

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Mira Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on interview, observation and record review the facility failed to ensure resident preferences for food were obtained and honored for 2 of 2 residents (Resident 28 and 43) reviewed for choices. The facility's refusal to allow residents to store personal foods in the facility refrigerators resulted in Resident 43 having limited ability to enjoy food items of their choosing and failure for Resident 28 to obtain dietary preferences. These failures placed residents at risk for decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Resident/Personal Food Storage, dated 07/2024 stated the facility allowed residents the opportunity to choose to accept foods from any friends, family, visitors, or other; however, the policy further stated that personal resident refrigeration units were not permitted in resident rooms due to electrical load capacity and that food or beverages brought in from outside sources may not be stored in facility pantries or refrigeration units. The policy stated any perishable food items not consumed the day of opening were to be discarded.</p> <p><RESIDENT 43></p> <p>Resident 43 was a long-term care resident of the facility since 2021 with diagnoses to include anxiety.</p> <p>Review of Resident 43's Quarterly Minimum Data Set (MDS- an assessment tool) dated 06/17/2024 showed the resident preferences were having snacks available and was coded as very important. Taking care of personal belongings was coded as can't do or no choice. The MDS showed Resident 43 was cognitively intact and the source of information for the assessment came directly from the resident.</p> <p>Review of Resident 43's current care plan showed the resident had preferences for snacks and also liked to order outside food (pizza, fast food), initiated on 06/30/2022.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/18/2024 at 9:55 AM, Resident 43 stated there was not a place for residents to store personal food in the facility. Resident 43 stated they had items they were keeping in their room such as a favorite salad dressing that should be kept in a refrigerator but stated the facility wouldn't let them store it in there. Resident 43 stated the staff came in and found their bottle of salad dressing in their drawer and threw it away. Resident 43 stated they have gone round and round about it with the administration and they will not allow them to put anything in the facility refrigerators. Resident 43 stated If you don't eat it right away, you have to throw it out. It makes no sense; how could I eat an entire bottle of salad dressing all at once? If I have leftovers, I can't keep them. I understand if everyone can't have their own fridge in their room, but I should be allowed to store my food.</p> <p>In an interview on 07/19/2024 at 12:27 PM, Resident 60, stated they were running for Resident Council President, and the issue with the refrigerators had come up and was on the agenda to address with the administration, because they (administration) said you can't keep any food here and we don't understand that. Resident 60 stated they did not know why residents wouldn't be able to have a space in the utility room refrigerator, if it is covered and labeled, what is the problem?</p> <p>In an interview on 07/23/2024 at 1:29 PM, Staff A, Administrator stated the facility policy had always been not to allow residents to keep any foods in the facility refrigerators. Staff A stated Resident 43 had previously been found to have perishable items in their room such as salad dressing and Resident 43 would attempt to have staff store items for them in the staff lounge refrigerator, which they cannot do. Staff A confirmed that residents did not have the option of having personal refrigerators in their rooms and that families and visitors were asked to bring in single serving items only, and residents were being required to dispose of any uneaten perishable foods due to the policy that outside food items would not be stored by the facility.</p> <p>47047</p> <p><RESIDENT 28></p> <p>Resident 28 admitted to the facility on [DATE] with diagnoses that included high blood pressure, atrial fibrillation (irregular heartbeat), and a broken right leg.</p> <p>In an interview on 07/18/2024 at 10:06 AM, Resident 28 stated the food at the facility is bland and lacks flavor. Resident 28 stated that they do not get to make choices on their food preferences often.</p> <p>Review of Resident 28's Electronic Medical Record showed no documentation related to their food preferences, likes or dislikes. Review of Resident 28's mini nutritional assessment dated [DATE] showed none of their food preferences.</p> <p>In a follow up interview and observation on 07/22/2024 at 11:32 AM Resident 28 stated they had not been interviewed about their food preferences since admitting to the facility. When asked about the menu on their overbed table, Resident 28 stated the menu was not accurate. Observed the menu dated July 21-27 with the resident's name and room number not filled out and no choices of meals were made.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/22/2024 at 12:06 PM Staff L, Dietary Supervisor, stated they had not met with or interviewed Resident 28 regarding their dietary preferences. Staff L stated they meet with residents within 72 hours of admissions and complete a resident food preference document which is then put into the electronic medical record.</p> <p>In an interview on 07/22/2024 at 10:57 AM Staff A, Administrator, stated the nurses were responsible for obtaining the food preferences for residents' and if they were unable to then Staff L would get them.</p> <p>Refer to F 813</p> <p>Refer to WAC 388-97-0900 (3)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on interview and record review, the facility failed to obtain and/or offer assistance to residents and/or their representatives to formulate Advance Directives (AD) for 2 of 6 residents (Resident 26 and 28) reviewed for ADs. These failures placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care.</p> <p>Findings included .</p> <p>Review of the facility's undated policy titled, Advanced Directives and Associated Documentation, showed,</p> <p>1. Prior to, upon, or immediately after admission, a facility staff member shall:</p> <p>a. provide the resident/family or responsible party written information, in a manner easily understood by the resident or resident representative, regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives</p> <p>b. document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives.</p> <p>c. inquire whether they have completed an Advanced Directive.</p> <p>5. When an Advanced Directive is completed:</p> <p>a. reviews the Advance Directive to validate the document reflects the resident choices and that the document is signed and dated by the resident or responsible agent.</p> <p><RESIDENT 26></p> <p>Resident 26 admitted to the facility on [DATE] with diagnoses to include stroke, high blood pressure, and peripheral vascular disease (narrowing of blood vessels).</p> <p>Review of Resident 26's Durable Power of Attorney (DPOA) document showed a designation of healthcare agent and alternative agents and was contained in one page. There was no date or signature contained in the one-page DPOA document.</p> <p>In an interview on 07/19/2024 at 2:57 PM Staff I, Admission Coordinator, stated they could usually get a copy of a resident's DPOA prior to admission and ask families to bring in any supporting documentation. If a resident wants to pursue an advance directive and they do not have one, then social services would assist with the process/coordination of getting one. Staff I stated they were not involved in obtaining Resident 26's DPOA documentation as their admission was prior to their employment.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/09/2024 at 3:00 PM Staff H, Medical Records Supervisor, stated the only document they had for Resident 26 was the one-page DPOA document. Staff H reviewed the overflow medical records folder for Resident 26 and stated the only DPOA the facility had on file for Resident 26 was the one-page, unsigned DPOA.</p> <p><RESIDENT 28></p> <p>Resident 28 admitted to the facility on [DATE] with diagnoses to include high blood pressure, atrial fibrillation (irregular heartbeat) and broken right leg.</p> <p>Review of Resident 28's medical record showed on 06/28/2024 they signed an Advanced Directive receipt and indicated they had not formulated an AD but were interested in formulating one. There was no other documentation found in Resident 28's medical record regarding the formulation, coordination or execution of an AD.</p> <p>In an interview on 07/22/2024 at 1:59 PM Staff G, Social Services, stated residents have options at the time of admission and packets are provided to residents who request assistance with developing an AD. Staff G stated Resident 28 was interested in an AD and was not sure what had been done. In a follow up interview at 2:35 PM, Staff G stated they had met with Resident 28 and there was no follow up to develop an AD and Resident 28 voiced wanting a DPOA completed. Staff G stated they scheduled a time to assist Resident 28 to complete a DPOA that week.</p> <p>Refer to (WAC) 388-97-0280 (3)(d)(i)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation, interview, and record review the facility failed to ensure the environment was clean, comfortable and homelike on 3 of 3 units observed. Stained carpets, broken blinds, damaged walls and dirty floors placed residents at risk of diminished quality of life.</p> <p>Findings included .</p> <p>In an observation on 07/18/2024 at 9:11 AM, the floor in room [ROOM NUMBER] floor was dirty and sticky. There were scattered wrappers and dirty paper towels on the floor around the room.</p> <p>In an observation on 07/18/2024 9:13 AM, the floor in room [ROOM NUMBER] was found soiled with dirt and debris</p> <p>Observations on 07/24/2024 at 2:30 PM showed:</p> <p><CARPETS/HALLS></p> <ul style="list-style-type: none"> - The wall baseboard was missing at end of 100 hall. - The carpet seam was pulling apart down the length of the 100 hall. - Near rooms 111-113, the baseboard was pulling away from the wall, being supported by rolling table pushed up against it. - Near room [ROOM NUMBER], there were 3 irregular dark stains on the carpet, approximately 12 x 6 inches. - Near room [ROOM NUMBER]-108, there was a long dark stain on the carpet, approximately 5 feet long. - Near room [ROOM NUMBER], there was a basketball sized round stain on the carpet. - The carpet seam was pulling apart down the length of the 200 hall. - Near rooms 204-206, there was a basketball sized dark stain on the carpet. - There were two shower rooms on the 200 hall and there were dark wheel stain tracks leaving both shower rooms and extending down the hall in both directions. - Near room [ROOM NUMBER], there was a large dark stained area on the carpet. - The wainscot in the 200 hallway was marked with drip like staining and scraped areas. - Near room [ROOM NUMBER] and 304, there were rips in the carpet in the shape of a large L. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Near rooms 303-305, there was a quarter sized area of white matter, dried, on the carpet.</p> <p><BROKEN BLINDS></p> <p>- In room [ROOM NUMBER] the edges of the blind slats were broken.</p> <p>- In room [ROOM NUMBER] there was a foot wide section of the blind slats broken off at the top of the blinds.</p> <p>- In room [ROOM NUMBER] there were broken blinds.</p> <p><WALLS/FLOORS></p> <p>- In room [ROOM NUMBER] there were large, gouged areas on the sheetrock behind the headboard.</p> <p>- In room [ROOM NUMBER] there was exposed sheetrock under the window.</p> <p>In an interview on 07/24/2024 at 2:40 PM, Staff A, Administrator, acknowledged the poor condition of the facility carpets, stating the facility had bids for new flooring but no scheduled replacement timeline. Staff A stated repairs and housekeeping were ongoing but did not have specific plans to address other issues.</p> <p>This is a repeat deficiency from survey dated 07/21/2023.</p> <p>Refer to WAC 388-97-0880 (1),(2)</p> <p>36787</p> <p>47047</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview, and record review the facility failed to provide assistance with activities of daily living (ADL) to include meal assistance, personal hygiene and bathing for 3 of 6 dependent resident's (11, 28 and 33), reviewed for ADL's. Facility failure to provide the resident's, who were dependent on staff for assistance with eating, bed mobility, hygiene including oral care, and showers placed residents at risk for weight loss, pressure ulcers, embarrassment, poor hygiene, unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's Policy/Procedure titled, Activities of Daily Living revised 07/2015, showed the policy documented interventions will be provided by staff in accordance with professional standards of quality and clinical practices. Nursing assistants will provide assistance with ADL's based on the residents individualized plan of care. These interventions will be on the Kardex (tool that directs nursing assistant's on how to provide resident care). Any changes noted in the resident's performance or abilities will be reported to the nurse.</p> <p><RESIDENT 11></p> <p>Resident 11 admitted to the facility on [DATE] with diagnoses to include Multiple Sclerosis (a disease resulting in nerve damage that disrupts communication between the brain and the body), hemiplegia (paralysis) on their right dominant side, chronic pain, neck and back stenosis (space inside the bone is too small, putting pressure on the spinal cord), left shoulder rotator cuff tear (an injury that causes pain and weakness when lifting your arm), history of pressure ulcers with need for assistance with their ADL care.</p> <p>Review of the Quarterly Minimum Data Set (MDS- an assessment tool) assessment on 06/26/2024 showed Resident 11 had limited range of motion (ROM) in both their upper and lower extremities on both sides and they did not have rejections of care.</p> <p>Review of the care plan intervention initiated on 10/09/2023 showed Resident 11 had adaptive equipment for the left hand to aid in self-feeding with their functional hand. The care plan revised on 05/23/2023 showed the resident had limited physical mobility related to contractures (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) to their right hand and limited function to their left hand. The care plan revision on 05/24/2023 directed one staff to assist the resident with eating in the main dining room and in their room. Foods were to be cut into bite size pieces and staff were directed to offer assistance with eating. The care plan showed Resident 11 required two-person assistance with bed mobility and assistance with turning every two hour including in the evening. The care plan showed the resident requested to be woken up for turns.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 07/18/2024 at 9:26 AM, Resident 11 lying in bed and stated they did not receive their shower last week or this week on Monday. Resident 11 stated staff never offered showers to them any other days. Resident 11 said they were not sure why their showers were skipped. The resident said they did not refuse their shower and sometimes staff documented a refusal when they do not refuse. The resident said staff did not turn them in bed on night shift, on most days.</p> <p>In a dining observation on 07/18/2024 at 1:04 PM, Resident 11 was seated at a table in their motorized chair with their right arm in a splint (material used for supporting and immobilizing an injured body part) resting under the table. Resident 11 made several attempts to put a piece of fish in their mouth. Multiple times during this observation the resident's left arm could not be raised high enough to reach the food into their mouth. Multiple times they dropped the piece of fish on their clothing protector. The resident had difficulty trying to dip their fish into the tartar sauce as the cup kept tipping over related to the residents limited use of their left hand. The resident repeatedly struggled attempting to get the fish into their mouth as their left arm would not raise high enough. At the end of the meal their hand and nails were covered in tartar sauce and food remnants. The resident used the tablecloth as a napkin in an attempt to clean their hand. The resident did not have any left-handed adaptive equipment in place. No staff meal assistance was provided to the resident during the meal although multiple staff were present for the entirety of the meal.</p> <p>In an interview on 07/18/2024 at 1:33 PM, Resident 11 said their husband used to come in and assist them with their meals, but their husband had passed away two weeks ago. The resident said they did have difficulty getting the food to their mouth at lunch.</p> <p>In an interview on 07/22/2024 at 1:30 PM, Resident 11 was up in their wheelchair in their room. Their lunch tray had been removed. Resident 11 said no one had helped them with eating but they were able to eat the fish with their hands. The resident said they would have liked to have some help with meals. Resident 11 said the only adaptive equipment they have is for their right arm that's paralyzed. The resident said staff were still not turning them at night, they occasionally repositioned them but most nights they did not.</p> <p>In an interview on 07/23/2024 at 9:22 AM, Resident 11 said they were only turned once last night, around 1:30 AM.</p> <p>In an interview on 07/23/2024 at 1:28 PM, Resident 11 was sitting up in their wheelchair in their room and said staff actually helped them eat their lunch today, which surprised them.</p> <p>In an interview on 07/24/2024 at 9:20 AM, Resident 11 was lying in bed watching TV, and said they had been able to eat their pizza last night by themselves.</p> <p>In an interview on 07/25/2024 at 9:21 AM, Resident 11 was in bed watching TV and stated they did not get turned at all on night shift last night. They said the last time they were repositioned was last night at 8 PM when they went to bed, and no one had repositioned them yet this morning. Resident 11 said staff did not assist them with dinner last night nor breakfast today.</p> <p>In an interview on 07/24/2024 at 2:45 PM, Staff D, Licensed Practical Nurse (LPN) said Resident 11 needed one person assistance with eating, and they usually had them eat in the dining room to get assistance. Staff D said sometimes the resident would ask staff to help them. Staff D said the resident had a hard time getting the bites up to their mouth.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/24/2024 at 2:50 PM, Staff C, LPN said Resident 11 needed assistance with eating and that the resident's spouse had recently passed who always helped the resident eat.</p> <p>In an interview on 07/25/2024 at 9:20 AM, Staff E, Nurse's Aide Certified (NAC) said Resident 11 needed meal assistance, encouragement and a lot of help. Staff E said staff needed to sit with them as the resident would sometimes fall asleep and had difficulty getting the food into their mouth. Staff E said Resident 11's spouse used to be at the facility the whole day and assist the resident at meals.</p> <p>In an interview on 07/25/2024 at 9:23 AM, Staff F, NAC said Resident 11 needed one person assistance for eating.</p> <p><RESIDENT 33></p> <p>Resident 33 admitted on [DATE] with diagnoses to include lung cancer, leukemia (blood cancer) and chronic obstructive pulmonary disease (COPD - group of diseases that cause airflow blockage and breathing problems).</p> <p>Review of the quarterly MDS assessment on 05/27/2024 showed Resident 33 had limited range of motion in both of their upper extremities and they did not have rejections of care.</p> <p>Review of Resident 33's current care plan initiated on 02/19/2024 showed the resident required set up assistance with their meals and staff were to assist as needed.</p> <p>In an observation on 07/23/2024 at 1:19 PM, Resident 33 was in bed with their overbed table out of reach with the uneaten lunch tray on it. Resident 33 was holding a roll and eating it. There was a glass of milk and juice not consumed. Resident 51, the roommate of Resident 33 was standing in the bathroom nearby. Resident 51 was shaking their head with a look of displeasure on their face and said, Excuse me, but (Resident 33) needs help. The food needs to be closer, and you have to put the food on the fork and tell (them) what it is. (Resident 33) needs help.</p> <p>In an interview on 07/25/24 9:24 AM, Staff E, NAC said Resident 33 needed to be in the dining room so they could sit with them and encourage them to eat, or they would close their eyes and go to sleep.</p> <p>In an interview on 07/25/2024 at 10:19 AM, Staff B, Director of Nursing said Resident 11, 28 and 33 needed to be assisted in the dining room for meals. Staff B was not aware of the lack of meal assistance for the residents. Staff B said the NAC's have a list of who needs assistance for meals on their hall and staff were aware who needed help.</p> <p>47047</p> <p><RESIDENT 28></p> <p>Resident 28 admitted to the facility on [DATE] with diagnoses that included high blood pressure, atrial fibrillation (irregular heartbeat), and a broken right leg.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 28's MDS assessment dated [DATE] showed they were alert and oriented and required set up or clean up assistance for oral hygiene.</p> <p>Review of Resident 28's care plan, dated 06/10/2024 showed they had their natural teeth and was able to rinse, spit and brush their teeth.</p> <p>On 07/18/2024 at 10:04 AM Resident 28 stated that they brush their own teeth. There was no observed sign of a toothbrush within reach/sight of them.</p> <p>In an interview/observation on 07/22/2024 at 11:32 AM, Resident 28 stated their hygiene products to include a toothbrush was in their closet. With permission, Resident 28's hygiene products were located in a wash bin in the upper cabinet of their closet. The bin contained a toothbrush, a kidney basin (a receptacle used to hold body fluids), a hairbrush, a hand towel and toothpaste, all items dry with no indication of recent use. Resident 28 stated they brush their own teeth.</p> <p>In an interview/observation on 07/23/2024 at 9:58 AM, Resident 28 stated that they had not had oral care done or offered. With permission, located Resident 28's wash bin which were in the same location as the day prior, upper cabinet of their closet. Resident 28's toothbrush and kidney basin were dry with no indication of recent use. The contents of the wash bin were in the exact same location as the day prior.</p> <p>In an interview/observation on 07/24/2024 at 10:55 AM, Resident 28 stated they had not had oral care done this morning or offered the night before. With permission, located Resident 28's wash bin which was found in the closet. The items in the wash bin were in the same location and were dry with no indication of recent use.</p> <p>In an interview with Staff J, NAC, stated they had offered and provided Resident 28 with oral care the last 2 days and had not offered to them yet today. Staff J stated Resident 28 required assistance with brushing their hair, getting dressed, and changing their clothes but was able to brush their teeth independently when sitting up. Staff J stated the expectation for the NAC's was to ensure oral care was provided as needed in the morning and in the evening.</p> <p>This is a repeat deficiency from 07/21/2023</p> <p>WAC reference 388-97-1060 (2)(c).</p>		

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NAME OF PROVIDER OR SUPPLIER Mira Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 South 18th Street Mount Vernon, WA 98274	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on interviews and record reviews, the facility failed to identify the risk of sun exposure, adequately supervise and initiate interventions to avoid a sunburn for 1 of 1 resident (Resident 26) reviewed for accidents. Resident 1 sustained a first-degree sunburn to their forehead and arms when they left the facility on an outing. This failure placed the resident at risk for a more severe sunburn, pain and decreased quality of life.</p> <p>Findings Included .</p> <p>Resident 26 admitted to the facility on [DATE] with diagnoses that include stroke, high blood pressure, and peripheral vascular disease (narrowing of blood vessels).</p> <p>Review of Resident 26's Quarterly Minimum Data Set (MDS- An assessment Tool) dated 06/03/2024 showed they were cognitively intact, required assistance with their upper and lower dressing, and had impaired range of motion (the capability of a joint to go through its complete movements) of their upper and lower extremities on their left side.</p> <p>Review of a progress note dated 07/15/2024 at 1:09 PM, showed the provider met with Resident 26 and found they had a sunburn to their forehead and arms.</p> <p>Review of Resident 26's Medication Administration Record (MAR) for July 2024 showed they had an order for sunblock external lotion to be applied to exposed, bare skin topically as needed for skin protection. The order date was 05/15/2024, revised on 07/16/2024. The MAR for May 2024, June 2024 and July 2024 showed the sunblock could only be provided from the 15th of the month though the end of the month.</p> <p>Review of Resident 26's current care plan showed they had a potential in behavior problem related to refusals to wear sunblock when going outside of the facility and they had an actual impairment to their skin related to a sunburn (Initiated 07/15/2024). There were no other noted care plan problems related to sunblock use or sunburns prior to 07/15/2024.</p> <p>Review of the facility incident report dated 07/15/2024 showed Resident 26 sustained a sunburn over the weekend of 07/13/2024 and 07/14/2024 while he was out at a park and the sunburn was found on 07/15/2024 by the resident's provider. The incident report showed no interviews from staff that worked that weekend, or that nursing staff were educated/in-serviced to offer residents sunblock when they go outside.</p> <p>Review of the facility sign in/sign out sheet located in a binder at the nurse's station, undated, showed no entries for Resident 26.</p> <p>In an interview on 07/18/2024 at 1:06 PM Resident 26 stated they sustained a sunburn while out of the facility, was not offered sunblock, and was not aware that the facility had sunblock available to residents. Resident 26 stated the facility staff was aware of his outing to the park over the weekend of 07/13/2024. Resident 26 denied any pain related to the sunburn.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/24/2024 at 11:28 AM Staff K, Licensed Practical Nurse, stated Resident 26 sustained a sunburn over the weekend of 07/13/2024. Staff K stated Resident 26 had left the facility twice during their day shift on 07/14/2024 and they were not sure how long they were out of the facility. Staff K stated they did not offer Resident 26 sunblock and they did not have an order for sunblock when they worked on 07/14/2024. Staff K stated the nursing assistants did not report to them if sunblock was offered to Resident 26. Staff K stated they learned Resident 26 had sustained a sunburn over the weekend on Monday 07/15/2024. Staff K stated they were not interviewed by management regarding Resident 26 and the sunburn sustained.</p> <p>In an interview on 07/24/2024 at 1:07 PM Staff A, Administrator, stated the facility did not have a policy related to sunblock use or sunburn prevention. Staff A stated sunblock was kept in the treatment carts, accessible only to nurses. Staff A stated all residents had orders for sunblock, were offered sunblock as needed and applied by nursing if accepted.</p> <p>In an interview on 07/24/2024 at 1:15 PM Staff B, Director of Nursing Services, stated Resident 26 sustained a sunburn on either Saturday 07/13/2024 or Sunday 07/14/2024 and was unable to recall the actual date. Staff B stated they spoke with the nurse that worked on 07/13/2024 who reported that Resident 26 was offered and refused sunblock application. Staff B stated they did not interview any other staff about the sunburn Resident 26 sustained. Staff B stated Resident 26 had orders for sunblock as needed. Staff B reviewed Resident 26's MAR for July 2024 for sunblock and stated the order started after July 15, 2024, and they did not know why. Staff B stated they had revised the order on 07/16/2024 and they could not determine what was revised.</p> <p>Refer to WAC 388-97-1060(3)(g)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation and interviews, the facility failed to ensure resident meals were prepared and stored in accordance with professional standards of food safety for 1 of 1 facility kitchens, and 1 of 1-unit refrigerators. The failure to ensure the kitchen was free from potential contaminants, the maintenance to ensure the kitchen refrigerator, freezer and unit refrigerators were properly maintained left residents at risk for food contamination, food borne illnesses, and spoiled food.</p> <p>Findings Included .</p> <p><KITCHEN></p> <p>REFRIGERATOR</p> <p>During an observation on 07/18/2024 at 9:15 AM, the walk-in refrigerator was observed with a broken door seal, and the temperature was 45 degrees Fahrenheit (F). The temperature log taped to the front of the door on the refrigerator showed the temperature was documented at 38 degrees F on 7/18/2024 with no time. A 5 gallon, opened and undated, bucket of pickles was observed inside the refrigerator sitting on a stool directly to the right of the refrigerator door with a rim lined with small circular green dots consistent with mold.</p> <p>During an interview and observation on 07/22/2024 at 11:43 AM, Staff L, Dietary Manager was shown the bucket of pickles with the green dots of mold located in the walk-in refrigerator. The bucket was observed undated, and the lid to the bucket not completely closed, and small circular green dots consistent with mold around the outer rim . Staff L stated pickles last forever as the reason for them not being dated and they would have the green dots cleaned off the outside of the bucket.</p> <p>FREEZER</p> <p>During an observation on 07/18/2024 at 9:15 AM the walk-in freezer door, located in the back of the walk-in refrigerator was observed to have a three-inch layer of ice covering the window and bottom of the door. The freezer contained a plate of unidentified food, covered in plastic wrap, with a date of 7/13 or 7/15 written on it. The temperature of the freezer was found to be 9 degrees F.</p> <p>During an observation on 07/22/2024 at 11:43 AM the walk-in freezer door was observed to contain the same three-inch layer of ice covering the window and bottom of the door. The ice was slick to touch.</p> <p>KITCHEN FOOD PREPARATION AREA</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 7/18/2024 at 9:15 AM the cooking and meal preparation area to include a metal tiered shelving unit located next to the refrigerator unit which contained pots/pans and mixing bowls was observed. In the corner of the shelving unit, next to the pots/pans and mixing bowls there were visible cobwebs, debris, and small black partials of matter. A piece of tile that had been adhered to the wall had fallen off and was leaning against the metal shelving unit. A wash rag was lying on the floor next to the side of the stove. The flooring throughout the kitchen had black markings around the plastic floor mats and spots throughout the flooring consistent with spills (circular in shape with splatter marks). The walls throughout the kitchen contained discoloration with splash like dried drip patterns with a variety of brown hue discolorations.</p> <p>In a follow-up observation on 07/22/2024 at 11:43 AM the same black markings and discoloration remained on the kitchen flooring in the same spots observed on 07/18/2024.</p> <p><UNIT PANTRY></p> <p>During an observation on 07/23/2024 at 9:27 AM the unit refrigerator was observed to have a temperature of 45 degrees F. The refrigerator contained a spill, sticky to touch on the shelving unit holder. The freezer bottom contained dry food particles and debris and was sticky to touch. The ice machine, located in the pantry, the lid was open, had an orange wet discoloration on the sides of the sliding lid track. The drawers contained sealed dried foods; the bottoms of the containers had food debris were sticky to touch.</p> <p>In an interview on 07/22/2024 at 11:43 AM Staff L, Dietary Supervisor, stated the kitchen was cleaned daily which included mopping the floors. When asked about a marking consistent with a spill Staff L used a butter knife to scrape the debris/spill off the floor and stated the spill was likely too hard to get off just using the mop. Staff L stated the kitchen usually gets a deep clean every 6 months where the shelving units are moved and cleaned underneath. Staff L stated the ice on the freezer door had been there for some time, are cleaned, and the ice reaccumulates. Staff L stated the bucket of pickles should not have had the small circular green dots consistent with mold around the rim. Staff L stated that pickles last forever when asked when the pickle bucket had been opened. Staff L stated the seal to the refrigerator had been broken for approximately two weeks and was on order for replacement. Staff L stated they reported the broken seal to maintenance and the refrigerator has been keeping the appropriate temperature as it should.</p> <p>In an interview on 07/22/2024 at 12:11 PM Staff N, Maintenance Staff, stated the the had been broken for approximately two weeks. Staff N stated the kitchen staff had informed them of the need for the seal to be repaired and the part was on order and should be delivered soon. Staff N stated they were aware of the ice buildup on the front of the freezer door and thought the seal to the freezer door required replacement. When asked for the maintenance log, Staff N stated that they had not logged the repair needed for either of the seals.</p> <p>In an interview on 07/24/2024 at 2:40 PM Staff A, Administrator, stated the seal was broken by a delivery person a few weeks ago. Staff A stated the part was due to be delivered to the facility on [DATE].</p> <p>Refer to WAC 388-97-1100 (3)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>37890</p> <p>Based on interview and record review the facility failed to ensure their policy related to foods brought in from outside sources included how the facility would safely store those foods and the manner in which it would ensure they were stored in a way that was either separate or easily distinguishable from facility food. This failure placed residents at risk for decreased quality of life related to an inability to exercise their right and preference to have food items of their choice brought into the facility and safely stored.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Resident/Personal Food Storage, dated 07/2024 stated the facility allowed residents the opportunity to choose to accept food from any friends, family, visitors, or other; however, the policy further stated that personal resident refrigeration units were not permitted in resident rooms due to electrical load capacity and that food or beverages brought in from outside sources may not be stored in facility pantries or refrigeration units. The policy stated any perishable food items not consumed the day of opening were to be discarded.</p> <p>In an interview on 07/23/2024 at 1:29 PM, Staff A, Administrator, stated the facility policy had been not to allow residents to keep any foods in the facility refrigerators. Staff A confirmed that residents did not have the option of having personal refrigerators in their rooms and stated families and visitors were asked to bring in single serving items only, and residents were being required to dispose of any uneaten perishable foods due to the policy that outside food items would not be stored by the facility.</p> <p>Refer to F 561</p> <p>No associated WAC reference</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation, interview, and record review, facility staff failed to follow accepted infection control practices during the provision of catheter care and management for 2 of 4 residents (Residents 43 and 222) reviewed for urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag). This failure placed residents at risk for facility acquired or healthcare-associated infections and related complications.</p> <p>Findings included .</p> <p><RESIDENT 222></p> <p>Resident 222 admitted to the facility on [DATE], hospitalized on [DATE] and readmitted on [DATE] with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movements), urinary retention, and repeated falls.</p> <p>Review of Resident 222's hospital records dated 07/11/2024 showed the resident was hospitalized with a urinary tract infection associated with their urinary catheter</p> <p>In an observation and interview on 07/23/2024 at 10:58 AM, Staff M, Nursing Technician, was observed emptying Resident 222's catheter bag without cleansing the spout before or after. Staff M was observed to change gloves after emptying the urinal and did not complete hand hygiene in between. When asked about cleansing the spout prior to and after emptying the catheter bag, Staff M stated they should have used an alcohol wipe to cleanse the spout.</p> <p>37890</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility in 2021 and had a long-term urinary catheter related to neurogenic bladder (condition affecting the nerves that control the bladder.)</p> <p>Review of Resident 43's care plan dated 09/27/2021 showed an intervention was in place directing staff to secure the catheter to facilitate flow of urine, prevent kinking and prevent accidental removal.</p> <p>In an observation on 07/19/2024 at 10:48 AM, Resident 43 was outside the facility self-propelling in their wheelchair with their catheter bag hanging in a pink privacy bag under their wheelchair. The tubing of the catheter was observed to be unsecured and was hanging down dragging on the concrete.</p> <p>In a continued observation on 07/19/2024 at 10:53 AM, Resident 43 was returning from outside of the facility with their catheter tubing dragging along the concrete. The resident re-entered the facility and the tubing drug over the door threshold and continued to drag along the carpeting once back inside the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 07/23/2024 12:17 PM, Resident 43 was up in the hallway self-propelling and their catheter tubing was observed to have one loop hanging low and dragging on the carpet.</p> <p>In an interview on 07/25/2024 at 8:40 AM Staff A, Administrator, stated they in-serviced/educated their staff yesterday with regard to ensuring catheter tubing was not dragging on the floor. Staff A stated they usually pay very close attention to catheter tubing for infection control reasons.</p> <p>Refer to WAC 388-97-1320(1)(a)</p>		