. Doses included: On 04/02/2024 dose given at 10:07 PM (two hours and seven minutes late), On 04/09/2024 dose give at 10:57 PM (two hours and 57 minutes late), On 04/10/2024 dose given at 10:44 PM (two hours and 44 minutes late), On 04/20/2024 dose given at 9:37 PM, On 04/23/2024 dose given at 9:58 PM, and On 04/24/2024 dose given at 9:20 PM. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] with a diagnosis to include diabetes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 04/26/2024 at 12:11 PM, Collateral Contact 1 (CC1), Resident 2's family member, stated they had been visiting one day in the evening and the nurse came in and stated they had forgot to give Resident 2 their insulin. CC1 stated Resident 2's blood sugars were difficult to control, but they were better managed on a strict schedule. Review of Resident 10's MAR, dated 04/16/2024 - 04/22/2024, showed an order for aspart (fast acting) insulin before meals as well as an order for aspart insulin sliding scale before meals and at bedtime. On 04/21/2024, the 4:30 PM dose was blank which indicated the insulin was not given. On 04/19/2024 the sliding scale dose of aspart insulin, scheduled at 11:30 AM, was given at 7:50 AM (three hours and 40 minutes early). On 04/18/2024, the 4:30 PM routine dose of aspart was given at 7:27 PM (two hours and 57 minutes late). Review of Resident 10's MAR, dated 04/16/2024 - 04/22/2024, showed an order for glargine insulin every morning at 7:00 AM. Two of the six doses administered were given more than one hour after the scheduled time, to include doses at 10:51 AM (three hours 51 minutes late) on 04/19/2024 and, 11:00 AM (four hours late) on 04/22/2024. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with a diagnosis of diabetes. Review of Resident 5's MAR, dated 04/02/2024 - 04/12/2024, showed an order for aspart sliding scale insulin before meals and bedtime. Three doses were documented as given more than one hour after the scheduled time. Doses included: On 04/06/2024 the 4:30 PM dose was documented as given at 6:27 PM, On 04/10/2024 the 8:30 PM dose was documented as given at 9:57 PM, and On 04/11/2024 the 8:30 PM dose was documented as given at 11:15 PM (two hours and 45 minutes late). Review of Resident 5's MAR, dated 04/02/2024 - 04/12/2024, showed an order for NPH (intermediate acting) insulin every morning scheduled at 7:00 AM. On 04/08/2024 the dose was given at 9:27 AM (two hours and 27 minutes late). During an interview and record review on 05/03/2024 at 1:37 PM, Staff B, Registered Nurse/Director of Nursing Services stated the nurse has one hour before or after the scheduled time to administer the medication. Staff B reviewed the MARs with the surveyor for Residents 4, 2, and 5. Staff B stated there were multiple doses of insulin given out of compliance. Staff B could not provide any further information about the insulin being given out of compliance. During an interview and on 05/03/2024 at 3:20 PM, Staff A, Administrator, stated they had never thought to review administration times of insulin before. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to WAC 388-97-1060 (3)(k)(iii)