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	06/28/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure informed consent for psychotropic medication (a drug that affects behavior, mood, thoughts, or perception) was completed prior to administration for 2 of 5 residents (Residents 15 & 20), reviewed for unnecessary medications. This failure placed the residents and/or their representatives at risk of not being fully informed of the risks and benefits before making decisions about medications prior to administration. Findings included . Review of the facility's policy titled, Psychotropic Medication Management, revised in November 2021, showed that the resident/resident representative would be informed of the medication order, indication for use, and the right to refuse. The policy further showed that resident would be informed of the risk versus benefits of the medication to be administered. RESIDENT 15 Review of the physician's order dated 03/09/2024 showed Resident 15 had an order for a medication for anxiety. Review of the March 2024 to June 2024 medication administration record showed Resident 15 was taking a medication for anxiety since 03/10/2024. A joint record review and interview on 06/28/2024 at 10:30 AM with Staff D, Resident Care Manager, showed Resident 15 did not have a consent for a medication for anxiety. Staff D stated that Resident 15's consent was missed but that there should have been one. In an interview on 06/28/2024 at 11:33 AM, Staff B, Director of Nursing, stated that they expected residents to have a consent prior to taking psychotropic medications to explain the risks and benefits of the medication. Staff B stated that the consent should be completed prior to Resident 15 starting a medication for anxiety. 50891 RESIDENT 20 (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the face sheet showed Resident 20 admitted to the facility on [DATE] with multiple diagnosis including major depression (a serious mood disorder that causes persistent feeling of sadness and loss of interest). Review of Resident 20's physician orders showed 50 milligrams (mg-a unit of measurement) of an antidepressant medication was ordered to give one and a half tablets by mouth at bedtime for depression with sleep disturbances related to major depression on 01/24/2024. In a joint record review and interview on 06/28/2024 at 2:21 PM with Staff D, showed there was no consent for the antidepressant in Resident 20's electronic health record. Staff D stated that if they received an order for a psychotropic medication, they would get a consent since it was a psychotropic medication. Staff D stated that they were unable to find the consent and would have to dig through the progress notes. In an interview on 06/28/2024 at 2:31 PM, Staff B stated that they would get consent for the antidepressant medication as part of their process. Reference: (WAC) 388-97-0260

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care) was obtained from the resident and/or their representative and ensure a copy was readily available in the medical records for 2 of 3 residents (Residents 4 & 21), reviewed for advance directives. This failure placed the resident and/or their representative at risk for losing their right to have their preferences honored to receive care according to their choice. Findings included . Review of the facility's policy titled, Advance Directives, revised in March 2024, showed, If the resident or legal representative has executed one or more advance directive(s), these documents are obtained, incorporated and consistently maintained in the same section of the resident's health information record readily retrievable. RESIDENT 4 Review of the admission Minimum Data Set (MDS-an assessment tool) dated 04/17/2024, showed Resident 4 admitted to the facility on [DATE]. Review of Resident 4's Electronic Health Record (EHR), showed no documentation that Resident 4 had an advance directive. On 06/27/2024 at 11:15 AM, Resident 4 stated, I have one [advance directive]. In an interview and joint record review on 06/27/2024 at 11:34 AM, Staff C, Social Services Director, stated that if a resident had an advance directive, it would be scanned into the EHR and that they expected it to be there. In a joint record review of Resident 4's EHR showed no documentation that Resident 4 had an advance directive. Staff D stated, I don't see any documentation of a DPOA or advance directive. On 06/28/2024 at 12:40 PM, Staff A, Administrator, stated that if a resident had an advance directive I would expect there to be a copy in their medical records. 47680 RESIDENT 21 Review of the quarterly minimum data set (an assessment tool) dated 05/16/2024 showed that Resident 21 admitted to the facility on [DATE]. On 06/27/2024 at 11:19 AM, Resident 21 stated that they had an advance directive and that their Power of Attorney (POA- a type of advance directive) carried a copy with them. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's nursing progress note dated 03/19/2024 showed that their representative was their POA. Review of Resident 21's EHR showed no documentation of their advance directive. In an interview on 06/27/2024 at 11:43 AM, Staff C stated that if a resident had an advance directive, the document would get scanned into the miscellaneous tab in point click care (charting system) and expected it would be there if the resident had one. Staff C stated that they did not see an advance directive for Resident 21 and that typically they would ask family to provide a copy of their advance directive. Staff C further stated that they were aware that Resident 21 had a POA but had no paperwork to back it up. In an interview on 06/28/2024 at 10:50 AM, Staff A stated that they expected staff to follow their policy. Staff A further stated that if a resident had an advance directive, they expected they would have a copy of it. Reference: (WAC) 388-97-0280 (3)(a)

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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. 47680 Based on interview and record review, the facility failed to issue Notification of Medicare Non-Coverage (NOMNC- a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) at least two calendar days before the Medicare coverage ended for 1 of 3 residents (Resident 331), reviewed for beneficiary notification. This failure placed the resident and/or their representative at risk for not being fully informed and losing their right to an appeals process. Findings included . Review of the facility's policy titled, Medicare and Medicare Advantage Notices for Skilled Nursing Facilities, revised in February 2023, showed, It is the policy of the Company that notices for skilled nursing facilities are delivered to residents according to Medicare and Medicare Advantage plan guidelines. Review of the undated Centers for Medicare and Medicaid Services online form titled, Form instructions for the notice of Medicare Non-Coverage (NOMNC) CMS-10123, showed, The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Review of the admission minimum data set (an assessment tool) dated 01/02/2024 showed that Resident 331 admitted to the facility under their skilled Medicare A benefits with a state date of 12/27/2023. Review of Resident 331's NOMNC showed a last day of Medicare A coverage of 01/23/2024, signed on 01/24/2024, one day after the end of Medicare A coverage. Review of the social services progress note dated 01/24/2024 showed that the NOMNC was signed on 01/24/2024 by Resident 331's representative and that Resident 331 had asked for their representative to sign for them. In an interview and joint record review on 06/26/2024 at 2:23 PM with Staff C, Social Services Director, stated they issued the NOMNC at least 2 days prior to end of Medicare coverage. Staff C stated that if a resident declined or was unable to sign the NOMNC form, they would email it to the resident's representative and have them acknowledge the receipt. Joint record review of Resident 331's NOMNC showed that it was signed on 01/24/2024. Staff C stated they emailed Resident 331's representative to inform them that Resident 331 would rather have them sign the NOMNC form and informed them to acknowledge the email. Staff C stated that they would find the email and would provide it. In a follow up interview at 2:41 PM, Staff C stated that they could not find the email that was sent to Resident 331's representative and that they should have emailed Resident 331's representative. In an interview on 06/28/2024 at 3:28 PM, Staff A, Administrator, stated that they expected the NOMNC to be issued at least 2 days before the last covered Medicare day and that it would be documented that it was given or that the resident preferred the representative to sign it. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0300 (1)(e)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48899 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the residents/representatives and to the Office of the State Long-Term Care Ombudsman (an advocacy group for residents in a nursing home) for 2 of 3 residents (Residents 230 & 10), reviewed for hospitalization . These failures placed the residents at risk for not having an opportunity to make informed decision about transfers/discharges. Findings included . Review of the facility's policy titled, Discharge/Transfer, revised in November 2017, showed that the transfer/discharge notice would be issued as soon as practicable when an immediate transfer or discharge is required by the resident's urgent medical condition. The policy further showed that the copy of discharge notice must be sent to the State office of Long-Term Care Ombudsman. RESIDENT 230 Review of the nursing progress note dated 06/14/2024 showed that Resident 230 was sent to the hospital for further evaluation. Review of the Electronic Health Record (EHR) did not show documentation that a written notice of transfer/discharge was provided to Resident 230 and/or their representative, and to the Office of the State Long-Term Care Ombudsman. In an interview on 06/27/2024 at 3:26 PM, Staff C, Social Services Director, stated that they did not provide a written notice to the resident/family and State Ombudsman office and said, If it should be done that would be me but I have not been doing it. In an interview on 06/28/2024 at 10:30 AM, Staff D, Resident Care Manager, stated that they notified family by phone and did not provide a written transfer notice to Resident 230 and/or their representative. Staff D also stated that they did not notify the Ombudsman's office about the transfer. In an interview on 06/28/2024 at 11:33 AM, Staff B, Director of Nursing, stated that they informed the resident/their family by phone, and they did not have a written notice to provide to the resident and/or their representative. Staff B also stated that the facility did not send a copy of transfer notice to the State Long-Term Care Ombudsman office. In an interview on 06/28/2024 at 2:03 PM, Staff A, Administrator, stated that it was their expectation for the facility to follow its discharge/ transfer policy. 47680 RESIDENT 10 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discharge minimum data set (an assessment tool) dated 03/30/2024 showed that Resident 10 discharged to the hospital. Review of the nursing progress notes dated 03/30/2024 showed that Resident 10 left to the emergency room due to emesis (vomiting) and abdominal pain. Review of Resident 10's EHR did not show documentation that the resident and/or their representative were notified in writing of the reason for discharge to the hospital. In an interview on 06/27/2024 at 3:45 PM, Staff C stated that they have not been notifying the resident and/or their representative in writing of the reason for discharge and sending a copy of the notice to the Ombudsman. Staff C further stated that if it were being done, it was done by nursing. In an interview on 06/27/2024 at 5:12 PM, Staff D stated they did not notify the resident and/or their representative in writing of the reason for discharge and do not send a copy of the notice to the Ombudsman. Staff D stated that they had not personally sent one to the Ombudsman. In an interview on 06/28/2024 at 2:20 PM, Staff B stated that they have not been notifying the residents and/or their representatives in writing of the reason for discharge and/or sent a notice to the Ombudsman. In a joint record review of the facility's discharge policy showed that the notice was to be given to the resident/representative and Ombudsman. Staff B stated that if it was the regulation, it should have been done. In an interview on 06/28/2024 at 2:29 PM, Staff A stated that they expected staff to follow their policy. Reference: (WAC) 388-97-0120 (2)(a)(b)(c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure bed hold (the opportunity to pay for the bed the resident currently occupied while out of the facility in order to ensure their bed/room was available when they are ready to return) notices were offered to residents who were hospitalized for 2 of 3 residents (Residents 230 & 10), reviewed for hospitalization . The failure to offer bed holds placed residents at risk for unwanted, avoidable room changes upon readmission, and frustration. Findings included . Review of the facility's policy titled, Bed Hold, revised on January 2020, showed before a nursing facility transferred a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed hold policy under the State plan, if any during which the resident is permitted to return and resume residence in the nursing facility and the bed payment policy. RESIDENT 230 Review of the nursing progress note dated 06/14/2024, showed that Resident 230 was sent to the hospital for further evaluation. Review of the Electronic Health Record (EHR) did not show that Resident 230 was offered a bed hold notice for their transfer to the hospital. In an interview on 06/26/2024 at 8:47 AM, Resident 230 stated that they were hospitalized on [DATE] and readmitted to the facility on [DATE]. Resident 230 stated they were not offered a bed hold notice. In an interview on 06/27/2024 at 3:26 PM, Staff C, Social Services Director, stated they spoke to Resident 230 and their representative about the bed hold but did not offer written bed hold notice. Staff C further stated that they did not offer the bed hold notice because the facility had no problem readmitting residents. In an interview on 06/28/2024 at 2:03 PM, Staff A, Administrator, stated that it was their expectation for the facility to follow its discharge/ transfer policy. 47680 RESIDENT 10 Review of the discharge minimum data set (an assessment tool) dated 03/30/2024 showed that Resident 10 discharged to the hospital. Review of the nursing progress notes dated 03/30/2024 showed that Resident 10 left to the emergency room due to emesis (vomiting) and abdominal pain. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's EHR showed no documentation that the resident and/or their representative were notified of a bed hold notice. In an interview on 06/27/2024 at 3:45 PM, Staff C stated they did verbal communication of the bed hold notice and that it was not documented. Staff C further stated that they did not provide residents and/or their representatives with a written bed hold notice. In an interview on 06/28/2024 at 2:29 PM, Staff A stated that they expected staff to follow their bed hold policy. Reference: (WAC) 388-97-0120 (4)(a)(b)(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to accurately assess 1 of 3 residents (Resident 28) reviewed for hospitalization . The failure to ensure accurate assessment regarding discharge status resulted in inaccurate information in the resident's clinical record and placed the resident at risk for unidentified care needs. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.17.1, dated October 2019, showed: Accuracy of Assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate RAI (i.e., comprehensive, quarterly, annual, significant change in status). Review of Resident 28's electronic health record showed a nursing progress note dated 06/07/2024 that showed, This resident was cleared .to go home safely. Review of the discharge Minimum Data Set (MDS-an assessment tool) dated 06/08/2024, showed Resident 28's MDS was coded for discharge to Short-term General Hospital. In an interview and joint record review on 06/27/2024 at 3:44 PM, Staff E, MDS coordinator, stated that Resident 28 discharged to the community, and they expected the discharge MDS to be coded for that. In a joint review of the discharge MDS dated [DATE], showed it was coded for Short-term General Hospital. Staff E stated it should be coded for community and I will modify it. In an interview on 06/28/2024 at 1:59 PM, Staff B, Director of Nursing, stated they expected the MDS to be accurate. Reference: (WAC) 388-97-1000 (1)(b)

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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** 50891 Based on interview and record review, the facility failed to ensure 4 of 5 residents (Residents 20, 12, 10, & 21), had a completed and an accurate Preadmission Screening Resident Review (PASRR) (an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), intellectual disabilities; or related conditions are not inappropriately placed in nursing homes for long term care) on admission. This failure placed these residents at risk for unmet care needs, unmet mental needs, and a decreased quality of life. Findings included . Record review of the facility's policy titled, PASSR-Preadmission Screening and Resident Review policy, dated October 2023, showed that the company will abide by the federal requirement for PASRR to ensure that individuals are not inappropriately placed in nursing facilities for long term care. This policy showed PASRR required that (1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings. RESIDENT 20 Review of the face sheet showed Resident 20 admitted to the facility on [DATE] with multiple diagnoses including major depression (mood disorder that causes persistent feeling of sadness and loss of interest). Review of the Level I PASSR for Resident 20 showed it was completed on 06/28/2024, seven days after their admit day. On 06/28/2024 at 2:31 PM, Staff C, Social Services Director, stated that the PASSR was usually filled out by the hospital prior to admission to the facility. Staff C stated that if the PASSR was not filled out at the hospital, then they themselves would fill it out. Staff C admitted that Resident 20's PASSR was filled out a week after admission to the facility. 46912 RESIDENT 12 Review of the entry Minimum Data Set (MDS- an assessment tool) dated 12/14/2023, showed Resident 12 admitted to the facility on [DATE]. Review of the comprehensive care plan printed on 06/26/2024, showed Resident 12 had a diagnosis of depression. Review of Resident 12's Level I PASRR dated 12/13/2023, showed nothing marked for SMI. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 06/27/2024 at 11:59 AM, Staff C stated that when a resident admitted from the hospital, they checked the Level I PASRR and verified that it was accurate. In a joint record review of Resident 12's electronic health record, showed Resident 12 had a diagnosis of depression. In a joint record review of the Level I PASRR dated 12/13/2023, showed there was nothing marked under the SMI section for depression. Staff C stated the Level I PASRR should have been marked for depression and I didn't catch it. On 06/28/2024 at 12:38 PM, Staff A, Administrator, stated they expected the Level I PASRR to be looked at and be accurate. 47680 RESIDENT 10 Review of the significant change in status MDS dated [DATE] showed that Resident 10 readmitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mental illness that affects a person's mood and thoughts). Review of Resident 10's Level I PASRR form completed on 04/04/2024 showed that SMI was marked no. RESIDENT 21 Review of the admission MDS dated [DATE] showed that Resident 21 admitted to the facility on [DATE] with multiple diagnoses that included depression and anxiety (intense, excessive and persistent worry and fear about everyday situations). Review of Resident 21's Level I PASRR form completed on 02/14/2024 showed that SMI was marked no. In an interview and joint record review on 06/27/2024 at 11:59 AM, Staff C stated that they were responsible in ensuring the Level I PASRR form were accurate. Staff C stated that if the PASRR form was completed by the hospital, they would look at the diagnosis and verified it was accurate. Joint record review of Resident 10 and Resident 21's PASRR form showed that they were not marked for SMI. Staff C stated that they should have been marked for SMI and referred for Level II PASRR (an in-depth evaluation to determine whether the resident requires specialized rehabilitation services). In an interview on 06/28/2024 at 10:56 AM, Staff A stated that they expected staff to follow the regulation and their policy. Staff A further stated that they expected the PASRR forms to be accurate. Reference: (WAC) 388-97-1915 (1); 1975(1)(2)(3)

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	505520	A. Building B. Wing	06/28/2024

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Mirabella Seattle	116 Fairview Avenue N Seattle, WA 98109

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to develop person-centered comprehensive care plans for 5 of 11 residents (Residents 230, 4, 19, 21, & 20) whose care plans were reviewed. The facility's failure to develop individualized, comprehensive care plans left residents at risk for unmet care needs. Findings included . Review of the facility's policy titled, Care Planning, revised in October 2023, showed that within 21 days of admission and/or 7 days after the completion of the comprehensive assessment the interdisciplinary team including the resident and/or responsible party would develop a comprehensive care plan. RESIDENT 230 Review of the physician's order, dated 05/29/2024, showed Resident 230 had an order of oxygen (O2) at two liters (unit of measurement) per minute via nasal cannula (flexible tubing that sits inside the nostrils and delivers O2 as needed for shortness of breath. Review of Resident 230's June 2024 Medication Administration Record (MAR) showed Resident 230 was using O2 since 05/29/2024. Review of Resident 230's comprehensive care plan printed on 06/26/2024, showed no O2 care plan. In an interview on 06/26/2024 at 8:17 AM, Resident 230 stated that they were using O2 since they admitted to the facility on [DATE]. In a joint record review and interview on 06/28/2024 at 10:30 AM with Staff D, Resident Care Manager, showed the care plan for O2 use was initiated on 06/26/2024. Staff D stated that Resident 230 was using O2 since 05/29/2024, and the care plan was not initiated until 06/26/2024. In an interview on 06/28/2024 at 11:33 AM, Staff B, Director of Nursing, stated the care plan for Resident 230's O2 use should have been developed whey they started using O2. 46912 RESIDENT 4 Review of the admission Minimum Data Set (MDS-an assessment tool) dated 04/17/2024, showed Resident 4 admitted to the facility on [DATE]. Review of the mobility care plan revised on 04/30/2024, showed Resident 4 was one person limited to extensive assist for bed mobility and transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation and interview on 06/25/2024 at 11:52 AM, showed Resident 4's bed with the right-side rail in the raised position. Resident 4 stated they used the side rails for getting up from lying down. Additional observations on 06/26/2024 at 2:16 PM and at 2:29 PM, showed Resident 4 with bilateral (both sides) side rails in the raised position. Review of the comprehensive care plan printed on 06/26/2024, showed no care plan for Resident 4's side rails. On 06/27/2024 at 9:07 AM, Staff P, Certified Nursing Assistant, stated that Resident 4 used their side rails and they come in handy. In an interview and joint record review on 06/27/2024 at 9:25 AM, Staff G, Registered Nurse (RN), stated they would expect there to be a care plan for side rails. In a joint record review of Resident 4's comprehensive care plan, showed no care plan for side rails. Staff G stated, I would expect there to be one. In an interview on 06/28/2024 at 1:50 PM, Staff B stated that prior to adding side rails to a resident's bed, there needed to be an assessment, consent, physician's order, and it should be care planned. 47680 RESIDENT 19 Review of the quarterly MDS dated [DATE] showed that Resident 19 readmitted to the facility on [DATE] with diagnoses that included congestive heart failure (long-term condition that happens when the heart cannot pump blood well enough to give the body a normal supply causing blood and fluids to collect in the lungs and legs over time). Review of Resident 19's June 2024 MAR showed an order for O2 saturation every shift for routine monitoring. Give O2 via nasal cannula to keep O2 saturation greater than 95 percent. Notify provider if using greater than three liters dated 06/04/2024. Review of Resident 19's comprehensive care plan printed on 06/26/2024 did not show a care plan for O2 use. In an observation and interview on 06/25/2024 at 2:05 PM showed Resident 19 sitting in their recliner using two liters of O2 via nasal cannula. Resident 19 stated that they started using O2 due to pneumonia (lung infection). In an interview and joint record review on 06/26/2024 at 3:45 PM, Staff F, RN, stated that O2 use would be part of the residents' care plan. In a joint record review of Resident 19's care plan did not show a care plan for O2 use. Staff F stated Resident 19 should have had a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/27/2024 at 5:22 PM, Staff D stated that O2 use should be care planned. Staff D stated that an O2 care plan was added on 06/26/2024 and that they should have had initiated a care plan when Resident 19 started using O2. In an interview on 06/28/2024 at 9:24 AM, Staff B stated that they expected O2 use to be care planned. RESIDENT 21 Review of the quarterly MDS dated [DATE] showed that Resident 21 was admitted to the facility on [DATE]. It showed that Resident 21 had an active range of motion restorative nursing program and was performed for two days for at least 15 minutes. Review of the restorative task form from 05/30/2024 to 06/23/2024 showed that Resident 21 was provided their restorative nursing program nine times. Review of Resident 21's comprehensive care plan printed on 06/26/2024 did not show a care plan for their restorative program. In an interview on 06/28/2024 at 1:56 PM, Staff E, MDS Coordinator, stated that once a resident comes off therapy, they would make recommendations for a restorative program. Staff E stated that the restorative program should be part of the resident's care plan and stated, there might be some that are not in there. Staff E reviewed Residents 21's Kardex (care guide for CNAs) and stated that they did not see it. Staff E stated that if it was not in the Kardex, it was not in their care plan. Staff E stated that it needed to be in the care plan for it to show in the Kardex and that Resident 21 should have had a restorative care plan. In an interview on 06/28/2024 at 2:09 PM, Staff B stated Resident 21 should have had a restorative care plan. 50891 RESIDENT 20 Review of the face sheet showed Resident 20 admitted to the facility on [DATE] with multiple diagnoses including a history of cerebral vascular accident (a loss of blood flow to part of the brain, which damages brain tissue). Review of Resident 20's physicians orders showed anticoagulant medication used to treat and prevent blood clots 2.5 milligrams (mg-a unit of measure) one tablet two times a day was ordered on 10/27/2024. In an interview and joint record review with Staff D, on 06/28/2024 at 2:07 PM, showed that the anticoagulant medication was not included in the care plan. Staff D stated, It looks like it did not make it in the care plan. Staff D stated that the anticoagulants were usually included. Staff D stated that when they clicked on a certain box in the electronic health record system, it would automatically create a care plan for anticoagulant therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint record review and interview with Staff B on 06/28/2024 at 2:34 PM, Staff B stated that they just saw a blood thinner in the care plan but it looks like it was just added within the hour. Staff B stated their process for a resident starting an anticoagulant included updating their care plan. Reference: (WAC) 388-97-1020(1)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview and record review, the facility failed to ensure appropriate treatment and services related to gastrostomy tube (G-tube - a medical device used to provide nutrients through a tube directly into the stomach) were followed for 1 of 1 resident (Resident 21), reviewed for tube feeding management. The failure to check for G-tube placement by visual inspection of aspirated stomach content prior to medication administration placed the resident at risk for medical complications and a diminished quality of life. Findings included . Review of the facility's policy titled, Enteral [tube placed in the stomach to provide nutrition and medications] Tube Feeding and Medication Administration, dated November 2022, showed that medication administration would include checking placement prior to administration. It further showed that placement would be checked before each feeding and before each medication administration or intermittently as ordered. Review of the quarterly minimum data set (an assessment tool) dated 05/16/2024 showed that Resident 21 admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (surgical opening in the stomach) status. Further review showed that Resident 21 received nutrition through a feeding tube. Review of Resident 21's June 2024 medication administration record (MAR) showed an enteral feed order every shift to check tube for proper placement by visual inspection of aspirated stomach content prior to instilling medication, initiating a feeding or when there is an interruption of feeding, or at least every shift for continuous feeding dated 02/14/2024. Observation on 06/27/2024 at 11:02 AM, showed Staff G, Registered Nurse, inserted a syringe in Resident 21's G-tube port. Staff G removed the syringe from the G-tube port and removed the plunger from the syringe. Staff G then re-inserted the syringe back into the G-tube port and flushed it with water. Staff G poured a medication cup with one dissolved medication into the syringe and then flushed it with water. Staff G did this same process until they were done administering all of Resident 21's medications. When Staff G was done, they flushed the G-tube with water. Staff G did not check G-tube placement by visual inspection of aspirated stomach content prior to administering Resident 21's medications. In an interview on 06/27/2024 at 11:23 AM, Staff G stated that they did not check G-tube placement prior to administering Resident 21's medications and that they should have. In an interview on 06/27/2024 at 5:32 PM, Staff D, Resident Care Manager, stated that their process for administering medications by G-tube was to check for placement, and to flush with water before, in between, and after administering medications. Staff D stated that they followed the MAR on how to check for G-tube placement. Staff D further stated that they expected Staff G to check for G-tube placement prior to administering medications. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/28/2024 at 9:15 AM, Staff B, Director of Nursing, stated that they expected staff to check for G-tube placement per physician order. Staff B further stated that they expected Staff G to check for G-tube placement per physician order prior to administering medications. Reference: (WAC) 388-97-1060 (3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure necessary respiratory care and services were provided in accordance with professional standards of practice for 3 of 3 residents (Residents 5, 19, & 230), reviewed for respiratory care. Specifically, oxygen (O2) equipment was not maintained to include care of O2 tubing and nasal cannula (flexible tubing that sits inside the nostrils and delivers O2) and did not have signage for when oxygen was in use. This failure had the potential to affect the resident's respiratory status, including respiratory infections and related complications and the potential to create a hazardous environment. Findings included . Review of the facility's policy titled, Oxygen/Respiratory Therapy and Safety, revised in January 2020, showed, The resident's room will have a sign signifying when oxygen is in use. The policy showed, Oxygen/respiratory equipment tubing/cannula/mask and plastic container bag will be changed at least weekly and anytime as needed .and would be dated and initialed each time it is changed. It further showed that When oxygen/respiratory equipment is not in use, place the tubing/cannula/mask into the bag to keep clean and prevent contamination. RESIDENT 5 Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 04/04/2024, showed Resident 5 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of the June 2024 Medication Administration Record (MAR) showed Resident 5 had an order for Oxygen at 2L [Liters - a unit of measurement]/min [minute] via NC [nasal cannula] continuously. Observations on 06/25/2024 at 8:37 AM and at 1:21 PM, showed Resident 5 had an O2 concentrator (a machine that delivers oxygen) in their room with a nasal cannula not in use and not stored in a bag. It also showed there was no sign that stated O2 was in use. Observation on 06/26/2024 at 8:21 AM, showed Resident 5's nasal cannula on the floor and not stored in a bag. It also showed there was no sign that stated O2 was in use. Additional observation on 06/26/2024 at 9:41 AM, showed Staff R, Registered Nurse (RN), put the nasal cannula that was on the floor on Resident 5. In an interview and joint observation on 06/26/2024 at 9:50 AM, Staff R stated that O2 tubing should be labeled. Staff R stated when the nasal cannula was not in use, they just set it aside and if it was found on the floor, if it's soiled, throw away and get a new one [nasal cannula]. Joint observation of Resident 5's portable O2 tubing showed no label or date. Staff R stated that it was not labeled or dated. Staff R further stated that they had picked up the nasal cannula from the floor and put in on Resident 5 because it didn't look soiled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint observation on 06/27/2024 at 9:43 AM, Staff G, RN, stated that Resident 5 was on O2. Joint observation showed there was no O2 in use sign for Resident 5's O2. Staff G stated that there was no O2 in use sign and I've never seen a sign. In an interview on 06/28/2024 at 11:03 AM, Staff D, Resident Care Manager/Infection Preventionist, stated they expected the nasal cannula to be in a bag when not in use and should be off the floor. In an interview on 06/28/2024 at 1:58 PM, Staff B, Director of Nursing, stated they expected O2 tubing to be labeled and dated. Staff B stated that when the nasal cannula was not in use it should be in a bag and if it was found on the floor staff should replace it. Staff B further stated that the O2 in use sign should be there. 47680 RESIDENT 19 Review of the quarterly MDS dated [DATE] showed that Resident 19 readmitted to the facility on [DATE]. Review of the care plan printed on 06/26/2024 showed they had diagnoses that included pneumonia (infection in one or both of the lungs which can cause cough and difficulty breathing) and congestive heart failure (long-term condition that happens when the heart cannot pump blood well enough to give the body a normal supply causing blood and fluids to collect in the lungs and legs over time). Review of Resident 19's June 2024 MAR showed an order for O2 saturation every shift for routine monitoring. Give O2 via nasal cannula to keep O2 saturation greater than 95 percent. Notify provider if using greater than three liters dated 06/04/2024. Observation and interview on 06/25/2024 at 2:05 PM, showed Resident 19 sitting in their recliner using O2 via an unlabeled nasal cannula. Resident 19 stated that they started using O2 due to pneumonia. Observation on 06/26/2024 at 1:16 PM, showed Resident 19's O2 tubing on the floor and their unlabeled nasal cannula was laying on top of the O2 concentrator with the nasal prongs touching the floor and was not in a bag. In an interview and joint observation on 06/26/2024 at 3:45 PM, Staff F, RN, stated that they stored the nasal cannula in a bag when not in use, changed it every 72 hours and as needed and labeled/dated the nasal cannula tubing. Joint observation showed Resident 19's O2 nasal cannula was touching the floor, was unlabeled and was not stored in a bag. Staff F stated that the nasal cannula should not have been on the floor, that it should have been labeled and stored in a bag when not in use. On 06/28/2024 at 9:24 AM, Staff B stated that they expected the nasal cannula to be labeled, changed weekly and stored in a bag when not in use. 48899 RESIDENT 230 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order dated 05/29/2024 showed Resident 230 had an order of O2 supply at two liters per minute via nasal cannula as needed for shortness of breath. Review of Resident 230's June 2024 MAR showed Resident 230 was using O2 since 05/29/2024. Observations on 06/26/2024 at 8:17 AM and on 06/26/2024 at 3:05 PM, showed the resident was lying in bed, receiving two liters per minute O2 via nasal cannula. The observation showed tubing was undated. The observations further showed that there were no O2 in use sign on the Resident 230's room door. In an interview on 06/26/2024 at 8:17 AM, Resident 230 stated that they were using O2 since they admitted to the facility. A joint observation and interview on 06/27/2024 at 8:23 AM with Staff J, RN, showed that the tubing was dated 06/26/2024. The observation also showed that there was no signage on Resident 230's door. Staff J said, the signage will be a good thing, but we did not put it. Staff J added that they change and date the tubing every week and the staff from 06/26/2024 night shift changed and dated the tubing. A joint record review and interview on 06/28/2024 at 10:30 AM with Staff D, showed the order for tubing change was placed on 06/26/2024. Staff D stated that there should have been an order for O2 tubing change when Resident 230 started using it on 05/29/2024. Staff D further stated that Resident 230's room door had no O2 in use sign. In an interview on 06/28/2024 at 11:33 AM, Staff B stated that an order for tube change should have been obtained when Resident 230 started using O2. Staff B added that they did not put O2 signage on the door because they were not a smoking facility. Staff B further stated that the facility's O2 policy should be followed. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47680 Based on observation, interview, and record review, the facility failed to maintain the medication room refrigerator temperature logs in 1 of 3 medication room refrigerators (Medicine Refrigerator) reviewed for medication storage and labeling. This failure placed the residents at risk for receiving compromised or ineffective medications. Findings included . Review of the facility's policy titled, Medication Storage in the Facility, revised on 01/01/2023, showed medications requiring refrigeration were kept in a refrigerator at temperatures between 36 Fahrenheit (F- a temperature scale)- 46 F with a thermometer to allow temperature monitoring. It further showed the facility should maintain a temperature log in the storage area to record temperatures at least once a day. Joint observation on 06/26/2024 at 3:25 PM with Staff B, Director of Nursing, showed that there were three refrigerators (medicine refrigerator, intravenous [within a vein] refrigerator and food refrigerator) in the medication storage room. The medicine refrigerator had one pneumococcal (helps protect against some types of bacterial infections) vaccine and other multiple resident medications. Record review of the facility's medication storage room temperature logs from April 2024 to June 2024 showed the following: -Five temperatures were logged for 04/01/2024 to 04/24/2024. -One temperature was logged for 05/01/2024 to 05/24/2024. -No temperature was logged for 06/01/2024 to 06/26/2024. In a joint record review and interview on 06/26/2024 at 4:05 PM with Staff B, showed that the June 2024 refrigerator temperature log was not completed for the medicine refrigerator for 26 of 26 days. Staff B stated that the temperature in medicine refrigerator should be tracked twice a day. Staff B further stated that temperatures were not consistently checked for April 2024 and May 2024. Joint observation of the medicine refrigerator on 06/27/2024 at 8:25 AM with Staff B showed the following: -Eight unopened medication that works by lowering levels of sugar in the blood) pens for Resident 230. -One opened box of a test for tuberculosis [a contagious infection caused by bacteria that mainly affects the lungs) -Three unopened boxes of a (brand name- tuberculosis testing solution) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One opened pneumonia vaccine -Four unopened boxes of a medication that prevents blood clots In an interview on 06/27/2024 at 8:35 AM, Staff B stated that the medications noted above were there on 06/26/2024 and that nothing had been taken out. Staff B further stated they should have been tracking the temperatures in the medicine refrigerator. Reference: (WAC) 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview, and record review, the facility failed to keep the kitchen refrigerator and storage free of expired food and staff failed to demonstrate handwashing while preparing lunch for all residents. These failures placed all residents at risk for a food borne illness by potentially serving expired food products and cross contamination from poor hand hygiene during food preparation. Findings included . Review of the facility's General Food Storage Standards, dated [DATE], showed the food storage should incorporate specific standards and criteria to maintain a clean and safe environment for healthful delivery to the residents. The procedure included that any food items that reached their expiration date would be discarded. Review of the facility's Hand Hygiene policy, dated [DATE], showed that the facility considered hand hygiene the primary means to prevent the spread of infections. The policy showed all personnel should be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. The policy did not address hand hygiene during food preparation. The policy showed to perform hand hygiene after removing gloves and before and after eating or handling food. In a joint observation and interview on [DATE] at 8:30 AM, a jar of thousand island dressing was observed in the refrigerator. The expiration label on the jar read [DATE]. Staff M, healthcare lead cook, stated that they did not know why it was there. Staff M stated, people put things where they shouldn't. In a joint observation and interview on [DATE] at 8:32 AM, a tray of clams was observed on the refrigerator shelf. The label on this tray read Must use by [DATE]. Staff L, Kitchen staff/receiving, stated that they meant to discard the tray of clams but had not gotten to it. In a joint observation and interview with Staff N, Head chef on [DATE] at 9:49 AM, three jars of mustard were observed on the shelf in the facility's dry storage room. The three jars of mustard had a manufacturer's expiration label of [DATE]. After pointing out the expiration date to Staff N, Staff N stated that it was just mustard, then continued to pull the mustard jars off the shelf to discard them. In an observation on [DATE] at 9:31 AM, Staff O, kitchen cook, was observed cleaning a thermometer during meal preparation, then put the thermometer down and pick up a metal bowl. Observation showed Staff O continued to set up a tray of potatoes, don gloves, and finished preparing the potatoes before placing them in the oven. There was no handwashing observed in this sequence of events. Staff O was then observed picking up a dirty rag at the end of the counter that they had just worked on and stated, that shouldn't be on my table. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:42 PM, Staff A, Administrator, stated that their expectation for labeling food was to follow the food labeling policy. Staff A stated, if it was expired, it should be thrown away. Staff A stated that they expect kitchen staff to follow the hand hygiene policy. Reference: WAC [DATE] (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on observation, interview, and record review, the facility failed to ensure the facility's water management program included a flow diagram to assess or monitor the potential growth of legionella (a water-borne bacteria that can cause pneumonia [a lung infection]) or other waterborne pathogens (an organism that can cause disease), and to review infection prevention and control policy (IPCP) at least annually. Additionally, the facility failed to ensure proper hand hygiene practices were followed during room tray and activity flyer delivery for 2 of 6 staff (Staff H & I) and failed to put isolation precautions for Aerosolizing Generating Procedure (AGP-a medical procedure that produce minute particles that become suspended in the air) for 1 of 2 residents (Resident 4), reviewed for infection control. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . LEGIONELLA WATER MANAGEMENT PROGRAM In an interview on 06/28/2024 at 8:50 AM, Staff K, Facility Services Director, stated that the facility's water management plan did not have a flow diagram to identify areas where legionella could grow and spread, and the facility did not have a process in place for communicating the water management program to residents, staff and/or others. Staff K further stated that the water management system for the entire building was overseen by the vendor, and they did not have a specific water management program for the floor where the skilled nursing unit was located. INFECTION PREVENTION AND CONTROL POLICY In an interview on 06/27/2024 at 2:10 PM, Staff D, Resident Care Manager/ Infection Preventionist, stated that they did not know how often the IPCP document was being reviewed. A joint record review and interview on 06/28/2024 at 11:33 AM with Staff B, Director of Nursing, showed that the IPCP was last revised in November 2017 and approved in February 2023. The IPCP also showed that the next IPCP review was in February 2024. Staff B stated that the policies were being reviewed at the corporate level and they did not know how often they reviewed the IPCP. In an interview on 06/28/2024 at 2:03 PM, Staff A, Administrator stated that they did not know about the facilities water management program and how often the IPCP document was being reviewed. 46912 AGP/CPAP Review of the admission minimum data set (an assessment tool) dated 04/17/2024, showed Resident 4 admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's physician orders showed, CPAP [Continuous Positive Airway Pressure- a therapy that pumps air into the lungs through the nose or nose and mouth that keeps the airway open {a type of AGP}] on at HS [bedtime]/Off at AM every day and evening shift. Observation on 06/25/2024 at 6:40 AM, showed an isolation cart outside Resident 4's room and a sign placed on top of the cart that showed Special Droplet/Contact Precautions (which required Personal Protective Equipment [PPE-including gown, gloves, and N95 mask {a protective device designed to have an efficient filtration of airborne particles} when entering the room]. In a joint observation and interview on 06/25/2024 at 6:43 AM, Staff Q, Certified Nursing Assistant (CNA), showed a Special Droplet/Contact precautions sign on top of the isolation cart. Staff Q stated, these signs weren't here before and they will ask a nurse before going in. Staff Q stated they spoke with a nurse that said Resident 4 used their CPAP until 8:00 AM and had a private caregiver who takes it off and then we can go in there [Resident 4's room] without PPE. Observation on 06/25/2024 at 7:40 AM, showed a newspaper, a container of sanitizing wipes, and a box of gloves sitting on top of the Special Droplet/Contact precautions sign. Observation on 06/25/2024 at 8:12 AM, showed Staff R, Registered Nurse, went in to Resident 4's room with no PPE and at 8:33 AM, showed Staff R went into Resident 4's room only wearing gloves. Additional observations on 06/26/2024 at 10:33 AM and on 06/27/2024 at 8:26 AM, showed a newspaper, a container of sanitizing wipes, and a box of gloves sitting on top of the Special Droplet/Contact precautions sign. In an interview on 06/27/2024 at 8:50 AM, Staff P, CNA, stated that Resident 4 was not on any precautions and if they were they would have a sign on the door and visible. Staff P stated that Resident 4 was on CPAP at night. In an interview and joint observation on 06/27/2024 at 9:43 AM, Staff G, RN, stated that Resident 4 was on CPAP. Joint observation showed the Special Droplet/Contact precautions sign on top of the isolation cart. Staff G stated, I thought it [the sign] was supposed to be on the door. Staff G further stated that they did not know if there was an amount of time after the CPAP was turned off that PPE should be used and I will ask about that. In a follow up interview on 06/27/2024 at 1:43 PM, Staff G stated they talked to Staff D who said that PPE should be worn while the CPAP was on and for three hours after. In an interview on 06/28/2024 at 11:03 AM, Staff D stated that they followed the Center for Disease Control and Prevention guidelines for AGP and that precautions should be in place anytime the CPAP is running and three hours after. Staff D stated they expected the Special Droplet/Contact precautions sign to be on the door and should not be on the isolation cart underneath a newspaper, a container of sanitizing wipes, and a box of gloves. In an interview on 06/28/2024 at 2:00 PM, Staff B stated PPE should be used when CPAP was in use and for three hours after. Staff B stated that the Special Droplet/Contact precautions sign should not be underneath a newspaper, a container of sanitizing wipes, and a box of gloves and if a resident did not want it on the door, it would need to be in the care plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47680 HAND HYGIENE DURING MEAL ROOM TRAY DELIVERY Observation on 06/25/2024 at 12:59 PM, showed Staff H, CNA, took a meal tray from the meal cart and delivered it to room [ROOM NUMBER]. Staff H removed the plastic covering on the plates, opened a soda can, and poured it into a cup. Staff H then touched the bedside table, closed the door and went back to the meal cart without performing hand hygiene. Staff H then took another meal tray from the meal cart, filled a cup with coffee, opened a tea bag and placed it in a cup and delivered it to room [ROOM NUMBER] that had an Enhanced Barrier Precaution (EBP-an infection control intervention designed to reduce transmission of resident organism that employs targeted gown, and gloves use during high contact resident care activities) signage on the door. Staff H touched the doorknob to enter the room. Staff H took two plastic food bags from Resident 6 and placed it down on the bedside table. Staff H then left room [ROOM NUMBER], closing the door by touching the doorknob. Staff H took another meal tray from the meal cart, poured coffee in a cup, and opened the door and entered room [ROOM NUMBER] that had an EBP signage on the door. Staff H left room [ROOM NUMBER] and went back to the meal cart, took a meal tray that was on top of the cart and delivered it to room [ROOM NUMBER]. Staff H removed the plastic covering off the plate, closed the door as they exited the room and walked down the hallway without performing hand hygiene. Staff H did not perform hand hygiene before and after entering rooms on EBP precautions. In an interview and joint observation on 06/25/2024 at 1:14 PM, Staff H stated that they performed hand hygiene when entering/exiting rooms, when coming in contact with residents and when providing hygiene care. Staff H stated during meal pass, If I'm just setting it on the table, I don't need to sanitize hands and if that they were repositioning the resident, they would need to perform hand hygiene. Staff H stated that they would apply gown and gloves when they provided care to residents on EBP. Joint observation of the EBP signage on room [ROOM NUMBER]'s door showed EVERYONE MUST: Clean their hands, including before entering, and when leaving the room. Staff H stated that they should have performed hand hygiene before entering and after exiting resident rooms. In an interview on 06/27/2024 at 5:26 PM, Staff D stated that their process was to perform hand hygiene before and after entering any rooms, whether a resident was on EBP or not. Staff D further stated that Staff H should have performed hand hygiene before entering and after exiting resident rooms. HAND HYGIENE DURING ACTIVITY FLYER DELIVERY Observation on 06/26/2024 at 9:25 AM, showed Staff I, Activities Director, handing out activity flyers to residents. Staff I exited room [ROOM NUMBER] that had an EBP signage on their door and entered room [ROOM NUMBER] that had an EBP signage on their door. Staff I then entered room [ROOM NUMBER] without performing hand hygiene before entering and exiting rooms. In another observation at 9:31 AM, showed Staff I exited room [ROOM NUMBER] that had an EBP signage on their door without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2024 at 9:32 AM, Staff I stated that they perform hand hygiene before/after they provided snacks, during one on one activity, when providing resident care and when going to resident rooms. Staff I stated that they performed hand hygiene before going into EBP rooms. Joint observation of the EBP signage in room [ROOM NUMBER] showed that everyone must clean their hands before entering and leaving the room. Staff I stated that they should have performed hand hygiene before entering and after exiting resident rooms. In an interview on 06/27/2024 at 5:31 PM, Staff D stated that they expected Staff I to perform hand hygiene before entering and after exiting resident rooms. In an interview on 06/28/2024 at 9:18 AM, Staff B stated that they expected staff to perform hand hygiene anytime staff entered/exited resident rooms, linen change, peri care (cleaning the private areas), after touching anything in the residents' rooms, after they touch their face, hair, and cough. Staff B stated that they expected staff to perform hand hygiene before and after exiting residents' rooms on EBP and contact precautions. Staff B further stated that Staff H and Staff I should have performed hand hygiene before entering and after exiting resident rooms. Reference: (WAC) 388-97-1320 (1)(a)(c)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to conduct routine maintenance to ensure side rails were safe to use for 1 of 6 residents (Resident 4) reviewed for accident hazards. This failure placed the residents at risk for injury and/or entrapment. Findings included . Review of the facility's policy titled, Side Rail Assessment, revised in August 2022, showed, The Maintenance department will conduct regular inspection of all the bed frames, mattresses, and side rails as part of their regular maintenance program to identify areas of possible entrapment. Review of the admission minimum data set (an assessment tool) dated 04/17/2024, showed Resident 4 admitted to the facility on [DATE]. Review of the mobility care plan revised on 04/30/2024 showed Resident 4 was one person limited to extensive assist for bed mobility and transfers. In a joint observation and interview on 06/25/2024 at 11:52 AM with Resident 4, showed Resident 4's bed with the right-side rail in the raised position. Resident 4 stated they used the side rails for getting up from lying down. Additional observations on 06/26/2024 at 2:16 PM and 2:29 PM, showed Resident 4 with bilateral (both sides) side rails in the raised position. On 06/27/2024 at 9:07 AM, Staff P, Certified Nursing Assistant, stated that Resident 4 used their side rails and they come in handy. In an interview and joint observation on 06/28/2024 at 9:16 AM with Staff S, Maintenance Manager, stated they have not been checking side rails for safety. Staff S stated that they had not seen any side rails and were not aware of any side rails in use by residents. In a joint observation of Resident 4's bed, showed bilateral side rails in the raised position. Staff S stated, I've never seen these before. Staff S further stated that beds were checked only when a resident discharged or admitted to the facility and there was no routine maintenance for side rails. In an interview on 06/28/2024 at 12:42 PM, Staff A, Administrator, stated that facilities was responsible for side rails being added to beds. In a follow-up interview at 1:23 PM, Staff A stated, there is no process for routine maintenance of side rails and there was no documentation that side rails were checked for safety. Reference: (WAC) 388-97-2100 (1)