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	03/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 3 of 3 halls (Residents 15,16, 18, 20, 27, 33, 43, 44, 47, 54, 64, 63, 67, 68, 70, 71, 5, 95, 94, 86) reviewed for influenza outbreak, 4 of 4 rooms reviewed for TBP (Rooms 212, 316, 213 and 115) and failed to implement their respiratory protection plan (RPP - a safety plan ensuring staff are properly trained, medically cleared, and fit-tested to wear an N95 mask) for 85 of 109 employed staff. The facility failed to ensure the staff used appropriate hand hygiene practices, staff were wearing personal protective equipment (PPE) in accordance with national standards (room [ROOM NUMBER]) and clean and disinfect universal resident medical equipment (room [ROOM NUMBER]). These failures placed all residents and staff at risk for potential infections. Findings included . Review of facility policy titled, Infection Prevention and Control Program, revised date 04/2025, documented that facility personnel will wash their hands after each direct resident contact and that the facility will use effective methods for safe storage, transport and disposal of garbage and infectious waste. Review of the facility policy titled, IPCP Standard and Transmission-Based Precautions, revised date 03/2024, documented that residents on Contact Precautions (precautions used for residents with known or suspected infections that can be transmitted through direct or indirect contact) should include a plan for discontinuation, and private rooms are preferred but if not available may be roomed with residents that have the same pathogen (germs that cause infection and disease). Contact Precautions require a gown and gloves for all interactions with the resident or resident's environment and the resident should be restricted to their room. Review of the facility policy titled, IPCP Standard and Transmission-Based Precautions, revised date 03/2024, documented that resident's on Droplet Precautions (precautions used for residents with known or suspected to be infected with pathogens transmitted by respiratory droplets) should be in a single room if possible. Mask and eye protection if indicated upon entry to the room is required. The policy also stated that a trash can must be positioned inside of the resident's room and near the exit for discarding PPE after removal, prior to exit of the room and that patient-care equipment (such as vitals equipment) would be preferred dedicated or disposable but if common use of equipment for multiple patients is unavoidable, to clean and disinfect the equipment before use on another patient. Review of the facility policy titled, IPCP Standard and Transmission-Based Precautions, revised date 03/2024, documented that resident's on Enhanced Barrier Precautions need to have expended PPE of gown and gloves during high-contact care activities. High-contact care activities can include wound care and urinary catheter (a tube inserted into the bladder to drain urine) care. Review of the untitled policy for the RPP, dated [DATE], documented that every employee who must wear a respirator will be provided with a medical evaluation before they are allowed to use an N95 (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mask, that fit testing will be repeated in accordance with State and Federal guidance, and that the records will be kept in the employees personnel file. <INFLUENZA OUTBREAK> In an observation on [DATE] at 9:06 AM, there was a sign posted on the facility's entrance door notifying all individuals who entered the facility was experiencing an increase in respiratory infections and visitor were encouraged to wear masks. The receptionist was handing out Aura 1870+ N95 respirators and requested the survey team to place one on. Note: each individual should be fit tested for a N95 respirator to ensure respirator was specifically fitted for that person. On [DATE], multiple observations from 9:06 AM to 4:00 PM, were made throughout the facility of staff wearing the same type of N95 respirator. In an interview on [DATE] at 10:48 AM, Staff D, Registered Nurse (RN)/Infection Preventionist (IP)/Assist Director of Nursing (ADON), was asked regarding the N95 respirators' being handed out to individuals who entered the building and if they have been specifically tested to the N95 respirator being handed out by the receptionist. Staff D stated N95 respirators should not have been handed out. Staff D stated the local health department directed the facility to wear N95 respirators during the influenza outbreak. Staff D stated the local health department directed the facility staff to wear surgical masks in the hallways but should continue to wear the N95 respirators when entering a resident's room identified as being on droplet precautions. In a record review, on [DATE], at 12:46 PM, Staff G, Acting Administrator, documented the facility's N95 respirator fit test program was incomplete and outdated. <RESPIRATORY PROTECTION PROGRAM> In a record review, on [DATE], at 12:46 PM, Staff G, Acting Administrator, provided N95 fit testing documentation for staff. N95 fit testing forms documented 50 staff had expired N95 fit testing and 35 staff had not been tested at all. The documentation the facility provided did not include the staff's medical evaluations. In an interview on [DATE], at 10:48 AM, Staff D stated that staff were fit tested on hire and annually. In an interview on [DATE], at 1:44 PM, Staff A, Interim Administrator, and Staff G stated that no medical evaluations were documented for staff who were to wear N95 masks. <CONTACT ENTERIC PRECAUTIONS> <room [ROOM NUMBER]> In an observation on [DATE], at 10:59 AM, room [ROOM NUMBER] was observed to have a Contact Enteric Precautions sign posted outside the door signifying the resident had Clostridium Difficile (C. Diff - a highly contagious bacteria that causes severe diarrhea and intestinal inflammation). Contact Enteric Precaution sign notified staff they must wear gown and gloves upon entry to the room and must wash hands upon exit. The sign also signified that the resident should be isolated until their room unless medically necessary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a record review on [DATE], at 11:00 AM, the electronic medical record confirmed that room [ROOM NUMBER] had a diagnoses of C. Diff. In a continuous observation on [DATE], at 11:01 AM, Staff BB, Physical Therapy Assistant (PTA), was walking the resident from room [ROOM NUMBER] down the hallway without the required PPE. Staff BB continued to walk down the hallway and then sat down in the reception area with the resident. In an interview on [DATE] at 11:04 AM, Staff D, Registered Nurse (RN)/Infection Preventionist (IP)/Assist Director of Nursing (ADON), was notified of the situation and immediately informed Staff BB they could not take residents out of their room who were on Contact Enteric Precautions and they were required to wear gown and gloves at all times. In a continuous interview with Staff BB stated they did not understand or know about the Contact Enteric Precautions. <room [ROOM NUMBER]/RESIDENT 32> Resident 32 was admitted to the facility on [DATE] and had a diagnoses of C. Diff active on [DATE]. Resident 32 was in room [ROOM NUMBER]-2. In an observation on [DATE] at 9:20 AM, room [ROOM NUMBER] was observed to have a Contact Enteric Precautions sign posted outside the door signifying the resident had C. Diff. It was observed that two residents resided in the room. In an interview on [DATE] at 9:21 AM, Staff M, RN, stated the resident in bed two did have an active diagnosis of C. Diff, but the resident in bed one did not have a diagnosis of C. Diff. Staff M stated bed two was off their antibiotics prescribed for the C. Diff, and were not having the associated symptoms, such as, watery diarrhea. Staff M stated they do not know why room [ROOM NUMBER] was not off of Contact Enteric Precautions. In an interview on [DATE], at 9:21 AM, Staff D stated that the resident in bed two had not been taken off Contact Enteric Precautions due to the resident cancelling their appointment for [DATE] on [DATE] that would have potentially cleared them of C. Diff. Staff D stated they were still waiting for next steps from the provider to be able to discontinue the Contact Enteric Precautions. Staff D stated bed one, resident without C. Diff, was in there because bed two used a brief and bed pan. Staff D could not recall if bed one was offered a room move. <HAND HYGIENE> In an observation of meal tray delivery on [DATE] at 12:13 PM, Staff A, Interim Administrator, was observed to take a resident meal tray out of the cart, delivered to a resident in room [ROOM NUMBER], assisted the resident with set up of their meal. The resident requested condiments for their meal, Staff A was observed to leave the resident room without performing hand hygiene, go to the meal cart, open it, pull out a box of condiments, touched items in the box, took out the condiments the resident requested, close the meal cart, and deliver condiments into the resident room without performing hand hygiene. <TRANSMISSION BASED PRECAUTIONS (TBP)> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation and interview on [DATE] at 1:09 PM, Staff C, Registered Nurse (RN), was observed in a TBP room with PPE signage on the room door that indicated an N95 respirator and eye protection were required to enter. Staff C was observed wearing a surgical mask and no eye protection while in the room. Staff C obtained vital signs on the resident and left the room when completed. When asked about the signage on the door, Staff C stated they did not follow the PPE signage on the door and should have worn an N95 respirator and eye protection to enter the room. <RESIDENT 32/room [ROOM NUMBER]> Resident 32 was admitted to the facility on [DATE] with diagnoses to include high blood pressure, heart failure, and weakness. In a review of Resident 32's Kardex (resident specific guide for staff on how to care for the resident), dated [DATE], documented conflicting information related to infection control/precautions. Under the safety section of the Kardex, Resident 32 was documented to require contact precautions and under infection control documented they were on enhanced barrier precautions. In a review of Resident 32's progress note, dated [DATE], documented the resident was having foul smelling bowel movements, tested positive for Clostridioides difficile (C-diff-a bacteria causing severe often healthcare associated diarrhea and colitis), and placed on contact precautions. On [DATE] at 12:20 PM Staff F, Nursing Assistant Certified (NAC), was observed to leave Resident 32's room with a lunch tray wearing a gown, placed the meal tray on the top of the dining meal cart, then removed their gown in the hallway next to the meal cart. On [DATE] at 11:30 AM, a contact precaution sign was observed on the door to room [ROOM NUMBER], belonging to Resident 32 and Resident 81. Observed two white trashcans with lids lined with red plastic bags, one labeled for trash and the other one for gowns. The trashcans were located in the middle of the room. Both trashcans' lids were observed to be covered with a fabric sling (flexible strap used with mechanical lift systems to move residents from one place to another) which hung to the floor. <RESIDENT 12/room [ROOM NUMBER]> Resident 12 admitted to the facility on [DATE] with diagnoses to include a pressure ulcer to their sacral region and complete paraplegia. On [DATE] at 1:40 PM, observed the door to Resident 12's room, 213, with a sign indicating droplet precautions, use of PPE of eye protection and mask. After an interview with Resident 12, this surveyor was unable to locate a trash can in the room or immediately outside the room to dispose of used PPE. In an interview on [DATE] at 1:40 PM Staff F stated they disposed of used PPE in trashcans in the resident rooms. On [DATE] at 2:12 PM observed Staff E, NAC, enter room [ROOM NUMBER], responding to their call light, wearing a mask and no eye protection. Observed a sign on the door indicating droplet precautions, underneath the droplet precautions sign was an enhanced barrier precaution sign indicating Resident 12 required PPE of a gown, gloves and mask. Observed Staff E assisting Resident 12 in their bed and adjusting linens. Observed Staff E exit room [ROOM NUMBER] with no gown, gloves or eye protection. In an interview on [DATE] at 2:12 PM Staff E stated they were assisting Resident 12 and they should have been wearing gloves and a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<room [ROOM NUMBER]> In an observation and interview on [DATE] at 1:58 PM observed Staff F, NAC in room [ROOM NUMBER] with a sign on the door for enhanced barrier precautions, wearing no gown or gloves. When Staff F exited room [ROOM NUMBER], asked what care they were providing and what precautions were in place, Staff F stated they were emptying catheters for each of the residents in the room. Staff F stated they had not realized the PPE required in the room. <MEAL DELIVERY> In an observation on [DATE] at 12:45 PM, Staff I, NAC delivered a meal tray to room [ROOM NUMBER] with a posted droplet precaution room. Staff I was wearing a N 95 mask and goggles but no gown or gloves. In an observation on [DATE] at 12:47 PM, Staff I, NAC entered room [ROOM NUMBER] and 115 with posted droplet precaution sign with a N 95 on and face mask but no gown or gloves. No hand hygiene was performed prior to entry to the rooms or after. In an observation on [DATE] at 2:03PM, Staff J, NAC, was putting on PPE prior to entering a room on droplet precautions and an EBP sign (single occupant room [ROOM NUMBER]) on the door. Staff J was observed to put on a mask, face shield, gloves, and did not put on a gown. Staff J entered room [ROOM NUMBER] with the Vital Sign (VS) cart, which had a blood pressure cuff, thermometer, and pulse oximeter. Staff J exited room [ROOM NUMBER] at 2:04 PM, with no face shield or gloves, sanitized hands and took the VS cart down the 300-hall next to the treatment medication cart. In an interview on [DATE] at 2:19 PM, Staff J was observed sanitizing the VS cart. Staff J was asked regarding exiting room [ROOM NUMBER] with the VS cart and not sanitizing the VS cart. Staff J stated they would be sanitizing the care in between residents. Reference WAC 388-97-1320(1)(a)(c)(2)(b)(4)(5)(c)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the level one Pre-admission Screening and Resident Review (PASRR- assessment/a federal requirement for Medicaid-certified nursing facilities to ensure individuals, especially those with mental illness, seeking admission are appropriately placed and receive necessary services) were accurate, referred after expiration of an exemption, and updated for 4 of 5 residents (Residents 2, 5, 11 and 20) reviewed for PASRR. This failure placed residents at risk of unmet mental health services and a diminished quality of life. Findings included .In a review of the facility policy titled, PASRR screening for Mental Disorder/ Intellectual Disability (F644) revised 03/10/2026 documented the facility procedures included Social Services Director/ Social Services Assistant must ensure the facility coordinated with appropriate, state-designated authority, all individuals would be screened for possible serious mental disorders or intellectual disabilities and related conditions, and a referral for a level two evaluation upon identification that an individual may have a serious mental illness/developmental disability. Expiration of an exemption was not part of the policy. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] with diagnoses to include high blood pressure and right hip fracture. Review of Resident 2's PASRR dated 12/01/2025 documented they had no serious mental illness or intellectual disability (SMI/ID), the physician certified they required fewer than 30 days of nursing level of care and a were exempted from a Level II evaluation. In an interview on 03/09/2026 at 1:15 PM Staff R, Social Services Director (SSD), stated Resident 2 admitted on [DATE], discharged to the hospital 01/14/2026 and readmitted on [DATE]. Staff R stated the only PASRR in Resident 2's electronic health record was the initial Level I with a 30-day exemption. Staff R stated they had not seen the exemption and must have missed it. Staff R stated they reviewed provider orders and if a resident was not on any psychotropic medications, then would assume the PASSR Level I was negative. Staff R stated they keep track of exemptions on their computer and send them to the evaluator on the 25th day. <RESIDENT 11> Resident 11 admitted to the facility on [DATE] with diagnoses to include right hip fracture, history of stroke, and unspecified dementia. Review of Level I PASRR evaluation dated 10/04/2025 documented Resident 11 did not have symptoms of serious mental illness, nor depressive or anxiety disorder. Review of Resident 11's psychiatric evaluation dated 10/23/2025 documented they had been struggling with agitation and anxiety to include verbal aggression and presented as such during the evaluation which could be related to depression. Review of Resident 11's Significant Minimum Data Set (MDS-an assessment tool) dated 12/26/2026 documented they took psychotropic medications routinely. The Care Area Assessment (CAA-care planning tool) documented Resident 11 was diagnosed with dementia and had agitation and (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aggression at times and use of an anti-anxiety medication was helpful. In a review of Resident 11's clinical record showed no other PASRR's were completed. In an interview on 03/11/2026 at 9:07 AM Staff R, SSD, stated they could not locate an updated Level I PASRR for Resident 11. Staff R stated if a resident had a change in condition the resident would be discussed by the interdisciplinary team for psychotropics and an updated Level I PASRR would be completed. Staff R stated Resident 11 required an updated Level I PASRR. <RESIDENT 5> Resident 5 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder with psychotic symptoms. Review of Resident 5's electronic medical record (EMR) documented the PASRR Level I was completed on 01/28/2026 and they required a referral for a PASRR Level II. The document showed Resident 5 was exempted from the PASRR Level II referral since they would require less than 30 days of care at the facility. The PASRR Level I documented a PASRR Level II must be completed if the anticipated discharge within 30 days does not occur. Review of Resident 5's EMR showed no documentation related to PASRR Level II follow up. In an interview on 03/09/2026 at 11:12 AM, Staff D, SSD, stated they kept a list of exempted residents and followed up with a PASRR Level II referral on 25th day after admission. Staff D confirmed they did not complete any documentation in Resident 5's EMR related to the PASRR Level II referral and stated they failed to get any documentation completed. <RESIDENT 20> Resident 20 admitted to the facility on [DATE] with diagnoses to include unspecified dementia (a disease that is a decline in mental abilities severe enough to interfere with daily life), insomnia, and anxiety. Review of Level l PASRR, dated 08/12/2025, documented Resident 20 had a 30-day hospital exemption but would require a Level ll PASRR if the scheduled discharge did not occur. Review of Level ll PASRR, dated 12/20/2025, documented an invalidation of the PASRR Level ll due to the resident being discharged from the facility, however Resident 20 had not been discharged . In a review of Resident 20's progress notes, dated 12/20/2025, at 5:42 PM, Staff R, SSD, documented that an incorrect PASRR invalidation was received from the evaluator. Staff R documented they emailed the PASRR evaluator about the error and was awaiting reply. No further documentation regarding the PASRR was located in Residents 20's EMR. In an interview on 03/09/2026, at 1:20 PM, Staff R, stated they had emailed the PASRR evaluator the incorrect PASRR from December 2025 and had not received a new one. Staff R reviewed their email correspondences and found an email from 12/27/2025 with a PASRR invalidation for Resident 20. Staff R stated they missed the email and their process did not include documenting correspondence with the PASRR evaluator. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1975 (1)(5)(9)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete and accurate for 7 of 7 residents (Residents 20, 32, 53, 92, 2, and 93) reviewed for certified nursing assistant (CNA) documentation, and 2 of 3 residents (Residents 92 and 53) reviewed for resident weekly skin checks. This failure included missing documentation for activities of daily living (ADLs - routine self-care such as dressing, bathing, eating, toilet, etc.), behaviors/interventions, meal consumption, voiding, and the completion of timely skin check observations which placed residents at risk for incomplete and inaccurate medical records and unmet care needs. Findings included . Review of the facility policy titled, Charting and Documentation, revised April 2008, documented all services provided to the resident shall be documented in the resident's medical record. <NURSING ASSISTANT CERTIFIED DOCUMENTATION> <RESIDENT 20> Resident 20 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia, unspecified muscle weakness, unspecified dysphagia (difficulty swallowing), and cognitive communication deficit. Review of Resident 20's care plan, dated 12/01/2025, documented they had an ADL self-care performance deficit related to dementia and weakness. Resident 20 required assistance of one person for toileting, transferring, bed mobility, bathing, personal hygiene, dressing, and eating. Review of Resident 20's Minimum Data Set (MDS - an assessment tool) assessment, dated 02/04/2026, documented substantial/maximum assistance was required for oral hygiene, toileting hygiene, showering, dressing, personal hygiene, and transferring. Review of Resident 20's Documentation Survey Report v2 (DSR-v2 - a report that showed the Nursing Assistant Certified documentation to specific tasks performed with a resident) report, dated 03/01/2026 to 03/08/2026, showed no documentation for the following areas: -Behavior Monitoring and Interventions on the evening shift on 03/01/2026, 03/02/2026, 03/04/2026, and 03/06/2026. -Bladder Continence on the evening shift on 03/02/2026, 03/04/2026, and 03/06/2026. -Bowel Movement on the evening shift on 03/01/2026, 03/02/2026, 03/04/2026, and 03/06/2026 and on night shift on 03/06/2026. -Toileting Hygiene on the evening shift on 03/02/2026, 03/04/2026, and 03/06/2026. -Turned and repositioned on the evening shift on 03/01/2026, 03/02/2026, 03/04/2026, and 03/06/2026. Review of Resident 20's February 2026 DSR -2 report, showed missing documentation was identified for the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Behavior Monitoring and Interventions on the evening shift on 02/19/2026, 02/20/2026, 02/25/2026, and 02/28/2026. -Bladder Continence on the evening shift on 02/19/2026, 02/20/2026, 02/25/2026, and 02/28/2026. -Bowel Movement on evening shift the on 02/07/2026, 02/19/2026, 02/20/2026, 02/25/2026, and 02/28/2026. -Toileting Hygiene on the evening shift on 02/19/2026, 02/20/2026, 02/25/2026, and 02/28/2026. -Turned and repositioned on the evening shift on 02/19/2026, 02/20/2026, 02/25/2026, and 02/28/2026. Review of Resident 20's January 2026 DSR v-2 report, showed missing documentation was identified on: -Behavior Monitoring and Interventions on the evening shift on 01/14/2026, 01/21/2026, and 01/31/2026 and on the night shift on 01/22/2026 and 01/31/2026. -Bladder Continence on the evening shift on 01/14/2026, 01/21/2026, and 01/31/2026 and the night shift pm 01/22/2026 and 01/31/2026. -Bowel Movement on the evening shift on 01/14/2026, 01/21/2026, and 01/31/2026 and night shift on 01/22/2026 and 01/31/2026. -Oral Hygiene on the evening shift on 01/22/2026 and 01/31/2026. -Personal Hygiene on the evening shift on 01/22/2026 and 01/31/2026. -Toileting Hygiene on the evening shift on 01/14/2026, 01/21/2026, and 01/31/2026 and on the night shift on 01/22/2026 and 01/31/2026. -Turned and repositioned on the evening shift on 01/14/2026, 01/21/2026, and 01/31/2026 and on the night shift on 01/22/2026 and 01/31/2026. <RESIDENT 32> Resident 32 was admitted to the facility on [DATE] with diagnoses to include muscle weakness, after surgical care, and heart failure. Review of Resident 32's care plan, dated 02/26/2026, documented that they had an ADL self-care performance deficit related to generalized weakness, impaired balance, decreased activity tolerance, and decreased motivation. Resident 32 required substantial to dependent assistance toileting, two-person assistance for transferring, one person assistance for bed mobility, bathing, and dressing. Review of Resident 32's Documentation Survey Report v2 (DSR-v2 - a report that showed the Nursing Assistant Certified documentation to specific tasks performed with a resident) report, dated 03/01/2026 to 03/08/2026, showed no documentation for the following care: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Behavior Monitoring and Interventions on day shift on 03/02/2026 and evening shift on 03/03/2026, 03/07/2026 and night shift on 03/06/2026. -Bladder Continence on day shift on 03/02/2026, evening shift on 03/03/2026 and 03/07/2026, and on night shift on 03/06/2026. -Bowel Movement on day shift on 03/02/2026, on evening shift on 03/03/2026 and 03/07/2026, and on night shift on 03/06/2026. -Oral Hygiene on day shift on 03/02/2026, and on evening shift on 03/06/2026. -Personal Hygiene on day shift on 03/02/2026 and on evening shift in 03/06/2026. -Toileting Hygiene on day shift on 03/02/2026, on evening shift on 03/03/2026 and 03/07/2026, and on night shift on 03/06/2026. -Turned and repositioned on day shift on 03/02/2026. -Evening shift: 03/03/2026 and 03/07/2026 and on night shift on 03/06/2026. In a review of Resident 32's February 2026 DSR-v2 report, showed no documentation was identified for the following: -Behavior Monitoring and Interventions on day shift on 02/16/2026 and on evening shift on 02/12/2026, 02/16/2026, 02/17/2026, and 02/22/2026. -Bowel Movement on day shift on 02/16/2026 and on evening shift on 02/12/2026, 02/16/2026, 02/17/2026, and 02/22/2026. In an interview on 03/11/2026 at 9:36 AM, Staff D, Registered Nurse (RN)/Infection Preventionist (IP)/Assist Director of Nursing (ADON), stated there was a designated staff member that reviewed the NAC documentation daily, report it to the team, and the team was responsible to inform the NAC's to review and complete their daily documentation. <RESIDENT 53> Review of Resident 53's January 2026 Documentation Survey Report v2 (DSR-v2 - a report that showed the Nursing Assistant Certified documentation to specific tasks performed with a resident) report, showed missing documentation on all shift under the intervention/task sections of activities of daily living (ADL's – dressing, transfers, upper body and lower body dressing, oral hygiene, personal hygiene, toileting, bathing, bed mobility, bowel and bladder continence, walking, and eating), of behavioral symptoms, and bowel monitoring. There was missing documentation for three days on the AM shift (on 01/01/2026, 01/28/2028, and 01/29/2026), two days on the PM shift (on 01/17/2026 and 01/26/2026), and four days on the night shift (on 01/01/2026, 01/17/2026, 01/21/2026 and 01/31/2026) Review of Resident 53's 03/01/2026 through 03/07/2026 DSR-v2 report, showed missing documentation in the intervention/task sections of ADL's, behavioral symptoms, and bowel (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every Monday. Review of Resident 92's LN (Licensed Nurse)- Skin Evaluation – PRN (as needed)/ Weekly, showed no documentation on the TAR the skin evaluation was completed on 12/08/2025 and 12/15/2025. Review of Resident 92's January 2026 TAR, documented a skin check was completed on 01/10/2026. Review of Resident 92's LN- Skin Evaluation – PRN, dated 01/10/2026, showed the skin assessment was not completed/locked until 01/13/2026, three days after it was documented completed. Review of Resident 92's LN- Skin Evaluation – PRN, dated 01/31/2026, showed the skin assessment was not completed/locked until 02/03/2026, three days after it was documented completed. <RESIDENT 53> Review of Resident 53's January TAR, directed the LN to perform a skin check every seven days and complete the skin eval UDA PRN form every Friday. The LN documented a skin assessment was completed on 01/23/2026 and 01/30/2026. Review of Resident 53's LN- Skin Evaluation – PRN, dated 01/23/2026, showed the skin assessment was not completed/locked until 01/26/2026, three days after it was documented completed. Review of Resident 53's LN- Skin Evaluation – PRN, dated 01/30/2026, showed the skin assessment was not completed/locked until 02/09/2026, 10 days after it was documented completed. Review of Resident 53's February 2026 TAR, directed the LN to perform a skin check every seven days and complete the skin eval UDA PRN weekly form every Friday. The LN documented a skin assessment was completed on 02/22/2026. Review of Resident 53's LN - Skin Evaluation – PRN / Weekly, dated 02/20/2026, showed the skin assessment was not completed/locked until 03/05/2026, 13 days after it was documented completed. On 03/10/2026 at 1:40 PM, a interview was conducted with Staff B, Registered Nurse (RN)/Director of Nursing Services, and Staff AA, Clinical Resource RN. Staff B stated the expectation was when the LN filled out a UDA it should be completed at the same time. Staff B and Staff AA were made aware this was not done for Resident 92 and 53. Reference WAC 388-97-1720 (1)(a)(i)(ii)(iii)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide required liability notices for 3 of 3 residents (Residents 28, 101, and 102) reviewed for liability notices who remained in the facility after skilled services ended and 1 of 3 residents (Resident 28) reviewed for issuance of Notification of Medicare Non-Coverage (NOMNC) at least two calendar days prior to their Medicare services ending. These failures placed residents at risk for not being fully informed of the cost of, and/or fully understanding their Medicare benefits.Findings included.Review of Resident 28's notification review documented their Medicare Part A service episode started on 11/28/2025 and ended 12/24/2025. The facility documented they were unable to locate the NOMNC or the liability notice provided to Resident 28 or their representative. Resident 28's medical record documented they remained in the facility after their Medicare A service episode ended.Review of Resident 101's notification review documented their Medicare Part A service episode started 01/22/2026 and ended 02/11/2026 and the liability notice was unable to be located.Review of Resident 102's notification review documented their Medicare Part A service episode started 11/28/2025 and ended 01/18/2026 and the liability notice was unable to be located.In an interview on 03/11/2026 at 9:05 AM Staff R, Social Services Director, stated there was a change in the business office managers, who had been directing when to provide a liability notice to residents, and since that change the liability notices had not been completed. Staff R stated they were unable to locate the NOMNC for Resident 28, no other information was provided.Reference WAC 388-97-0140

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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. Based on interview and record review, the facility failed to initiate grievances for 2 of 4 residents (Residents 32 and 39) reviewed for grievances. The facility's failure to initiate, log, investigate verbalized concerns, and inform the residents of their findings and the actions taken, precluded the facility from identifying grievance trends and placed the residents at risk of feeling frustrated, unimportant, and with a decreased self-worth and quality of life.Findings included . Review of the facility policy titled, Grievances, revised date 02/01/2017, documented the facility grievance process is to make prompt efforts to resolve grievances the resident may have. The policy's procedures documented the grievance official is to respond to the individual expressing the concern withing three working days of the initial concern. The grievance log was to be maintained by the grievance official. <RESIDENT 32>In an interview on 03/04/2026 at 11:45 AM, Resident 32 stated their current mattress was uncomfortable and felt like they were laying on metal bars. Resident 32 stated they had complained a few months ago of their mattress being uncomfortable and felt that it had a hole in the middle and it was replaced with the current one. Resident 32 stated they had complained and nothing had been done. Resident 32 stated the mattress was not fitted properly for the bed frame and the metal securement device (preventing movement of the mattress on the bed frame) were not able to be used because the mattress was too big for the bed frame. In a joint interview on 03/10/2026 at 3:00 PM Staff S and T, Maintenance, stated they had initially replaced the mattress on 01/13/2026 and had not filled out a grievance related to the replacement. No other details about why the mattress was replaced was provided. In review of a maintenance request dated 01/13/2026 at 12:39 PM documented nursing requested Resident 32's mattress to be replaced and was inputted by Staff S and completed by Staff T. No other information was provided in the maintenance request. In an interview on 03/10/2026 at 3:08 PM Staff U, Resident Care Manager/Licensed Practical Nurse, stated they were unaware of any concerns related to Resident 32's mattress. Staff U stated the process for grievances included when a grievance was reported by a cart nurse, they would meet with the resident, gather details, fill out a grievance and provide it to social services. In an interview on 03/10/2026 at 3:15 PM Staff V, Nursing Assistant Certified (NAC), stated the grievance process included providing residents with a grievance form, located outside the office of the administrator, and assist the resident in filling it out if needed. <RESIDENT 39>In an interview on 03/04/2026, at 11:09 AM, Resident 39 stated they had two blouses that went missing. Resident 39 stated they had reported the missing blouses and were told to order two more blouses to replace the missing ones, and the facility would reimburse them. Resident 39 stated they still had not been reimbursed and one of the new blouses had already gone missing. In an interview on 03/06/2026, at 9:27 AM, Resident 39 stated they reported the missing blouses to their nurse and social services. Review of the grievance logs from October 2025 through February 2026 and March 1st through 6th 2026, contained no documentation with regard to Resident 39's missing blouses. In an interview on 03/09/2026, at 9:28 AM, Staff R, Social Services Director, stated they were aware of Resident 39's missing blouses. Staff R stated they put the missing blouses on a grievance form and handed it off to the previous administrator for reimbursement in January 2026. Staff R stated they (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed invoices to reimburse Resident 39 and they didn't have them. Staff R was unaware of the follow-up with Resident 39 as they had handed it off to the prior administrator. In an interview on 03/09/2026, at 9:58 AM, Staff G, Acting Administrator, stated that they would take care of Resident 39's missing blouses. Staff G stated that Resident 39's grievance was done during transition of the Administrator and that it was missed. Reference WAC 388-97-0460

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 of 5 residents (Residents 11 and 48) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure appropriate indication for psychotropic medications. This deficient practice placed residents at risk of experiencing unnecessary side effects such as sedation, decline in physical functioning, and placed residents at risk of experiencing an undignified life. Findings included . As referenced in the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of the facility policy titled, Chemical Restraints and Psychotropic Medication Management, revised April 2025 documented it was the policy of the facility to ensure that residents were free from chemical restraints imposed for the purpose of discipline or convenience or that are not required to treat a specific condition as diagnoses or documented in the clinical record. <RESIDENT 11>Resident 11 admitted to the facility on [DATE] with diagnoses to include right hip fracture, history of stroke, and unspecified dementia (a disease that causes loss of memory, language, problem-solving and other thinking abilities). Review of Level 1 Pre-admission Screening and Resident Review (PASRR- a mental health screening tool) evaluation dated 10/04/2025 showed Resident 11 did not have symptoms of serious mental illness, nor depressive or anxiety disorder. Review of Resident 11's psychiatric evaluation dated 10/23/2025 documented resident and their representative discussed use of an antidepressant for signs and symptoms of depression. Per the evaluation Resident 11 had been struggling with agitation and anxiety to include verbal aggression and presented as such during the evaluation. Review of Resident 11's Behavioral Health Progress Note dated 12/08/2026 documented no hallucinations reported or observed during assessment, however the narrative documented the resident as almost paranoid. The note documented Resident 11's thoughts were potentially delusional due to dementia, and their thought process was severely impaired related to dementia. The recommendations were to monitor for increased signs of emotional or behavioral disturbance such as increased confusion, psychosis (hallucination-perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality) or delusions), changes in sleep or appetite or refusals of care. Review of Resident 11's order summary documented behaviors being monitored for the use of antipsychotics included agitation, anger, hitting, and yelling every shift starting 11/28/2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's progress notes from 12/08/2025-03/05/2026 showed no monitor or documentation of signs of psychosis as outlined in the behavioral health recommendations. Review of Resident 11's Medication Administration Record (MAR) for December 2025 showed a physician's order for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) at bedtime for dementia with agitation dated 11/28/2025. In an interview on 03/11/2026 at 9:31 AM Staff U, Resident Care Manager/Licensed Practical Nurse, stated they did not know if Resident 11 had a diagnosis of psychosis and would need to confirm with the psychiatric provider. Staff U stated Resident 11 did have a diagnosis of dementia with behaviors. Staff U stated Resident 11 had not been prescribed an antidepressant during their stay at the facility. Staff U stated there was not a discussion of use of an antidepressant for Resident 11 in their clinical interdisciplinary meetings and did not always review the behavioral health notes, often relying on the provider to discuss orders/recommendations after their visit with residents. When asked how interventions were developed when a resident was started on a psychoactive medication, Staff U, stated they use batch orders to choose from. <RESIDENT 48>Resident 48 admitted [DATE] with diagnoses to include dementia with behavioral disturbance and depression. Review of the PASRR dated 04/14/2025 showed Resident 48 had mood and anxiety disorder. Psychosis was not marked as a condition. Review of level II PASRR invalidation on 04/15/2025 showed Resident 48 did not have symptoms of serious mental illness, nor depressive or anxiety disorder. Review of Resident 48's quarterly Minimum Data Set assessment, dated 01/08/2026, showed the resident did not experience signs of psychosis such as hallucinations. The resident was taking an antipsychotic medication, and a gradual dose reduction had not been attempted. Review of physician's orders showed Resident 48 began receiving Seroquel, an antipsychotic daily for dementia with agitation, an inappropriate indication since admission. Review of the psychotropic care plan showed Seroquel was used related to agitation and dementia. Review of Resident 48's behavior monitoring directed staff to monitor for episodes of psychotic behavior as evidenced by yelling, aggressive language, name calling, and demanding tasks every shift beginning 12/16/2025. Psychotic behavior is defined as a severe mental state characterized by loss of contact with reality, where the person experiences hallucinations-sensing things not present and delusions-false fixed beliefs, or disorganized thinking. Behavior monitors showed there were no behaviors documented December 2025, two shifts with behaviors in January 2026, one behavior in February and no behaviors in March as of 2026. Review of progress notes beginning 04/15/2025 to 03/10/2026 showed no documentation Resident 48 exhibited psychosis. Review of psychoactive medication evaluations on 04/15/2025, 07/15/2025 10/15/2025, and 01/15/2026 showed Resident 48 had no paranoia, delusions or hallucinations observed in the look back period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 48's sleep monitors showed the resident sleeps 12-17.5 hours a day. In observations on 03/09/2026 at 9:11 AM and 11:40 AM Resident 48 was observed in bed asleep. In observations on 03/10/2026 at 9:14 AM, 10:25 AM, 11:13 AM Resident 48 was observed in bed asleep. In an interview on 03/10/2026 2:02 PM Staff G, Nursing Assistant Certified stated Resident 48 did not see or hear things not there and their thinking was clear. In an interview on 03/11/2026 at 9:25 AM, Staff D, Registered Nurse/Assistant Director of Nursing stated the monitoring should be modified to monitor delusions and hallucinations. Reference WAC 388-97-0620 (1)(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide written bed hold notice to the resident and their representative at the time of transfer to the hospital for 2 of 3 residents (Residents 53 and 92), and failed to ensure a resident hospital transfer documentation was completed as required to include the basis for hospital transfer and what specific resident needs were unable to be met by the facility for 1 of 3 residents (Resident 53) reviewed for hospitalization. These failures placed residents and their representative at risk for not having an opportunity to make informed decisions about their transfer/discharge rights, placed residents at risk with their right to hold their bed while in the hospital, and a diminished quality of life. Findings included. <RESIDENT 53> Resident 53 was transferred to the emergency room (ER) on 03/08/2026 related to an acute change in their medical condition and was unresponsive. On 03/10/2026 Resident 53's Electronic Medical Record (EMR) was reviewed for a Nursing Home Transfer or Discharge Notice and a Bed Hold Notification given to the resident and their responsible representative. There was no documentation or copies of the notifications documented in Resident 53's EMR. In an interview on 03/10/2026 at 11:11 AM, Staff Z, Social Service, stated if a resident's transferred or discharged was planned, then a Nursing Home Transfer or Discharge Notice was filled out and given to the resident and/or their representative, a copy placed in the resident's EMR, and a copy was sent to the office of the State Long-Term Care Ombudsman (an advocate for residents of nursing homes who protected and promoted resident rights under federal and state law and regulations). If the transfer or discharge was emergent, the transfer/discharge notice was filled out by the license nurse who was working, given to the resident and the resident's representative, and scanned to the Ombudsman. Staff Z stated a bed hold notification was also filled out and given to the resident or their representative upon transfer. Staff Z stated both notices were sent to medical records to be uploaded into the residents' EMR. Staff Z could not locate Resident 53's bed hold policy or a transfer/discharge notice and stated they could be with medical records waiting to be scanned into the resident's EMR. In an interview on 03/10/2026 at 11:34 AM, Staff Y, Medical Records Supervisor, located Resident 53's transfer/discharge and bed hold notices that were waiting to be scanned into the resident's EMR. Staff Y gave a copy of the resident's transfer/discharge and bed hold notice to the surveyor. Review of Resident 53's Nursing Home Transfer or Discharge Notice, dated 03/08/2026, documented this notice was given to the resident. Review of the transfer/discharge notice documented: -Under the section the reason for discharge or transfer a box was checked indicating the transfer or discharge was necessary for the resident's welfare and their needs could not be met at the facility. There was a section left blank where the facility was to provide a brief explanation to support this action and to attach additional documentation if necessary. -A box was checked indicating a written notice of the facility's bed-hold policy was provided to the resident and the resident's representative. -There was a line drawn through the box titled, Resident Representative Printed Name and Date. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 53's Bed Hold Notification, dated 03/08/2026, documented the resident was unresponsive at the time of transfer to the ER. There was documentation the resident's representative was called four times and was not available. There was no further documentation in Resident 53's medical record that the resident's representative was notified in writing of the transfer/discharge or offered a bed hold. On 03/10/2026 at 3:10 PM, an interview with Resident 53 was attempted while admitted to the local hospital. Resident 53 could not answer any questions asked. <RESIDETN 92> Resident 92 was sent to an outside wound care appointment, and the wound care center transferred the resident to the ER for a wound infection. Review of Resident 92's EMR showed no documentation the resident was offered a bed hold. In an interview on 03/10/2026 at 11:18 AM, Staff Z was asked about Resident 92's bed hold. Staff Z looked in the resident's EMR and could not find one. In an interview on 03/10/2026 at 11:24 AM, Staff Y was asked if there was a bed hold document waiting to be scanned into Resident 92's EMR. Staff Y looked in what documents were waiting to be scanned into residents' EMR, then looked at Resident 92's EMR. Staff Y stated they could not find a bed hold for Resident 92. In an interview on 03/10/2026 at 3:10 PM, Resident 92 was interviewed at a local hospital. Resident 92 was asked if they had been offered a bed hold from the facility. Resident 92 shook their head and said no. Reference WAC 388-91-0120(4)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide assistance with activities of daily living (ADL's) to include personal hygiene and bathing for 1 of 2 dependent residents (Resident 10), reviewed for ADLs. Facility failure to provide the residents, who were dependent on staff for assistance with grooming, placed the resident and others at risk of embarrassment, poor hygiene, unmet care needs and a diminished quality of life.Findings included . Review of the facility's policy, Activities of Daily Living, revised 07/2015 documented nursing assistants would provide assistance with ADL's based on the residents individualized plan of care. <RESIDENT 10> Resident 10 admitted on [DATE] with diagnoses to include diabetes (high blood sugar resulting from inadequate insulin production or usage), muscle weakness and cognitive communication deficit. Review of the admission Minimum Data Set (MDS) assessment on 01/09/2026 showed Resident 10 could not perform grooming and were dependent on staff for ADL's. The resident did not reject care. Review of the ADL care plan initiated on 01/06/2026 showed Resident 10 needed total assistance from one staff for ADL needs including grooming. In an observation on 03/05/2026 at 1:29 PM, Resident 10 was lying in bed. Their hair was greasy and they had multiple white chin hairs approximately 1/8 inch long, each fingernail was jagged and filled with brown matter. In observations on 03/06/2026 at 9:09 AM, 11:15 AM, 1:08 PM the resident was lying in bed watching TV. The resident continued to have greasy hair, long facial hair and jagged fingernails with brown matter under them. In observations on 03/09/2026 at 9:10 AM, 11:09 AM, 1:27 PM, 2:32 PM and 3:40 PM, the resident was lying in bed and continued to have greasy hair, long facial hair and jagged fingernails with brown matter under them. In an interview on 03/10/2026 at 1:59 PM, Staff M, Registered Nurse (RN) and Staff N, RN stated nurses were responsible for nail care for residents who were diabetics. They stated the diabetic nail care should be in an order and on the Treatment Administration Record (TAR) which would prompt nurses to complete it. Review of Resident 10's January, February and March 2026 TAR did not include an order to do diabetic nail care. In observations on 03/10/2026 at 9:18 AM, 10:20 AM, 12:09 PM and 1:51 PM, Resident 10 was lying in bed watching TV. The resident continued to have long facial hair and jagged fingernails with brown matter under them. In an interview on 03/10/2026 at 2:01 PM, Staff H, Nurses Aide Certified stated Resident 10 required total care/assistance for ADLs. Staff H stated nurses were to complete diabetic nail care and shaving was to be done with showers. Staff H stated Resident 10 did not refuse care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In observation on 03/11/2026 at 7:25 AM, the resident was lying in bed watching television with long facial hair and jagged fingernails with brown matter under them. In an interview on 03/11/2026 at 9:25 AM, Staff D, RN/Assistant Director of Nursing was asked about Resident 10's lack of grooming. Staff D stated the nurses completed diabetic nail care, and they should be on the TAR, so the nurses would know they need to perform the task. In an observation on 03/11/2026 at 12:37 PM, Resident 10 was resting in bed and stated their nails got trimmed. They waved their fingers and smiled. Their fingernails were clean and trimmed. Resident 10's facial hair remained and the resident said they would agree to be shaved. Reference WAC 388-97-1060(2)(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** Based on interview, and record review, the facility failed to assess, thoroughly monitor, and take timely action in accordance with professional standards of practice for 1 of 3 residents (Resident 92) reviewed for non-pressure wounds, and 1 of 1 hospice residents (Resident 11) reviewed for hospice services. Failure to ensure Resident 92's left thigh wound was assessed and measured to ensure the wound was healing and no further medical interventions were required, the failure to implement a change in Resident 11's blood pressure medications placed residents at risk for potential complications in wound healing going undetected, and risk for continued low blood pressures, and a decreased or diminished quality of life. Findings included . <NON-PRESSURE SKIN> Resident 92 was admitted to the facility on [DATE] with diagnosis to include paraplegia (the impairment of motor or sensory function in the lower body). Review of Resident 93's Initial Admissions assessment, dated 10/25/2026, showed no documentation that the resident had a left thigh wound. Review of Resident 92's physician order, dated 10/30/2025 and discontinued 12/02/2025, directed the License Nurse to clean and apply foam dressing every three days to the resident's left thigh wound. Review of Resident 92's progress note, dated 10/31/2025, documented there was a wound to the resident's left thigh and a treatment order was implemented. There was no description of the wound documented. Review of Resident 92's progress note, dated 11/01/2025, documented the resident had a skin injury with a dressing in place on their left thigh. Review of Resident 92's progress notes, dated 11/04/2025, 11/05/2025, 11/07/2025, 11/07/2025, and 11/14/2025, documented the resident had a pre-existing injury to the left thigh. There was a dressing in place. Review of Resident 92's LN- Skin Evaluation – PRN, dated 11/01/2025, 11/10/2025, 11/1/2025, 11/22/2025, 11/24/2025 showed no documentation of the resident's left thigh wound. Review of Resident 92's Electronic Medical Record showed no description, size, or assessment of the resident's left thigh wound. There was no documentation located regarding when the left thigh wound healed. On 03/10/2026 at 1:40 PM, a interview was conducted with Staff B, Registered Nurse (RN)/Director of Nursing Services, and Staff AA, Clinical Resource RN. Both staff were asked regarding the lack of Resident 92's left-high wound documentation. Staff B was shown Resident 92's October 2025 and November 2025 Treatment Medication Administration Record documented what treatment was being done to their left thigh wound. Staff B stated they would investigate the lack of documentation to the resident's left thigh wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 11> Resident 11 admitted to the facility on [DATE] with diagnoses to include right hip fracture, history of stroke, and unspecified dementia. Resident 11 admitted to hospice services on 12/19/2025. Review of Resident 11 hospice comprehensive admission assessment dated [DATE] with a faxed timestamp of 12/19/2025 documented they had documented low blood pressures in the prior week an order to reduce Lisinopril (medication to treat high blood pressure) and Amlodipine (medication to treat high blood pressure). Review of Resident 11's hospice routine visit note by the registered nurse, dated 12/23/2025, documented the medication list was refaxed as the facility had not implemented the changes for ordered decrease in Lisinopril and Amlodipine. In a review of Resident 11's December 2025 Medication Administration Record showed their Lisinopril and Amlodipine were decreased on 12/23/2025. In an interview on 03/11/2026 at 9:21 AM Staff U, Resident Care Manager/Licensed Practical Nurse stated when hospice completed a visit the facility received a fax with any new orders, the orders would be reviewed by the provider and then implemented. Staff U stated the floor nurses reviewed them and placed them in their box for further review. When asked about the delay in processing Resident 11's hospice orders received on 12/19/2025, Staff U stated they were not sure why there was a delay. Staff U stated there were no progress notes documenting that the orders were received on 12/19/2025. Refer to WAC 388-97-1060(1)(3)(c)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 2 residents (Resident 10) received the necessary care and services to prevent significant and severe weight loss within the first 60 days of admission. This failed practice caused potential harm for Resident 10 in the form of severe weight loss and placed the resident and others at risk for adverse health, safety and diminished quality of life.Findings included . According to the State Operations Manual (SOM), with an implementation date of 11/22/2017, the Centers for Medicare and Medicaid Services defined the parameters for significance of unplanned and undesired weight loss for severe weight loss as greater than 5% in one month. Review of the facility's policy titled, Nutrition Status Management, revised on April 2025 showed any resident weight that varies from the previous reporting by more than 5 percent (%) in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team (IDT) to determine the cause of weight loss/gain and intervention required. The policy documented the nurse will notify physician, family and/or resident of weight loss/gain with interventions. Further, any resident meeting the criteria for weight loss and any resident at risk would be weighed weekly with the weight entered into the electronic medical record and reviewed by the Registered Dietician (RD)/designee. If there was a significant change in the resident's condition related to weight or nutrition, the RD would make recommendations to offer additional nutrition to those residents including all high-risk residents. Options included, but were not limited to, fortified cereal, large portions, between meal snacks, and commercial nutritional supplements. Weights would be reviewed by the RD/designee. Resident 10 admitted on [DATE] with diabetes, cognitive communication deficit, difficulty swallowing and vitamin D deficiency. Review of the care plan, dated 01/06/2026, documented Resident 10 had a potential nutritional problem/risk for nutrition related to decreased intake, weakness, difficulty swallowing, lack of teeth, advanced age, diabetes, memory deficit and vitamin D deficiency. The goal was for Resident 10 to maintain adequate nutritional status as evidenced by maintaining weight with no signs of malnutrition through 04/22/2026. The interventions were diet as ordered, honor resident rights to make personal dietary choices and provide dietary education, meals in the dining room if resident is in agreement, monitor and report to doctor for any signs of decreased appetite, unexpected weight loss, offer snacks and fluids between meals and the RD to evaluate and make changes as needed. The interventions listed were not individualized and there were no revisions to the care plan after 01/16/2026. Review of the Minimum Data Set (MDS-an assessment tool) dated 01/09/2026, defined a clinically significant weight loss episode for nursing home residents as a loss equal to or greater than 5% within a 30-day period or 10% within a 180-day period. The assessment documented weight loss did not occur or was unknown. The resident required partial/moderate assistance for eating, had no teeth and had coughing or choking during meals and complaints of difficulty or pain while swallowing. Review of the Nursing nutrition/hydration Dietary Evaluation dated 01/09/2026 showed Resident 10 was lethargic, was able to feed themselves with verbal cues, had missing teeth, poor food intake of less than 25% of most meals and refused snacks and supplements. The total score of the evaluation was 18. The evaluation stated if the total score was 10 or greater, a prevention protocol should be initiated immediately and documented in the care plan. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Area Assessment (CAA-tool used to create the care plan) dated 01/09/2026 showed Resident 10 was currently on mechanical soft diet, thin liquid. Intake had been variable and poor. They were on a house oral nutritional supplement related to risk for malnutrition. The CAA documented the goal was for weight stability, improved intake and no signs of malnutrition. The CAA showed the weight was trending down with a trigger for weight loss of 7.5% for one week. Review of the resident's admission weight on 01/07/2026 was 157 pounds. The corresponding weights were: 01/08/2026 155.0 pounds 01/09/2026 152.0 pounds 01/13/2026, 145.3 pounds 01/16/2026 141.5 pounds 02/13/2026 137.7 pounds 03/03/2026 138.8 pounds Review of the physician orders on admission directed staff to obtain weekly weights. Review of the medical record showed they were not obtained weekly for close monitoring. Review of a Weight Change Note dated 01/20/2026 at 5:36 PM showed Resident 10 was discussed during the nutrition meeting. The note documented a weight loss of 9.9% or 15.5 pounds in two weeks. The note did not include any new interventions or provider notification. Review of the nutrition IDT note on 01/21/2026 documented a weight loss of 6.9 %. Meal intake was noted at 42.5%. The resident reported not enjoying food provided by the facility. The note documented that they would maybe have activities help with menu selection. Review of a Provider note dated 01/27/2026 documented poor oral intake, consistently refusing meals with minimal intake of supplements and noted a 7.5% decrease in weight since admission. Labs were reviewed and indicated a malnutrition risk. Review of the nutrition IDT note on 01/28/2026 documented a weight change of 6.9 % for one week, noting a clinically significant weight loss. Meal intake was at 44%. Resident 10 stated they did not care for the food, and they may have activities go over the menu with them weekly to help find things they liked. Review of a Weight Change Note dated 02/24/2026 at 8:36 AM documented Resident 10's weight loss of 12.3% or 19.3 pounds since admit was reviewed with the RD. The note did not include any new interventions or provider notification. Review of the 30-day lookback of Resident 10's meal monitors on 03/10/2026 showed the resident ate 0-25% of their meals at one lunch and 15 dinners. Resident 10 ate 26-50% for 10 breakfasts, 15 lunches & 8 dinners. They refused snacks for 10 days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Weight Change Note dated 03/06/2026 at 1:33 PM showed Resident 10 currently received house supplements twice daily and they would review with RD next week if the resident continued to trigger for weight loss. A weight warning showed the resident had a loss of 11.6% of body weight or 18.2 pounds. The note did not include any new interventions or provider notification. In an interview and observation on 03/11/2026 at 12:37 PM, Resident 10 was in bed with their lunch tray in front of them containing cottage cheese, kiwi fruit, orange slices and strawberries. There were only bites of the cottage cheese consumed. Resident 10 was asked about their weight loss, and they said they did not know they had lost weight, but it could be because they did not eat much. Resident 10 pointed to their plate and stated they could only eat the cottage cheese because they had no teeth and that fruit was too hard for them to eat. In an interview on 03/11/2026 10:59 AM Staff D, Registered Nurse/Assistant Director of Nursing was asked about Resident 10's significant weight loss of 11.6 %/18.2 pounds in two months. Staff D stated Resident 10 did not care for the food and activities were going to go through the menu weekly with them. Staff D stated the resident did not like supplements and they had offered them to go to the dining room. Staff D stated they would look to see if their diet was fortified and add sauces and gravies to meals. Staff D stated Resident 10 was seen by the RD and they would call them tomorrow. Staff D stated they would need to see if the provider had been recently notified of the continued weight loss. Review of Resident 10's dietary slip from the kitchen on 03/11/2026 showed the resident was on a mechanical soft diet, with menu notes for whole milk and water. In a phone interview on 03/11/2026 at 2:08 PM, Collateral Contact 1 (CC1), RD, stated they were going to discuss Resident 10 with the IDT tomorrow. CC 1 stated the resident was 157 pounds then 155 pounds, then 152 pounds then 145 pounds, then 141 pounds, to 137 pounds. CC 1 stated Resident 10's last weight on 03/03/2026 was 138.8 pounds but could have been a result of no recent bowel movement. They stated the resident was not taking their supplement often and they needed to give them something more enticing so they would accept it. CC 1 stated Resident 10 had been eating 45.37 % of their meals, and with this intake Resident 10 would have weight loss. CC 1 said maybe the facility could try a different supplement or another alternative to get them more calories. CC 1 said they saw the Resident 10 yesterday and recognized the weight loss and had yet to document their visit note. CC 1 said the resident needed to be prompted to go to the dining room. CC 1 said their expectation would be weekly weights with this amount of weight loss. CC 1 commented that the resident had been there for 2 months and 2 days and they needed to get ahead of the weight loss. In an interview on 03/11/2026 3:18 PM Staff L, Nurse's Aide Certified stated Resident 10 did not eat a whole lot and ate small amounts of their dinners. Staff L said Resident 10 would sometimes ask for snacks and accept a cookie. Reference WAC 388-97-1060 (3)(h)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure annual Certified Nursing Assistant (CNA) performance reviews were completed timely for 2 of 4 employees (Staff J and O) reviewed who had been employed longer than one year. This failed practice had the potential to negatively affect the competency of the CNAs and the quality of care provided to residents. Findings included .Staff J, CNA was hired on 02/08/2024. Review of Staff J's employee file showed the employee evaluation was completed late on 09/15/2025. Staff O, CNA was hired on 04/11/2025. Review of Staff O's employee file showed the employee evaluation was completed late on 09/12/2025. In an interview on 03/11/2026 at 9:25 AM, Staff D, Assistant Director of Nursing, confirmed there were two of four performance evaluations that were late. Staff D said there was a process and a plan to ensure performance evaluations were completed timely. Reference WAC 388-97-1680 (2) (a-c)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure nurse staffing information postings were current, accurate, and included the census/number of residents in the facility. These failures placed residents and visitors at risk for not being fully informed of current nurse staffing levels and resident census information. Findings included . In an observation on 03/04/2026 at 8:21 AM, the daily nurse staffing posting did not contain the census. At 4:01 PM, there were no totals at end of the shift. In an observation on 03/09/2026 at 8:50 AM, the daily nurse staffing posting did not contain the census. The daily nurse staffing postings from the weekend showed no census or hours worked on Sunday 03/08/2026. In an interview on 03/09/2026 at 10:20 AM, Staff P, Nurse's Aide Certified and interim scheduling stated they were responsible for updating the daily staffing posting. Staff P stated they updated the hours worked after shifts and would add the census if they knew it. Staff P stated they were unaware the postings needed to be revised as changes occured. Staff P stated there was no one to update the postings after hours or on weekends. They stated they updated the sheets from the weekends on Mondays. No associated WAC reference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview the facility failed to ensure 1 of 4 medication carts and 1 of 2 treatment carts on 2 of 3 halls had unsecured medications. These failures placed residents at risk for unauthorized access to medications and biologicals, and potential drug misuse. Findings included . Review of the facility policy titled, Storage of Medications dated April 2007 showed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available. <MEDICATION CART> In an observation on 03/11/2026 from 9:44 AM to 9:51 AM the 200-hall medication cart was observed to be unlocked and unattended. Resident 2 was in a wheelchair across from the cart. Staff B, Director of Nursing (DNS) walked up at 9:51 AM and commented they could see the medication cart was unlocked. Staff B then stayed at the medication cart. In an interview on 03/11/2026 at 11:01 AM, Staff Q, Licensed Practical Nurse/Supervisor said the expectation was for medication carts to be locked when a nurse walked away. <TREATMENT CART> In an observation on 03/05/2026, at 8:43 AM, the 300-hall treatment cart was observed to be unlocked and unattended. The treatment cart contained Betadine Solution (antiseptic), Santyl ointment (prescribed medication to remove dead tissue from wounds), Hydrocortisone cream (used to treat irritation and itching on the skin), Nystatin/triamcinolone (topical medication to treat skin infections) and more. Staff C, Registered Nurse, returned to the treatment cart from a resident's room and acknowledged the unlocked cart and then locked the treatment cart. Reference WAC 388-97-1300(2)

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	03/11/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain and provide routine dental services for 1 of 2 sampled residents (Resident 39) reviewed for dental services. This failure placed residents at risk for continued dental problems, difficulty chewing, associated health complications, and a diminished quality of life. Findings included Resident 39 was admitted on [DATE] with diagnoses to include dysphagia (difficulty swallowing). In an interview on 03/04/2026, at 11:06 AM, Resident 39 stated their teeth were falling apart and needed to see a dentist. Resident 39 stated they had a hard time eating at times. In an observation during the interview Resident 39 had no upper teeth and their lower teeth were discolored and partially broken. In an interview on 03/06/2026, at 9:18 AM, Resident 39 stated they had not been offered to see a dentist while at the facility and would accept a referral. Review of Resident 39's admission MDS, dated [DATE], documented Resident 39 had no upper teeth and had many missing lower teeth with obvious and likely cavities/broken teeth. Review of Resident 39's Quarterly Minimum Data Set (MDS - an assessment), dated 02/05/2026, documented Resident 39 had a mechanically altered diet and no tooth, mouth or facial pain or discomfort/difficulty with chewing. Review of Resident 39's care plan, dated 01/02/2026, documented they had oral/dental problems related to no upper teeth and poor dentition on their lower teeth with many missing and obvious/likely cavities/broken teeth related to history of poor oral hygiene. In an interview on 03/09/2026, at 9:33 AM, Staff R, Social Services Director (SSD), stated they did not see Resident 39 on the facility dental hygienist list or any other dental care documentation. Staff R stated they discussed dental needs during care conferences, however had not been documenting it. In an interview on 03/11/2026 at 10:09 AM, Staff W, Licensed Practical Nurse/MDS Nurse, stated when they complete a MDS assessment for a resident they assessed for their dental health/dentition, interviewed them and offered them a dental referral. When asked where the documentation was located for dental referrals that were offered, Staff W stated it was not documented. In an interview on 03/11/2026, at 3:30 PM, Staff B, Director of Nursing, stated they would find documentation to support dental services; however, in an electronic communication received on 03/12/2026 they wrote there was no additional documentation located for dental services for Resident 39. Reference WAC 388-97-1060 (3)(j)(vii)