STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505315	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Care Center	300 South 18th Street Mount Vernon, WA 98274

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 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** 37035 Based on observation, interview, and record review, the facility failed to resolve resident grievances for 1 of 1 sampled resident (Resident 1) reviewed for grievances. The failure to resolve resident grievances placed residents at risk for unresolved missing personal property. Findings included . Resident 1 admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS- an assessment tool) assessment, dated 05/10/2024, Resident 1 was assessed to be cognitively intact. Review of Resident 1's undated Inventory of Personal Effects form included a list of the following items: - 1 belt, - $200.00 cash, - Burgundy felt hat, - 1 wooden bead necklace, - A floral suitcase, - 1 pair of black shoes and - 1 knee brace. Review of a progress note dated 05/24/2024 at 2:49 PM, showed Resident 1 had been admitted to the hospital. Review of the May 2024, June 2024 and 07/01/2024 through 07/09/2024 Grievance logs showed no issues had been logged regarding Resident 1. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a State Hot Line Report dated 06/10/2024, showed Resident 1 had reported they had missing property from their stay at the facility. The resident stated they had a suitcase with $200.00 cash and items inside including several bottles of vitamins, clothing, an expensive belt, and a pair of scissors that was missing. Review of a follow-up State Hot Line Report dated 06/13/2024, showed Resident 1 had reported they had not been able to retrieve their personal belongings and the facility kept giving the resident the run around. In a phone interview on 07/10/2024 at 9:51 AM, Resident 1, stated they had $200.00 tucked in a hiding area in their suitcase. In an interview on 07/09/2024 at 2:42 PM, Staff E, Interim Director of Nursing Services (DNS), stated if a resident left personal items upon discharge, the staff would box up the resident's personal items and store them in the Social Services office or in the Boiler room. Staff E stated they did not recall Resident 1 but knew the resident's name. In an interview on 07/09/2024 at 2:46 PM, Staff B, Social Services Staff, stated they had received a call from Resident 1 and had been playing phone tag, about the resident's missing belongings. Staff B stated Resident 1 had contacted the front desk about their missing items. In an interview on 07/09/2024 at 3:15 PM, Staff D, Business Office Manager, stated they knew that Staff E was aware Resident 1 had some medications left at the facility. Staff D stated typically when a resident discharges, their room was packed up and they would have 30 days to arrange to pick up their items. Staff D stated if there were missing items a grievance form would be completed but if the resident had discharged there would not be a grievance form. In an observation and interview on 07/09/2024 at 3:20 PM, Staff A, Director of Admissions, entered the Boiler room and stated Ooh here are Resident 1's items as they picked up a couple of plastic bags with personal items and a floral suitcase. Staff A stated usually resident's have 30 days to pick up or claim their missing items. Staff A looked through the plastic bags and suitcase and found several items including packets of Vitamin C, a stainless-steel water bottle, a pair of black sandals, a pair of sweatpants, a pair of shorts, scissors, an over-the-counter bottle (OTC) of lidocaine roll on pain relief ointment, several bottles of OTC vitamins, and a wooden beaded neckless. Refer to WAC 388-97-0460(1)(2)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review, the facility failed to provide a written transfer discharge notice for 1 of 3 sampled residents (Resident 1) who discharged to a hospital and refused to allow the resident to return (re-admit) back to the facility. In addition, the facility failed to notify the Office of the State Long-Term Care Ombudsman of Resident 1's discharge. This failed practice placed residents at risk of not knowing their appeal rights, risk of not having advocacy and risk of a diminished quality of life when not permitted to return to a facility in the community where their support system resided. Findings included . Review of the facility's policy, Continuum of Care/ Discharge and Transfer/, revision date 02/2016, showed the facility would; 1) provide the required written notice of transfer or discharge to the resident, 2) attach a department designated hearing request form to the transfer or discharge notice, 3) inform the resident in writing, in a language and manner the resident could understand that an appeal request could be made any time up to 90 days from the date of the notice of the transfer or discharge, the transfer discharge would be suspended when an appeal was requested and the facility would assist the resident to request a hearing to appeal the transfer or discharge. Resident 1 admitted to the facility on [DATE] with diagnoses to include type 2 diabetes mellitus (medical condition in which the body doesn't use insulin properly), high blood pressure, osteomyelitis (infection of the bone), complications of a left below knee amputation, muscle weakness and need for assistance with personal care. Review of the Admission Minimum Data Set (MDS- an assessment tool) assessment dated , 05/10/2024, showed Resident 1 was cognitively intact. Review of Resident 1's progress note, dated 05/24/2024, showed the resident went out to a wound care clinic appointment and was sent to the hospital where they were admitted related to a problem with their left below knee amputation. Review of the Discharge MDS dated [DATE], showed the assessment was coded as a Discharge assessment return not anticipated. In an interview on 07/09/2024 at 2:36 PM, Staff A, Director of Admissions, stated Resident 1 had gone out to the hospital and there were some issues and the facility felt Resident 1 would not be appropriate to be readmitted back to the facility. Staff A stated the prior Director of Nursing Services had the final say on who was readmitted back to the facility. In an interview on 07/09/2024 at 2:46 PM, Staff B, Social Service Staff, stated it was up to Admissions if Resident 1 was able to be readmitted or not. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/10/2024 at 9:51 AM, Resident 1, stated the facility would not take them back after they had gone to the hospital, and they did not know why. Resident 1 stated they had got along very well with all the staff. Resident 1 stated the facility did not provide them with a transfer discharge notice. Resident 1 stated they had to go to a facility down south which caused them difficulties as they had no one that could go see them as it was so far away. In an interview on 07/10/2024 at 10:44 AM, Collateral Contact (CC) 1, hospital case worker stated the facility had said they could not take Resident 1 back as Resident 1 had used drugs in their room and was distractive to other residents who were vulnerable residents. In an interview on 07/11/2024 at 2:00 PM, Staff C, Licensed Practical Nurse/ Nursing Supervisor, stated Resident 1 was demanding, and was found to have been hoarding their medications in their room. Refer to WAC 388-97-0120 (2)(a)(b)(c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 37035 Based on interview, and record review, the facility failed to provide a bed hold notice in writing at the time of a resident transfer to the hospital or within 24 hours of transfer to the hospital for 1 of 3 residents (Resident 1) reviewed for hospitalization s. This failed practice placed residents or their representative at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital. Findings included . Review of the facility's policy titled, Admission/Discharge/Transfer Bed Hold, dated 11/2016, stated the resident or resident's representative shall be informed in writing of their right to exercise the bed hold provision in the event of a transfer from the facility to a general acute care hospital. A review of Resident 1's medical record showed the resident was sent to a wound clinic appointment and was subsequently admitted to the hospital on 05/24/2024. Review of Resident 1's medical records, showed no documentation the resident or the resident's representative had been provided with a written bed hold notification at the time of their discharge or within 24 hours of discharge. In an interview on 07/09/2024 at 2:36 PM, Staff A, Director of Admissions, stated the nursing staff usually would give the completed bed hold form to medical records and they would upload the form into the electronic medical record. Staff A confirmed there was no bed hold form in Resident 1's medical record. In an interview on 07/09/2024 at 4:14 PM, Staff C, Licensed Practical Nurse/ Nurse Supervisor, stated they believed Social Services would follow up with the bed hold after a resident was sent to the hospital. In an interview on 07/10/2024 at 9:51 AM, Resident 1, stated the facility did not provide information or have them sign anything regarding a bed hold. Refer to WAC 388-97-0120 (4)(a-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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to follow physician orders to obtain a hospice referral for 1 of 1 resident (Resident 2) reviewed for change in condition. This failed practice placed the resident at risk of not receiving their hospice benefit for end-of-life support for both Resident 2 and their spouse. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses to include adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), chronic respiratory failure, thrombocytopenia (a condition that occurs when the platelet count in your blood is too low), history of cancer, heart disease, depression, and anxiety. Review of a nursing note dated 05/28/2024 at 3:45 PM, showed a hospice referral was received from the Advanced Registered Nurse Practitioner (ARNP) and was placed into the Social Services box. In an interview on 07/11/2024 at 12:45 PM, Staff G, ARNP, stated Resident 2 had begun declining and they had discussed hospice with Resident 2 and their spouse. Staff G stated they did not know what happened with the hospice order they had written on 05/28/2024 but the resident and their spouse had requested the hospice referral. In an interview on 07/11/2024 at 1:51 PM, Staff F, Social Services Manager, stated they had not seen the hospice referral in their box and had not referred Resident 2 to hospice. In an interview on 07/11/2024 at 1:53 PM Staff E, Interim Director of Nursing Services (DNS), stated the facility's process is to give hospice referrals to social services to implement. Staff E stated the provider would write out the hospice referral. Staff E stated they did not know why Resident 2's hospice referral was not followed up on. In an interview on 07/11/2024 at 2:15 PM, Staff G stated they were not happy about Resident 2 not receiving their hospice referral. Staff G stated they had wanted the Resident and their spouse to receive the mental component of hospice. Staff G stated they were shocked the order for the hospice referral was not followed as it was not something that was usually a problem at the facility. Refer to WAC 388-97-1060(1)(3)(b)