

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 06/06/2025
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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 2 of 6 residents (Residents 50, and 214) reviewed for unnecessary medications received medication specific monitoring. This failure placed residents at risk for unrecognized effects and/or side effects of high-risk medications.</p> <p>Findings included .</p> <p>&lt;RESIDENT 50&gt;</p> <p>Resident 50 admitted [DATE] with diagnoses which included depression and anxiety.</p> <p>Review of Resident 50's medical record on 06/05/2025 documented the resident admitted to the hospital after experiencing a side effect of their antidepressants which caused Syndrome of Inappropriate Antidiuretic Hormone (SIADH), (an issue with their body's production of antidiuretic hormone causing their body to retain more fluid) which caused their sodium levels to be too low.</p> <p>In an interview on 06/02/2025 at 1:00 PM, Resident 50 stated they had depression and a history of trauma. Resident 50 stated they were abruptly taken off the antidepressants they had been taking for 30 years. Resident 50 stated the medications had affected their sodium levels, and they had gotten really confused, dizzy, were falling and were told they had to stop those medications. Resident 50 stated they were now having more depression, and stated they had no motivation to do anything at all and just didn't care about anything. Resident 50 said they talked to someone about it and they had an order to start a new antidepressant medication tonight. Resident 50 stated they were worried about starting the new medication and how it would affect them.</p> <p>Review of the resident's mood and behavior monitoring since admission on [DATE] showed the resident had not been on any kind of depression symptom monitor. The resident's admission Minimum Data Set Assessment (a required assessment tool) dated 05/01/2025 showed the resident initially denied depression symptoms during interview and also during an admission visit with the facility behavioral health provider.</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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow up behavioral health provider note dated 05/28/2025, documented the resident acknowledged they had not been truthful about their mood during the initial visit with them. The provider conducted a standardized depression screening tool (PHQ-9) which showed a score of 10, which indicated mild to moderate depression recommending follow up. Review of Resident 50's record showed there had been no implementation of target behaviors or depressive symptom monitoring following this provider visit.</p> <p>Review of Resident 50's physician's orders showed an order for Trazodone (an antidepressant) to start the evening of 06/02/2025.</p> <p>Review of Resident 50's record on 06/05/2025 showed the resident's new antidepressant medication had been administered as ordered on 06/02/2025, 06/03/2025 and 06/04/2025. There were no target behaviors, side effect monitoring, depressive symptom monitoring or update to the care plan put in place related to the new medication.</p> <p>In an interview on 06/05/2025 at 10:34 AM, Staff B, Director of Nursing Services (DNS), stated it was not indicated to have a depression monitoring in place for Resident 50 on admission despite their history and admitting diagnosis, because Resident 50 had denied depression symptoms and had not presented as being depressed. Staff B stated that typically the facility reviewed new orders for medications as a team to ensure that all the components were in place which would include target behaviors, symptom monitoring, side effect monitoring and updates to the care plan and stated this had been missed for Resident 50.</p> <p>&lt;RESIDENT 214&gt;</p> <p>Resident 214 was a new admission to the facility. Resident 214's diagnoses included depression.</p> <p>Record review of Resident 214's 'Provider's Orders' on 06/06/2025, documented that Resident 214 was prescribed two different types of antidepressant medication. Orders did not contain behavior monitors, medication side effect monitors or non-pharmacological interventions.</p> <p>Record review of Resident 214's 'Medication Monitors' on 06/06/2025, documented that Resident 214 was prescribed antidepressant medication. Orders did not contain behavior monitors; medication side effects monitors or non-pharmacological interventions.</p> <p>During an interview on 06/05/2025 at 1:00 PM, Staff D, Licensed Practical Nurse (LPN), stated that Resident 214 did not have behavior monitors, medication side effect monitors or non-pharmacological intervention for antidepressant medications.</p> <p>During a joint interview on 06/05/2025 at 1:15 PM, Staff B, and Staff C, Resident Care Manager (RCM)/LPN, stated that Resident 214 did not have behavior monitors, medication side effects monitors or non-pharmacological interventions in place.</p> <p>Reference WAC 388-97-0620</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** & RESIDENT 31&gt;</p> <p>Resident 31 was admitted to the facility on [DATE] with diagnoses to include CHF and HTN.</p> <p>Review of Resident 31's MAR for June 2025 showed the following order:</p> <p>-</p> <p>Carvedilol tablet 6.25 mg, give one tablet by mouth two times daily for HTN. Hold for HR &55 or SBP &100. There was no documentation indicating that BP or HR had been monitored prior to administering eight of eleven doses per physician orders.</p> <p>Review of Resident 31's clinical record vital signs with a print date of 06/06/2025, showed no documented BP or HR for the eight of the eleven doses of the Carvedilol given in June 2025. The documentation for the vital signs included:</p> <p>-</p> <p>On 06/01/2025, BP and HR were documented once.</p> <p>-</p> <p>On 06/04/2025, BP and HR were documented once.</p> <p>-</p> <p>On 06/05/2025, BP and HR were documented once.</p> <p>In an interview on 06/06/2025 at 8:30 AM, Staff D, LPN stated that for medications that have BP and HR parameters, they check the BP and HR first to ensure they are within the parameters and document the BP and HR results on the MAR or in the resident's chart under the vital signs tab. If the vital signs being taken are within the parameters, then they give the medications.</p> <p>In an interview on 06/06/2025 at 8:42 AM Staff M, LPN stated that the Nursing Assistant Certified (NAC) takes the BP and HR and if they were outside the parameters they would re-check them prior to giving the medications with parameters. Staff M stated that document the BP and HR in the MAR or in the resident's chart under the vital signs tab.</p> <p>In an interview on 06/06/2025 at 8:50 AM, Staff B stated that Licensed Nurses (LNs) were expected to document the vital signs in the residents' chart whether it's on the MAR or under the vital signs tab. Staff B stated their expectations for LNs is that the nurse reviews the vital signs obtained by [NAME] NAC and if they are outside the parameters the LN would recheck that resident's vital signs prior to administering the medications. Staff B stated they don't audit for medications given outside the parameters, and it does not print in their medication error report. If they find an error, then they would provide education to staff. Staff B was not aware of missing vitals in Resident 31's clinical record for Carvedilol medication parameters but stated they would review it.</p> <p><i>(continued on next page)</i></p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&lt;RESIDENT 40&gt;</p> <p>Resident 40 was admitted to the facility on [DATE] with diagnoses to include HTN and CHF.</p> <p>Review of Resident 40's physician orders showed the following:</p> <ul style="list-style-type: none"> - Carvedilol 6.25 mg, give 1.5 tablet by mouth two times a day. Hold if SBP &lt;110 or HR &lt;60 bpm. Order date was 05/17/2025. - Carvedilol 12.5 mg, give half a tablet by mouth two times a day. Hold if SBP &lt;110 or if diastolic BP (DBP - bottom number in the blood pressure reading, the pressure in your arteries when your heart is at rest between beats) or HR &lt;60 bpm. Order date was 04/11/2025 and was discontinued on 05/17/2025. <p>Review of Resident 40's June 2025 MAR with a print date of 06/03/2025 and electronic chart under the vital signs tab with a print date of 06/05/2025 showed no documentation of resident's HR for five of the nine doses for the Carvedilol given.</p> <p>Review of Resident 40's May 2025 MAR, with a print date of 06/03/2025 showed Carvedilol was given outside the parameters three times.</p> <p>Review of Resident 40's April 2025 MAR with a print date of 06/03/2025 showed Carvedilol was given outside the parameters once.</p> <p>Review of Resident 40's physician orders showed the following order:</p> <ul style="list-style-type: none"> - Hydralazine Hydrochloride (HCl) 10 mg, give 1 tablet by mouth two times a day. Only administer if SBP is greater than 150. Order date 05/17/2025. <p>Review of Resident 40's May 2025 MAR with a print date of 06/03/2025 showed that Hydralazine medication was given outside the parameters four times.</p> <p>In an interview on 06/06/2025 at 8:30 AM, Staff D stated that for medications that have BP and HR parameters, they check the BP and HR first, to ensure they are within the parameters and they document the BP and HR in the MAR or in the resident's chart under the vital signs tab. If it's within the parameters, then they give the medications.</p> <p>In an interview on 06/06/2025 at 8:42 AM Staff M, LPN stated that the NAC takes the BP and HR and if they were outside the parameters they would re-check them prior to giving the medications. Staff M stated that they document the BP and HR in the MAR or in the resident's chart under the vital signs tab. Staff M reviewed Resident 40's June 2025 MAR and stated there was no BP and HR documentation for the Carvedilol.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/06/2025 at 8:50 AM, Staff B stated that Licensed Nurses (LNs) were expected to document the vital signs in the residents' chart whether it's on the MAR or under the vital signs tab. Staff B stated their expectations for LNs is that the nurse reviews the vital signs obtained by [NAME] NAC and if they are outside the parameters the LN would recheck that resident's vital signs prior to administering the medications. Staff B stated they don't audit for medications given outside the parameters, and it does not print in their medication error report. If they find an error, then they would provide education to staff. Staff B was not aware that Resident 40 received medications when their vital signs were outside the ordered parameters in April and May 2025 or that there was missing documentation of the residents BP and HR in the clinical record but stated they would review it.</p> <p>Reference WAC 388-97-1620(2)(ii)</p> <p>Based on observation, interviews, and record reviews, the facility failed to follow professional standards of practice for 3 of 5 residents (Residents 54, 40, and 31) reviewed for unnecessary medications. Failure to follow physician orders when administering medications, and administering medications outside established parameters or without documented parameters placed residents at risk of medication errors and acute medical problems.</p> <p>Findings included .</p> <p>&lt;RESIDENT 54&gt;</p> <p>Resident 54 was a short-term resident of the facility with diagnoses that included congestive heart failure (CHF- a condition where the heart does not pump blood as well as it should), and hypertension (HTN- high blood pressure). According to the admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] showed the resident had mild cognitive impairment.</p> <p>Review of Resident 54's Physician order summary report as of 05/14/2025 showed the following orders:</p> <ul style="list-style-type: none"> - Midodrine (a blood pressure (BP) medication) 2.5 milligrams (mg) by mouth two times daily for heart failure, hold for Systolic Blood Pressure (SBP), top blood pressure number, greater than (&gt;) 110. Order discontinued on 05/14/2025. - Midodrine 5 mg by mouth three times daily for heart failure, hold for SBP &gt; 140. Order started on 05/22/2025. - Metoprolol (a BP medication) 200 mg by mouth one time daily for HTN, hold for SBP less than (&lt;) 110 or a Heart Rate (HR) &lt; 60. Order was initiated on 05/15/2025 with dose increased to 400 mg daily on 05/16/2025. <p>Review of Resident 54's May and June 2025 Medication Administration Record (MAR) documented the following:</p> <ul style="list-style-type: none"> - On 05/17/2025 AM dose, SBP=96, and metoprolol was administered outside physician-ordered parameters. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - On 05/18/2025 AM dose, SBP =100 and the medication was administered. - On 05/25/2025 AM dose, SBP=102 and the medication was administered. - On 05/31/2025 AM dose, SBP=104 and the medication was administered. - On 06/01/2025 AM dose, SBP=105 and the medication was administered. <p>Review of Resident 54 May 2025 Medication Administration Record (MAR) documented the following:</p> <ul style="list-style-type: none"> - On 05/15/2025, PM dose, SBP=115, and midodrine was administered outside physician-ordered parameters. - On 05/16/2025 AM dose, SBP=129 and the medication was administered. - On 05/16/2025 PM dose, SBP =138, and the medication was administered. - On 05/17/2025 PM dose, SBP =119, and the medication was administered. - On 05/20/2025 AM dose, SBP =113, and the medication was administered. - On 05/20/2025 PM dose, SBP =145, and the medication was administered. <p>During a joint interview on 06/05/2025 at 1:15 PM, Staff B, the Director of Nursing Services (DNS), and Staff C Resident Care Manager (RCM)/Licensed Practical Nurse (LPN) stated that a check mark by medication in the MAR indicated that the medication had been administered. Staff B and Staff C stated that on 05/17/2025 the metoprolol had been administered outside of the established parameters, but they were unable to navigate the MAR to view any of the other dates. Staff B and Staff C reviewed Resident 54's May 2025 Mar's and stated that the Midodrine medication had been administered outside of the parameters on 05/17/2025, but they were unable to access the computer system to check the other dates.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interviews, the facility failed to prepare food under safe and sanitary conditions in the facility kitchen. The failure to ensure hand hygiene when changing gloves and staff not wearing beard nets placed residents at risk for food contamination and foodborne illnesses.</p> <p>Findings included .</p> <p>According to the facility policy titled Dress policy dated 03/02/2015, kitchen staff, hair and beards must be effectively restrained upon entering the kitchen. Hair restraints include beard nets.</p> <p>In an observation on 06/03/2025 at 11:45 AM during tray line (a system used to assemble and distribute meal trays), Staff N, Dietary Supervisor and Staff O, Dietary Aid had beards and were not wearing beard nets.</p> <p>In an interview on 06/03/2025 at 11:45 AM, Staff N stated that as long as the beard was trimmed and short then staff did not need to wear a beard net. Both Staff N and Staff O had facial hair.</p> <p>In an observation on 06/03/2025 at 12:09 PM, Staff N put gloves on without washing their hands prior to preparing a salad plate with two slices of tomatoes and handed the plate to the cook, then Staff N took the gloves off and did not wash their hands.</p> <p>In an observation on 06/03/2025 at 12:25 PM, Staff N wearing gloves grabbed a container from the fridge and gave it to the cook. Staff N was then observed removing their gloves and did not wash their hands. Staff N put on new gloves without washing their hands and grabbed a turkey wrap from the fridge and gave it to the cook. Staff N removed their gloves and did not wash their hands.</p> <p>In an interview on 06/05/2025 at 8:49 AM Staff N stated that they wear gloves whenever they do food preparation, when they touch food or utensils and drinks. Staff N stated that the process prior to applying new gloves was for staff to wash their hands. Staff N stated when staff leave what they were doing to do something else, like when touching raw meat then they move to touching vegetables they should be changing their gloves. When asked about my observation regarding them not washing their hands before and after putting on gloves, they stated they were not touching anything before they put on new gloves. Staff N stated that if staff beard's are trimmed short, they don't have to wear beard nets.</p> <p>Reference WAC 388-97-1100(3)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &lt;RESIDENT 40&gt;</p> <p>Resident 40 was initially admitted to the facility on [DATE], was hospitalized then re-admitted on [DATE] with diagnoses to include depression and anxiety.</p> <p>In a record review on 06/04/2025, Resident 40's electronic chart showed two PASSR's. The first PASSR was dated 05/05/2024, with an evaluation done on 07/20/2024 and did not identify any issues. The second PASSR was dated 08/19/2024, and was marked evaluation required for significant change. There were no evaluations for significant change documented in resident's electronic chart.</p> <p>Review of Resident 40's progress notes with a print date of 06/03/2025, documented there were no notes regarding the 08/19/2024 PASSR.</p> <p>In an interview on 06/04/2025 at 2:56 PM, Staff K stated that for existing residents, they would fill out a new PASSR if there were changes in a residents' psychotropic medications (drugs that affect a person's mind, emotions, and behaviors) or mentation and send it to the PASSR Coordinator for review. When asked about Resident 40's PASSR dated 08/19/2024, Staff K stated that the other Social Services staff would have to speak to that.</p> <p>In a joint interview on 06/05/2025 at 9:46 AM, Staff K and Staff L, Social Worker/Patient Advocacy Resource, Staff L stated that the other staff was unavailable, and they were not able to find any notes regarding a follow up on Resident 40's 08/19/2024 PASSR. Staff L stated they talked to the PASSR Coordinator on 06/04/2025 and the PASSR may have been done in error.</p> <p>Reference WAC 388-97-1720(1)(ii)</p> <p>Based on interview and record review the facility failed to ensure a system in which resident's records were complete, accurate, accessible and systematically organized for 2 of 5 residents (Residents 460 and 40) reviewed. This failure included incomplete care conference documentation and Preadmission Screening and Resident Reviews (PASSR- a federally mandated process for identifying and ensuring appropriate placement and services for individuals with serious mental illness (SMI), which placed residents at risk for unmet needs, a delay in care or services and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;RESIDENT 460&gt;</p> <p>Resident 460 was admitted to the facility on [DATE] with hospice enrollment on the same day.</p> <p>In an interview on 06/02/2025 at 1:47 PM, Resident 460 stated they were unsure about their care plan or attending their care plan meetings. Resident 460 stated they did not know what hospice care was and they wanted to go home.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 460's care plan IDT (Interdisciplinary Team) conference initial review note on 05/27/2025 at 11:41 AM, documented only social services from the IDT attended the conference. The note documented Resident 460 had not experienced any sign and symptoms of depression or anxiety and had some cognitive impairment, and their discharge plan was to remain in the facility long term care with hospice services. Further review of the care plan showed the other care plan elements including disease diagnosis, health and skin conditions, special treatment, medication reconciliation and regimen review, nursing plan of care, dietary plan of care, activity plan of care, and therapy plan of care were blank. There was no documentation in the note regarding hospice care services.</p> <p>In an interview on 06/05/2025 at 9:44 AM, Staff K, Social Services Supervisor, stated the initial care conference was held in Resident 460's room with hospice social worker and the resident's representative. Staff K stated that the care conference reviewed Resident 460's plan of care and identified their care needs. Staff K stated Resident 460 mentioned they wanted to go home, and this was reported to the hospice staff. Staff K stated the care conference initial review note dated 05/27/2025 (10 days prior) was not completed and they were still working on the documentation.</p> <p>In an interview on 06/05/2025 at 4:09 PM, Staff A, Administrator, stated their expectation was for social services to complete the care conference documentation within a day or two but ideally should be completed on the same day.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &lt;RESIDENT 261&gt;</p> <p>Resident 261 admitted to the facility on [DATE] with diagnoses which included recent norovirus (a contagious gastrointestinal virus spread by contact) infection and Clostridium Difficile infection (a contagious gastrointestinal toxin spread by contact). Both Norovirus and Clostridium difficile organisms required enteric precautions of soap and water hand hygiene; alcohol hand sanitizer does not kill those organisms. According to regulation based on Centers for Disease Control and Prevention standards, contact precautions require the staff to put on personal protective equipment (PPE) before entering the room, which included gowning and gloving, to perform hand hygiene that is appropriate to the organism, and require the facility to post signage to communicate the required level of precautions for staff and visitors.</p> <p>In an observation on 06/02/2025 at 2:11 PM, Resident 261's room was observed which showed a contact precautions sign on the door. The contact precautions sign showed instructions for staff to perform hand hygiene prior to entering and exiting the room. The signage did not provide organism specific enteric precautions to wash hands with soap and water prior to exiting the room.</p> <p>In an interview on 06/02/2025 at 2:30 PM, Staff E stated that Resident 261 was still being treated for Clostridium Difficile and should be on contact enteric precautions which would include hand hygiene with soap and water, which should be posted for staff and visitors.</p> <p>In an interview and observation on 06/04/2025 at 1:44 PM, Collateral Contact (CC1), contract staff, was observed to enter Resident 261's room without stopping to don PPE. CC1 was observed to walk to the bedside and begin speaking with Resident 261. Staff A, Administrator and Staff E went to the doorway of the room and told CC1 they needed to don PPE. CC1 stated they had not noticed the sign on the door.</p> <p>In an interview on 06/06/2025 at 9:00 AM, Staff E stated they had found that further education of the staff was needed related to ensuring the proper signage was posted and followed, and records were clear regarding infection precautions.</p> <p>Reference WAC 388-97-1320 (1)(a)(c),(2)(b)</p> <p>&lt;Transmission based precautions&gt;</p> <p>During an observation/interview on 06/02/2025 at 12:15 PM, Staff H entered a resident's room that had an 'enteric precautions' sign on the door without wearing PPE. When Staff H exited the room, they stated that it was unnecessary to wear PPE in the room because the precautions were for a wound.</p> <p>&lt;Enhanced Barrier Precautions (EBP)&gt;</p> <p>&lt;RESIDENT 214&gt;</p> <p>Resident 214 was a new admission to the facility. The resident was admitted to the facility with a diagnosis of a newly placed PEG tube (feeding tube inserted through the abdomen to the stomach), to allow the resident to receive nutrition directly to the stomach.</p> <p>(continued on next page)</p>		

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 06/06/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 214's Order Summary Report with a print date of 05/06/2025, documented provider orders for EBP: Personal Protective Equipment (PPE) for high contact care activities due to the resident's PEG tube ordered on 06/01/2025.</p> <p>During multiple observations on 05/02/2025, 05/03/2025, and 05/04/2025, it was noted that Resident 214 did not have an EBP sign displayed on their door.</p> <p>During an observation on 06/03/2025 at 12:44 PM, Staff D, LPN, entered Resident 214's room and administered medication via the PEG tube. Staff D did not don appropriate PPE while providing care to the resident.</p> <p>During an interview on 05/06/2025, at 8:22 AM, Staff C stated that residents who were admitted with a PEG tube were to be placed on EBP upon arrival at the facility.</p> <p>During an interview on 06/06/2025 at 8:27 AM, Staff E stated that Resident 214 should have been on EBP upon arrival at the facility. Based on observation, interview and record review, the facility failed to ensure that staff were compliant with Infection Prevention and Control Guidelines (IPCP) and standards of practice of using Personal Protective Equipment ([PPE] - specialized clothing including gowns and gloves worn to protect from infection or illness) for 3 of 5 residents (Residents 11, 214, and 261). These failures placed all residents and staff at an increased risk for the potential transmission of infections.</p> <p>Findings included .</p> <p>Review of a facility policy titled, Transmission-Based Precaution, revised in October 2022, documented for contact precaution, wearing a gown and gloves for all interactions what involved contact with the patient's environment and donning PPE upon room entry was required.</p> <p>&lt;RESIDENT 11&gt;</p> <p>Resident 11 readmitted to the facility on [DATE] with diagnoses to include extended spectrum beta lactamase (ESBL) resistance (an enzyme produced by bacteria that confers resistance to many common antibiotics).</p> <p>In an observation and record review on 06/02/2025 at 11:16 AM, a contact enteric precautions signage was posted on Resident 11's room door. The signage documented Gown and glove when entering the room.</p> <p>In an interview on 06/02/2025 at 2:28 PM, Staff E, Licensed Practical Nurse (LPN)/Infection Preventionist, stated Resident 11 required contact precaution which was recommended by the health department.</p> <p>In an observation and interview on 06/03/2025 at 12:15 PM, observed Staff F, Nursing Assistant Certified (NAC) enter the room with a lunch tray without applying a gown and gloves Staff F touched the bedside table, set up the lunch on the bedside table, and moved the bedside table with lunch closer to Resident 11. Staff F stated they did not need to wear a gown or gloves because they did not provide care. Reviewed the signage on the door with Staff F about Gown and glove when entering the room; Staff F stated gown and gloves were only required for providing care.</p> <p>(continued on next page)</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 06/03/2025 at 12:44 PM, observed Staff G, NAC enter Resident 11's room, without donning a gown and gloves, . Staff G touched the bedside table and collected the lunch tray from Resident 11's bedside table. Staff G stated they did not need to wear a gown and gloves which were only required for providing care like changing briefs.</p> <p>In an interview on 06/04/2025 at 1:30 PM, Staff H, NAC, stated gowns and gloves were only needed for doing care for residents with contact enteric precautions.</p> <p>In a joint interview on 06/06/2025 at 2:05PM with Staff C, LPN/Resident Care Manager (RCM), and Staff B, Registered Nurse/Director of Nursing, Staff B stated staff should follow the instructions on the signage posted on the doors.</p>		