STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505520	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella Seattle	116 Fairview Avenue N Seattle, WA 98109

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to implement abuse and neglect policies and procedures to protect residents from misappropriation of property during the investigation of allegation for 1 of 3 residents (Resident 1), reviewed for abuse investigation. This failure placed the resident at risk for unidentified misappropriation/exploitation and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse and Incident Reporting, approved in June 2024, showed that a prompt and thorough investigation is the process used to determine what happened and the nurse supervisor or designee would immediately begin the investigation upon notification of an incident and/or alleged abuse. The policy further showed if a staff member is identified as allegedly/possibly involved in suspected abuse, they must be removed from all residents care pending further investigation in order to do all to protect the resident/other residents from further abuse. Review of the quarterly Minimum Data Set (an assessment tool) dated 02/20/2025 showed Resident 1's was cognitively intact. Review of the facility's undated incident investigation report showed that on 02/14/2025 Resident 1 reported that their [NAME] ceramic carriage figurine had gone missing the previous week. The investigation showed that Resident 1 provided a description of the staff member who was allegedly involved in taking their ceramic figurine and its estimated value. It also showed that Resident 1's representative initially reported the similar allegation to Staff B [Social Services Director] on 02/07/2025. Further review of the report showed that the incident was reported to the State Agency on 02/18/2025, 10 days after the allegation was initially reported to Staff B. In an interview on 03/13/2025 at 11:12 AM, Resident 1 stated that that they reported to the facility about their missing [NAME] ceramic carriage figurine, and they suspected that one of the night nurses, whose name begins with the letter T, and who worked night shift might have taken it. Resident 1 further stated that their representative had also reported similar allegation approximately a week prior to 02/14/2025. Review of the nursing staff schedule from 02/15/2025 to 02/19/2025, showed that the facility allowed Staff C, Registered Nurse, to continue to work and provide care to residents during the investigation of Resident 1's allegation of misappropriation of property. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/13/2025 at 3:08 PM, Staff A, Director of Nursing Services, stated that Staff C was not suspended and continued to work while the investigation was ongoing. Staff A further stated that they were unaware that suspending Staff C during an investigation was required. Reference: (WAC) 388-97-0640 (2)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure allegation of misappropriation of property was reported timely to the State Agency for 1 of 3 residents (Residents 1), reviewed for abuse allegation. This failure placed the residents at risk for potential unidentified misappropriation/exploitation and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse and Incident Reporting, approved in June 2024 showed, it was the policy of the company to protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, sexual and mental abuse and from neglect, exploitation, financial abuse (including misappropriation of property), use of photographs or recording in any manner that would demean or humiliate a resident, abandonment, or any treatment that would result in physical harm, pain or mental suffering. The policy further showed that the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknow source and misappropriation of resident property are reported appropriately and timely in accordance with Federal and State requirements. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, a nursing home employee (or other mandated reporter) is required to make a report if he or she has reasonable cause to believe the incident occurred. It further showed, Federal law requires the facility to report all allegations of abuse or neglect. This would include taking seriously any allegation from residents or others with a history of making allegations. Review of the quarterly Minimum Data Set (an assessment tool) dated 02/20/2025 showed Resident 1's was cognitively intact. Review of the facility's undated incident investigation report showed that on 02/14/2025 Resident 1 reported that their [NAME] ceramic carriage figurine had gone missing the previous week. The investigation showed that Resident 1 provided a description of the staff member who was allegedly involved in taking their ceramic figurine and its estimated value. It also showed that Resident 1's representative initially reported the similar allegation to Staff B [Social Services Director] on 02/07/2025. Further review of the report showed that the incident was reported to the State Agency on 02/18/2025, 10 days after the allegation was initially reported to Staff B. In an interview on 03/13/2025 at 11:12 AM, Resident 1 stated that that they reported to the facility about their missing [NAME] ceramic carriage figurine, and they suspected that one of the night nurses, whose name begins with the letter T, and who worked night shift might have taken it. Resident 1 further stated that their representative had also reported similar allegation approximately a week prior to 02/14/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/13/2025 at 2:37 PM, Staff B stated that they had received a report from Resident 1's representative on 02/07/2025 regarding the missing [NAME] ceramic carriage figurine with a description of the staff that might have taken it. Staff B stated, I understand that I was late in addressing this particular allegation. I have no justification for the delay, I initially thought I could resolve the matter by locating the missing item myself. Staff B further stated that they should have reported and documented the allegation in a timely manner. In an interview on 03/13/2025 at 3:08 PM, Staff A, Director of Nursing Services, stated that allegations of misappropriation of property should be reported and documented in a timely manner. Staff A stated that they first became aware of this specific allegation on 02/14/2025. Staff A further stated that the allegation should have been brought to their attention immediately and reported to the State Agency after it was initially reported to Staff B on 02/07/2025. Reference: (WAC) 388-97-0640 (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to timely initiate and/or thoroughly investigate allegation of misappropriation of property for 1 of 3 residents (Resident 1), reviewed for abuse investigation. This failure placed the residents at risk for potential unidentified misappropriation and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse and Incident Reporting, approved in June 2024 showed, it was the policy of the company to protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, sexual and mental abuse and from neglect, exploitation, financial abuse (including misappropriation of property), use of photographs or recording in any manner that would demean or humiliate a resident, abandonment, or any treatment that would result in physical harm, pain or mental suffering. The policy further showed that a prompt and thorough investigation is the process used to determine what happened and the nurse supervisor or designee at the scene will immediately begin the investigation upon notification of an incident and/or alleged abuse. Review of the quarterly Minimum Data Set (an assessment tool) dated 02/20/2025 showed Resident 1's was cognitively intact. Review of the facility's undated incident investigation report showed that on 02/14/2025 Resident 1 reported that their [NAME] ceramic carriage figurine had gone missing the previous week. The investigation showed that Resident 1 provided a description of the staff member who was allegedly involved in taking their ceramic figurine and its estimated value. It also showed that Resident 1's representative initially reported the similar allegation to Staff B [Social Services Director] on 02/07/2025. Further review of the report showed that the incident was reported to the State Agency on 02/18/2025, 10 days after the allegation was initially reported to Staff B. In an interview on 03/13/2025 at 11:12 AM, Resident 1 stated that that they reported to the facility about their missing [NAME] ceramic carriage figurine, and they suspected that one of the night nurses, whose name begins with the letter T, and who worked night shift might have taken it. Resident 1 further stated that their representative had also reported similar allegation approximately a week prior to 02/14/2025. In an interview on 03/13/2025 at 2:37 PM, Staff B stated that they had received a report from Resident 1's representative on 02/07/2025 regarding the missing [NAME] ceramic carriage figurine with a description of the staff that might have taken it. Staff B stated, I understand that I was late in addressing this particular allegation. I have no justification for the delay, I initially thought I could resolve the matter by locating the missing item myself. Staff B further stated that the investigation should have been initiated in a timely manner. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/13/2025 at 3:08 PM, Staff A, Director of Nursing Services, stated that allegations of misappropriation of property should be thoroughly investigated in a timely manner. Staff A stated that they first became aware of this specific allegation on 02/14/2025. Staff A further stated that the investigation did not include residents' interview, and it should have been brought to their attention, and investigated immediately after it was initially reported to Staff B on 02/07/2025. Reference: (WAC) 388-97-0640 (6)(a)(b)