

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Mirabella Seattle		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146</b></p> <p>Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 2 residents (Resident 1), reviewed for abuse and/or neglect investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse and/or neglect, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences . All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury or allegation of injury results from abuse or neglect.</p> <p>Review of the facility's policy titled, Abuse and Incident Reporting - SNF [Skilled Nursing Facility] [NAME], last revised in June 2024, showed, A prompt and thorough investigation is the process used to determine what happened. The Nurse supervisor or designee at the scene will immediately begin the investigation upon notification of an incident and/or alleged abuse. As the investigation continues root cause(s) will, if at all possible, be identified. The information gained will be entered into the resident's electronic health record (EHR) .Initiate further investigation, gathering witness statements and scanning them into the record. After the initial investigation, the full completion will be done by DNS [Director of Nursing Services] or designee and will include a summary of the findings, root cause analysis and a plan of correction as needed.</p> <p>Review of the nursing progress note dated 04/19/2025, showed that on 04/18/2025 at 9:30 PM, Resident 1 had an unwitnessed fall during mechanical lift transfer and was sent to the emergency room (ER).</p> <p>Review of the ER visit summary dated 04/19/2025 showed that Resident 1 was diagnosed with a tibial tuberosity (bony bump on the upper part of the shin) fracture (broken) after a fall.</p> <p>Review of the online incident report dated 04/19/2025 showed, CNA [Certified Nursing Assistant] had placed Hoyer sling under [the] resident . CNA left the room to get assistance from another CNA to transfer the resident. When they returned to the room [the] resident was on the floor.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility investigation document titled, Interview with [Resident 1] showed that Staff F, CNA, would not be able to work at the facility due to not following [the] correct protocol. Further review of the investigation did not show the summary of the findings, root cause analysis or to rule out or establish the likelihood that abuse, or neglect had occurred or may have contributed to the incident.</p> <p>In an interview and joint record review on 05/12/2025 at 1:50 PM, Staff B, Director of Nursing, stated that the goal of an investigation was to be able to determine if the incident was avoidable or unavoidable, rule out abuse/neglect, and to identify what interventions needed. A joint record review of the undated facility investigation for Resident 1 showed no summary of the findings, root cause analysis or the likelihood that abuse/neglect had occurred or may have contributed to the incident. Staff B stated that they did not think an investigation summary was completed or abuse/neglect was ruled out for Resident 1's fall investigation.</p> <p>In an interview on 05/14/2025 at 1:41 PM, Staff A, Director of Health Services, stated that their expectation was that when completing a possible abuse/neglect investigation, the facility would follow their abuse/neglect investigation policy and regulations. Staff A further stated they expected Resident 1's incident to be thoroughly investigated, and abuse/neglect ruled out.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)(b)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45146</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent avoidable accidents during mechanical lift transfers for 1 of 2 residents (Residents 1), reviewed for falls. Resident 1 experienced harm from an avoidable fall when left unsupervised on edge of their wheelchair after staff attempted applying a mechanical lift sling under the resident, subsequently falling out of their wheelchair and sustained a broken tibia (shin bone fracture) requiring a transfer to the emergency room (ER). This failure placed all residents at risk for avoidable falls, physical injuries, functional decline, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Transfer/Lift Techniques, last revised in October 2023, showed, It is the policy of the Company [facility] to establish a policy to minimize, to the best of our ability, the potential for injury to residents and employees during transfers/lifting by appropriate assessment of assistance needed. Steps will be taken by the facility to minimize the manual lifting of residents that require more than one person assist by using a mechanical lifting device, if determined necessary .The Licensed Nurse will assess the resident's need for assistance with transfer/lift and will determine the appropriate type of assistance or mechanical lifting device to be used. This information will be placed on the resident's care plan and touch screen profile.</p> <p>Resident 1 admitted to the facility on [DATE] with diagnosis that included paraplegia (the loss of muscle function in the lower half of the body, including both legs).</p> <p>Review of Resident 1's annual Minimum Data Set (an assessment tool) dated 01/23/2025 showed Resident 1 was cognitively intact. The assessment further showed Resident 1 had functional limitations on their both upper and lower extremities and was dependent on staff with transfers.</p> <p>Review of the care plan and Kardex (summary of care plan) printed on 04/28/2025 showed Resident 1 was dependent on staff with transfers and uses a Hoyer [mechanical lift transfer device]. Further review of the care plan did not show the number of staff needed for the mechanical lift transfer assistance for Resident 1.</p> <p>Review of the nursing progress note dated 04/19/2025, showed that on 04/18/2025 at 9:30 PM, Resident 1 had an unwitnessed fall during mechanical lift transfer and was sent to ER.</p> <p>Review of the ER visit summary dated 04/19/2025 showed that Resident 1 was diagnosed with fall and fracture of the tibial tuberosity (bony bump on the upper part of the shin).</p> <p>Review of the online incident report dated 04/19/2025 showed, CNA [Certified Nursing Assistant] had placed Hoyer sling under resident . CNA left the room to get assistance from another CNA to transfer the resident. When they returned to the room [the] resident was on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement from Staff F, CNA, dated 04/18/2025, showed that when Resident 1 requested help with transfer, Staff F put the mechanical lift sling underneath the resident's bottom. The statement showed Resident 1's bottom was on the edge of their chair, and Staff F offered to pull the resident back on the chair, but Resident 1 declined due to their shoulder arthritis (a disease that causes swelling, stiffness, and pain in a person's joints). The statement further showed that Staff F stepped out of the resident's room and when they returned to the room, they found the resident on the floor.</p> <p>Review of the undated facility investigation document titled, Interview with [Resident 1] showed that Staff F would not be able to work at the facility due to not following the correct protocol.</p> <p>During an observation and interview on 04/28/2025 at 11:17 AM, Resident 1 was in bed with their right shin wrapped with elastic bandage. When asked about the fall incident on 04/18/2025, Resident 1 stated they were in their powerchair, when staff F was trying to get the mechanical lift sling under them to transfer them. Resident 1 stated that Staff F kept pulling them out of the seat cushion of their power chair to apply the sling underneath them. Resident 1 stated, I was probably halfway off the cushion, and [Staff F] decided that [Staff F] needed some help because [Staff F] was having trouble getting the sling between my legs and left my room to get some help. Resident 1 stated Staff F was probably gone about ten minutes and, in that time, they just kept slipping out of their power chair and ended up on the floor. Resident 1 stated their right leg landed on the mechanical lift base. Resident 1 stated, I actually hollered at the top of my lungs after I was on the floor. Resident 1 further stated that they went to ER and learned that they had the right tibia fracture from the fall.</p> <p>In an interview and joint record review on 05/12/2025 at 10:38 AM, Staff E, CNA, stated that they would know the level of assistance a resident need from the resident's care plan and Kardex. Staff E stated two staff needed to transfer Resident 1 with a mechanical lift. A joint record review of Resident 1's Kardex did not show the number of staff needed for transfer assistance. Staff E further stated that the Kardex did not show Resident 1 required two-person assistance with a mechanical lift and it should have shown that.</p> <p>In an interview and joint record review on 05/12/2025 at 10:46 AM, Staff C, Resident Care Manager, stated that if a resident required mechanical lift transfer, the number of staff needed for assistance would be addressed under the resident's care plan. A joint record review of the care plan printed on 04/28/2025 did not show Resident 1 required two-person assistance with a mechanical lift transfer. Staff C stated that they did not see in the resident's care plan that the resident needed two-person assistance with mechanical lift transfers, and it should have been reflected in the care plan. Staff C further stated mechanical lift transfers should be completed with two-person assistance including sling application and Resident 1 should have had two staff assist during the transfer.</p> <p>In an interview on 05/12/2025 at 1:50 PM, Staff B, Director of Nursing, stated that mechanical lift transfer always required assistance from two staff and that the care plan should have had reflected two-persons assistance with the transfer.</p> <p>Reference: (WAC) 388-97-1060 (3)(g)</p>		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45146</p> <p>Based on interview and record review, the facility failed to obtain registry verification to ensure staff met competency evaluation requirements before allowing to serve as a nurse aide for 2 of 3 staff (Staff F and Staff G), reviewed for nursing aide registry. This failure placed the residents at risk for potential abuse, neglect and unmet care needs.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Abuse and Incident Reporting - SNF [Skilled Nursing Facility] [NAME], last revised in June 2024, showed, Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as board registrations and certifications. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This applies to all employees . The facility will not employ or otherwise engage an individual who: 1. Has a finding entered into the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of property.</p> <p><b>STAFF F</b></p> <p>Review of the facility's April 2025 staffing schedule showed Staff F, Certified Nursing Assistant (CNA), was a contract staff and worked at the facility on 04/08/2025, 04/10/2025, 04/18/2025, 04/20/2025, and 04/21/2025.</p> <p>A review of Staff F's employee file did not include documentation from the nurse aide registry.</p> <p><b>STAFF G</b></p> <p>Review of the facility's April 2025 staffing schedule showed Staff G, CNA, was a contract staff and worked at the facility on 04/02/2025, 04/07/2025, 04/08/2025, 04/09/2025, 04/10/2025, 04/15/2025, 04/16/2025, 04/17/2025, 04/21/2025, 04/22/2025, 04/24/2025, and 04/25/2025.</p> <p>A review of Staff G's employee file did not include documentation from the nurse aide registry.</p> <p>A review of e-mail communication on 05/14/2025 at 12:58 PM, Staff A, Director of Health Services, stated that they did not have the registry verification for Staff F and Staff G.</p> <p>In an interview on 05/14/2025 at 1:41 PM, Staff A stated that they assumed the contract agency would obtain registry verification for the contracted staff as part of their compliance package. Staff A further stated that the facility should have received the contract staff registry verification prior to working at the facility.</p> <p>Reference: (WAC) 388-97-1660(3)(c)</p>		