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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella	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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a foam pressure offloading dressing was consistently applied and changed per physician order to prevent pressure injury/pressure ulcer (PI/PU - localized damage to the skin and/or underlying soft tissue usually over a bony prominence as a result of intense and/or prolonged pressure), and to consistently complete weekly skin assessments for 1 of 3 residents (Resident 1), reviewed for PI/PU. Resident 1 experienced harm when they developed an unstageable pressure ulcer (injury occurs when the extent of tissue damage is obscured when slough [dead tissue forms over a wound] or eschar [a thick, dry, leathery layer of dead tissue that forms over a deep wound] on their left heel that required debridement by a wound care specialist. This failure placed residents at risk for skin injury, adverse outcomes, infection, and a diminished quality of life.Findings included. Review of the facility policy titled, Pressure Injury and Prevention, revised in June 2025, showed that a Braden Scale (a tool used to assess a patient's [resident's] risk of developing a pressure injury) would be completed upon admission, weekly for four weeks, and quarterly thereafter. It showed that actions taken to continue ongoing evaluation of skin include weekly total body examination, documentation, and that nurses must obtain physician orders for the removal of devices and/or methods to check skin. Further review showed, During showers/bathing and ongoing care, certified nursing assistants will observe the resident's skin and report to the licensed nurse (LN) any signs of skin abnormalities.Review of Resident 1's comprehensive care plan initiated on 12/07/2020 showed a self-care performance deficit related to immobility and directed staff to perform weekly and as needed skin inspection to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.Review of electronic medical records showed Resident 1 was readmitted to the facility on [DATE] with a diagnosis to include paraplegia (paralysis from the waist down).Review of Braden Scale completed on 01/15/2026 showed a score of15, indicating mild risk for developing pressure ulcers.Review of Resident 1's annual Minimum Data Set (MDS - an assessment tool) dated 01/05/2026, showed Resident 1 had intact cognition and required assistance with bed mobility. The MDS further showed Resident 1 had no pressure ulcer on their left heel.Review of Resident 1's nursing progress notes dated 03/09/2026 showed that they had abrasion on their right toe and excoriation on their coccyx (tailbone), and no pressure ulcer on their left heel.Review of the facility's investigation summary report titled, Pressure ulcer:. house-acquired, dated 04/05/2026 showed that on 04/05/2026, Staff E, Certified Nurse Assistant, noticed a dried fluid leaking through Resident 1's left sock and notified Staff D, Registered Nurse. The investigative report showed Staff D observed that the dressing on the resident's left heel was dated 03/08/2026, and that when the dressing was removed, an unstageable pressure ulcer was discovered on Resident 1's left heel. Staff B, Director of Nursing, interviewed Staff F, Licensed Practical Nurse, and Staff F stated that on 03/30/2026, I did peel it off and peeked only and reapplied the same dressing . I did not see the date though. I should have checked and changed the dressing. Review of the March 2026 Treatment Administration Records showed, Foam dressing to Left heel for protection one time a day every Mon [Monday] for skin integrity maintenance were initiated/signed on 03/09/2026, on 03/16/2026, on 03/23/2026, and on (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	03/30/2026. However, per the investigative report dated 04/05/2026, the last foam dressing changes was dated 03/08/2026.Review of Resident 1 nursing progress notes dated 04/05/2026, showed Resident 1 had developed an unstageable pressure ulcer on their left heel.In an interview on 04/20/2026 at 1:47 PM, Resident 1 stated that the dressing on their left heel was applied by Staff D on 03/08/2026 and it stayed there for a month. Resident 1 further stated that they were paraplegic and could not feel anything from the waist down. In an interview on 04/28/2026 at 11:50 AM, Staff C, Resident Care Manager, stated that for high-risk residents, comprehensive skin assessments were completed once a week as per physician order and that staff were expected to apply new dressing with current date and initials.A joint observation and interview on 04/28/2026 at 12:15 PM with Staff D, showed Resident 1 had an oval-shaped pressure injury on their left heel with yellow slough in the center and with dark discoloration along the wound edges. Staff D stated that the wound had been debrided by wound care specialist on 04/10/2026, and the wound remained unstageable, measuring 2.4-centimeter (cm) x 1.80 cm x 0.20 cm.In a joint record review and interview on 04/28/2026 at 12:37 PM with Staff B revealed that the 04/05/2026 investigative report showed that Staff F had peeked at the wound and reapplied the old dressing. When asked if the dressing had been changed weekly from 03/08/2026 through 04/05/2026, Staff B stated, No. Staff B stated that it was their expectation that staff would follow physician orders and perform wound dressing as prescribed.Reference: (WAC) 388-97-1060 (3)(b)