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	04/08/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interviews and record review, the facility failed to ensure a grievance was identified as an allegation of abuse or neglect for 1 of 3 residents (Resident 1) reviewed for care concern related grievances. The facility failed to ensure an allegation of abuse/neglect was identified when Resident 1 reported being left alone in their transport wheelchair for 6 hours and had become extremely sore, and 1 of 5 staff (Staff D) reviewed for annual abuse and neglect training had been completed within 12 months. These failures placed all residents at risk for abuse/neglect, psychosocial harm, physical harm, and a decreased quality of life. Findings included . Review of the facility provided policy, Abuse: Prevention of and Prohibition Against', revision date of 12/2023 documented the policy applied to all facility staff. Under the 'Definitions' part of the policy, documented: - Abuse- this includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. - Neglect- is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. - Reporting/Response- allegations of abuse, neglect will be reported outside the facility and to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations Resident 1 admitted to the facility on [DATE] with diagnoses to include orthostatic hypotension (sudden drop in blood pressure when a person stands up), cellulitis (bacterial infection of the skin and underlying tissues) of their left leg, need for assistance with personal care, dementia (progressive loss of cognitive function) and malnutrition. Review of Resident 1's grievance, dated 12/19/2024 at 3:45PM, documented that they had been left alone in their wheelchair from 1:00 PM until 7:00 PM on 12/18/2024. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/08/2025 at 12:21 PM, Staff D, Nursing Aide Certified (NAC) stated they would think it was a concern if a resident had reported they waited for 6 hours for assistance. Staff D stated they would ensure the resident was comfortable and alert the nurse. Staff D stated they were mandated reporters. Review of staff training records on 04/08/2025 at 3:00 PM, documented Staff D's last abuse and neglect training was completed on 01/28/2024, which was over 12 months. In an interview on 04/08/2025 at 12:32 PM, Staff E, NAC, stated they would apologize to the resident who had reported they had waited for 6 hours for assistance and notify their nurse. Staff E stated they were mandated reporters. In an interview on 04/08/2025 at 1:44 PM, Staff C, Licensed Practical Nurse, Resident Care Manager (LPN/RCM), stated they would need to do an investigation and report it if a resident had reported waiting 6 hours for care. Staff C stated they did not recall Resident 1's grievance had a specific time frame of 6 hours, and it should have been escalated to an allegation of abuse/neglect, reported to the state agency and an investigation completed. Staff C stated they discussed all grievances with the interdisciplinary team and thought Staff A oversaw grievances at the facility but was not for sure. Staff C stated they were a mandated reporter. In an interview on 04/08/2025 at 2:17 PM, Staff F, Social Services (SS), stated if they received a grievance where a resident had reported a 6 hour wait for care, they would get it to Staff C to complete training with staff and would also notify Staff A, Administrator, who was the facilities grievance officer. Staff F stated they were a mandated reporter, and anyone can report to the state agency hotline, and stated that the state agency hotline phone number was on the back of all staff badges. In an interview on 04/08/2025 at 3:10 PM, Staff B, Registered Nurse/Director of Nursing Services (RN/DNS), stated they were unsure of the last abuse and neglect training provided for staff, but that all staff were to complete training annually on the Relias computer program. Staff C stated Resident 1's grievance would have gone to the RCM and if they thought it was an allegation it should have been escalated to an investigation and reported to the state agency. Staff B stated a resident report of waiting 6 hours for care should be considered an allegation of abuse/neglect, and all staff are considered mandated reporters and can report to the state agency hotline. Reference WAC 388-97-0640(1)(2)(a)(b)(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview and record review, the facility failed to ensure a thorough investigation was completed for 1 of 3 residents (Resident 1) reviewed for care concern related grievances. The facility failed to ensure an allegation of abuse/neglect was investigated which placed all residents at risk for abuse/neglect, psychosocial harm, physical discomfort and a decreased quality of life. Findings included . Review of the facility provided policy, Abuse: Prevention of and Prohibition Against', revision date of 12/2023 documented the policy applied to all facility staff. Under the 'Investigation' phase of the policy, documented all allegations of abuse, neglect will be promptly and thoroughly investigated by facility administrator or their designee. Resident 1 admitted to the facility on [DATE] with diagnoses to include orthostatic hypotension (sudden drop in blood pressure when a person stands up), Cellulitis (bacterial infection of the skin and underlying tissues) of their left leg, need for assistance with personal care, dementia (progressive loss of cognitive function) and malnutrition. Review of a grievance for Resident 1 dated 12/19/2024 at 3:45PM, documented that they had been left alone in their wheelchair from 1:00 PM until 7:00 PM on 12/18/2024, and they were extremely sore. The grievance was addressed by Staff C, Licensed Practical Nurse (LPN), Resident Care Manager (RCM), on 12/22/2024. Staff C documented that staff were counseled on timely cares, and Staff A, Administrator documented the resolution was satisfactory on 12/23/2024. Review of Resident 1's progress notes dated 12/18/2024, 12/19/2024, and 12/20/2024 showed no documentation related to the 12/19/2024 grievance. In an interview on 04/08/2025 at 1:44 PM, Staff C stated if a resident reported they had waited for 6 hours to receive care they would escalate the grievance to an allegation of abuse/neglect and find out what to investigate. In an interview on 04/08/2024 at 3:10 PM, Staff B, Registered Nurse (RN), Director of Nursing Services (DNS) stated they would consider a resident wait time of 6 hours for care to be an allegation. Staff B stated if it was an allegation, the facility would do an investigation, and Staff A was responsible for overseeing or managing facility grievances. In an email sent on 04/08/2025 at 4:54 PM to Staff A, further documentation was requested related to Resident 1's grievance, and no further information was provided. Reference WAC 388-97-0640 (6)(a)