



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

MIRABELLA
MIRABELLA
116 FAIRVIEW AVENUE NORTH
SEATTLE, WA 98109

RE: MIRABELLA License # 2034

Dear Administrator:

This letter addresses Compliance Determination(s) 42762 (Completion Date 06/28/2024) and 38162 (Completion Date 04/18/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/28/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2130-3-b, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-a, WAC 388-78A-2140-2-a, WAC 388-78A-2140-5, WAC 388-78A-2140-2, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2230-2-a, WAC 388-78A-2230-2-b, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-b, WAC 388-78A-2305-1, WAC 388-78A-2350-7-a, WAC 388-78A-2474-1, WAC 388-78A-2474-2-c, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100-3, WAC 388-78A-3100-4

The Department staff who did the on-site verification:

Alma Duran, Licensors
Keiko Kitano, Licensors

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

MIRABELLA # 2034

06/28/2024

Page 2 of 2

Jamie Singer, Field Manager

Region 2, Unit J

Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: MIRABELLA

Provider Type: Assisted Living Facility

License/Cert.#: 2034

Compliance Determination #: 38162

Intake ID: 122579

Investigator: Alma Duran

Region/Unit #: RCS Region 2 / Unit J

Investigation Date(s): 03/18/2024 through 04/18/2024

Complainant Contact Date(s):

Allegation(s):

Named resident (NR) 1 ran his wheelchair into NR 2. NR 2 fell and sustained injuries.

Investigation Methods:

Sample:	Total residents: 37 Resident sample size: 8 including named residents Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Activities
Interviews:	Identified resident Nursing staff Residents Family members Staff development coordinator
Record Reviews:	Medical records Assessments Negotiated service agreements Incident investigation Facility policies Progress notes Staff training records

Investigation Summary:

Based on observation, interviews, and record review, the Assisted Living Facility (ALF) failed to develop approaches and interventions in the negotiated service agreement for staff to follow related to NM 1's agitative mood, physical aggression, and other behavioral changes. The ALF was cited under WAC 388-78A-2140(5) Negotiated service agreement content.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

04/22/2024

MIRABELLA
MIRABELLA
116 FAIRVIEW AVENUE NORTH
SEATTLE, WA 98109

RE: MIRABELLA # 2034

Dear Administrator:

This document references the following complaint numbers 122579.

The Department completed a full inspection of your Assisted Living Facility on 04/18/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services

Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

- (1) Medical history;
- (2) Necessary and contraindicated medications;
- (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Mental illness diagnosis, except where protected by confidentiality laws;
- (6) Level of personal care needs;
- (7) Activities and service preferences; and
- (8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

The Assisted Living Facility failed to ensure a system was in place to conduct preadmission assessments that included elements required by regulation for new residents. This placed new residents at risk due to lack of information to create appropriate plans of care.

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

- (1) Notify construction review services:
 - (a) In writing;
 - (b) Thirty days or more before the intended change in use;
 - (c) Describe the current and proposed use of the room; and
 - (d) Provide all additional documentation as requested by construction review services;

(2) Obtain the written approval of construction review services for the new use of the room; and

(3) Ensure the facility functional program and room list are updated to reflect the change.

The Assisted Living Facility failed to notify and obtain written approval from Facilities and Services Licensing Construction Review Services (State of Washington, Department of Health) prior to using a room for a purpose other than what was approved.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

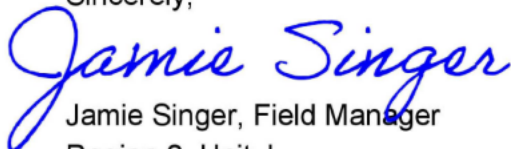
- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (253)312-1446.

Sincerely,



Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies

License #: 2034

Compliance Determination # 38162

Plan of Correction

MIRABELLA

Completion Date

Page 4 of 25

Licensee: MIRABELLA

04/18/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 03/18/2024 and 03/20/2024 of:

MIRABELLA

116 FAIRVIEW AVENUE NORTH

SEATTLE, WA 98109

This document references the following complaint numbers: 122579.

The following sample was selected for review during the unannounced on-site visit: 8 of 37 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licenser

Keiko Kitano, Licenser

From:

DSHS, Aging and Long-Term Support Administration

Residential Care Services, Region 2, Unit J

20311 52nd Ave W, Suite 100

Lynnwood, WA 98036

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

4/22/2024

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.



STATE OF WASHINGTON
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Statement of Deficiencies	License #: 2034	Compliance Determination # 38162
Plan of Correction	MIRABELLA	Completion Date
Page 4 of 25	Licensee: MIRABELLA	04/18/2024

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Residential Care Services

4/22/2024

Date

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Statement of Deficiencies
Plan of Correction
Page 5 of 25

License # 2034
MIRABELLA
Licensee: MIRABELLA

Compliance Determination # 38162
Completion Date
04/18/2024



Administrator (or Representative)

4/23/24
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (3) Evaluate, in order to determine if there is a need for further action:
- (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to evaluate and take appropriate action for the changing needs of 1 of 1 sampled resident (Resident 4) who experienced unintended/unplanned weight gain and loss. This placed Resident 4 at risk for deteriorating health status.

Findings included...

Review of an undated ALF policy for monitoring weight, procedure 4, showed that a weight change of five pounds (lbs) or 5% of body weight in a 30-day period, whichever is greater, was to be reported to the physician.

Records review showed that the ALF admitted Resident 4 on [REDACTED]/2022 with multiple medical diagnoses including [REDACTED]. Review of Resident 4's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 11/30/2023, showed that Resident 4's weight (Wt.) would be monitored monthly.

Review of Resident 4's Wt. for October, November, and December 2023, and January, February, and March 2024 showed the following:

- *On 10/01/2023 Wt. was 119.7 lbs.
- *On 11/01/2023 Wt. was 133.0 lbs (a gain of 13.3 lbs. in a month).
- *On 12/01/2023 Wt. was 120.0 lbs (a loss of 13 lbs. in a month).
- *On 01/01/2024 Wt. was 132.3 lbs (a gain of 12.3 lbs. in a month).
- *On 02/01/2024 Wt. was 124.8 lbs (a loss of 7.5 lbs. in a month).
- *On 03/01/2024 Wt. was 119.7 lbs (a loss of 5.1 lbs. in a month).

In an interview, on 03/20/2024 at 9:20 AM, when asked what they needed to do if a resident's weight had increased or decreased, Staff T (Caregiver) stated that Medication

Administrator (or Representative)

Date**WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:**

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Statement of Deficiencies	License #: 2034	Compliance Determination # 38162
Plan of Correction	MIRABELLA	Completion Date
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Technicians (MTs) and Nurses would review the weight log. Staff T stated that CGs were to just take each resident's weight once a month and document it in the log.

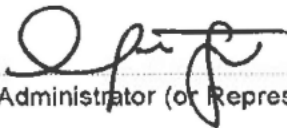
Review of Resident 4's Progress Notes showed no documentation as to whether the ALF identified or evaluated Resident 4's weight loss or gain. Review of Resident 4's active records showed no documentation to indicate that the ALF reported the issue to the physician per the ALF's policy.

In an interview, on 03/20/2024 at 02:30 PM, Staff B (Nurse Manager) stated that some of Resident 4's weight measurements seemed inaccurate, and staff should have retaken Resident 4's weight. Staff B acknowledged that there was no information that staff evaluated to determine need for further action was taken or notified the physician about Resident 4's weight changes.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/2/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.



Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to review and update the Negotiated Service Agreement (NSA) for 1 of 1 sampled resident (Resident 3) when the NSA no longer adequately addressed the residents' current needs and preferences. This placed Resident 3 at risk for not having care needs properly addressed and for deteriorating health conditions.

Findings included...

Technicians (MTs) and Nurses would review the weight log. Staff T stated that CGs were to just take each resident's weight once a month and document it in the log.

Review of Resident 4's Progress Notes showed no documentation as to whether the ALF identified or evaluated Resident 4's weight loss or gain. Review of Resident 4's active records showed no documentation to indicate that the ALF reported the issue to the physician per the ALF's policy.

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Findings included...

Statement of Deficiencies	License #: 2034	Compliance Determination # 38162
Plan of Correction	MIRABELLA	Completion Date
Page 7 of 25	Licensee: MIRABELLA	04/18/2024

Records review showed that the ALF admitted Resident 3 on [REDACTED] 2021 with multiple medical diagnoses including [REDACTED].

Review of a Progress Note (PN), dated 02/14/2024, showed Resident 3 inserted their right arm in between the right arm rest and right wheel of a wheelchair (WC), and when Resident 3 pulled their arm out, their skin got caught sustaining a skin tear in the lower third of the right forearm. The PN showed that bed sheets were being placed on both sides of the WC seat to hang over the arm rests to help prevent this occurrence.

Review of an incident document, regarding the skin tear, dated 02/15/2024, showed preventative measures to be implemented were that the armrests of Resident 3's WC would be covered with towels and pillowcases.

Observation and interview, on 03/20/2024 at 12:05 PM, showed Resident 3 in the WC in the Activity Room in the Memory Care Unit. The observation showed no towels or pillowcases covering the armrests on Resident 3's WC. A second observation with Staff B (Nurse Manager), on 03/20/2024 at 1:55 PM, showed Resident 3 in the WC with armrests not covered by towels or pillowcases. Staff B stated that staff should have placed sheets and pillows on both sides of the WC to prevent Resident 3 from inserting their arm down through the opening above the wheel.

Review of Resident 3's Special Instructions (SI - equivalent to a combination of a Full Assessment and an NSA), dated 11/30/2023, under the section on skin care, showed no information addressing Resident 3's history of inserting their arm between the arm rest and wheel of WC and the interventions to prevent further skin injuries.

In an interview, on 03/20/2024 at 2:50 PM, Staff B acknowledged that there was no plan in the SI for preventing Resident 3's skin injuries from the WC.

Plan/Attestation Statement

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Date _____

Statement of Deficiencies	License #: 2034	Compliance Determination # 38162
Plan of Correction	MIRABELLA	Completion Date
Page 8 of 25	Licensee: MIRABELLA	04/18/2024

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) contained information to meet the care needs for 4 of 4 sampled residents (Residents 1, 3, 5, and 6). This placed Residents 1, 3, 5, and 6 at risk for not having their care needs.

Findings included...

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2022 and moved to Memory Care Unit (MCU) on 02/28/2024 due to a change of condition. Resident 1's diagnoses included [REDACTED] with [REDACTED]. Review of the combined Assessment and Service Plan (A/SP – equivalent to NSA), dated 11/30/2023, under the section of Behavior, showed Resident 1 required daily monitoring for behavioral episodes occurring on a daily basis/shift basis which included refusing to leave other resident's apartments, throwing things, barricading the door to his apartment, and screaming at people.

Review of Progress Notes (PN), dated 02/29/2024 through 03/14/2024, showed

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

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documentation of Resident 1's worsening behavior that posed a threat to himself and others. On 03/11/2024, a PN showed Resident 1 ran his walker into another resident [Resident 2], causing her to fall sustaining injuries. A PN, dated 03/12/2024, showed Resident 1 ran his walker into residents and "was threatening verbally and physically, entered and would not exit another residents' room." Due to escalated behavior, staff called 911 and Resident 1 was taken to the hospital.

Review of the NSA, dated 03/11/2024, under behavior section, showed no approaches or interventions for staff to follow for Resident 1's agitative mood, physical aggression or other behavioral changes.

In an interview, on 03/20/2024 at 3:30 PM, Staff B (Assisted Living and Memory Care Nurse Manager) confirmed that the NSA lacked behavioral interventions for Resident 1.

Observation and interview, on 03/18/2024 at 11:05 AM, showed Resident 1 walking with a walker, outside his room with a private caregiver (PCG 1). Interview, at 03/18/2024 at 11:10 AM, PCG 1 stated he was assigned to Resident 1 from 10:00 AM through 4:00 PM to walk with him and be his companion and another [PCG 2] would come from 4:00 through 9:00 PM.

Interview, on 03/19/2024 at 10:40 AM, Staff A (Assisted Living & Memory Care Manager) stated PCG 3 drove Resident 1 to doctor's appointments and oversaw his overall care. Staff B stated PCG 3 also consult to Resident 1's doctors.

Interview, on 03/19/2024 at 11:00 AM, PCG 3 confirmed she oversaw Resident 1's well-being and drove him to doctors' appointments.

Review of the NSA, dated 03/11/2024, showed no information of the ALFs' staff or PCGs' roles and responsibilities, and no alternate plans for if the PCGs were unavailable.

RESIDENT 3

Records review showed that the ALF admitted Resident 3 on [REDACTED] 2021 with multiple medical diagnoses including [REDACTED] [REDACTED]. Review of Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 11/30/2023, showed that Resident 3 required two-person maximum assistance with bathing. The SI showed that Resident 3 had been receiving hospice (end of life care) care and services, including bathing services, from a hospice agency.

In interviews, on 03/18/2024 at 02:18 PM, Staff E (Caregiver) stated that Resident 3 had been receiving bathing assistance three times a week from a hospice bath aide.

Review of Resident 3's SI, dated 11/30/2023, showed no alternate plan should the hospice

documentation of Resident 1's worsening behavior that posed a threat to himself and others. On 03/11/2024, a PN showed Resident 1 ran his walker into another resident [Resident 2], causing her to fall sustaining injuries. A PN, dated 03/12/2024, showed Resident 1 ran his walker into residents and "was threatening verbally and physically, entered and would not exit another residents' room." Due to escalated behavior, staff called 911 and Resident 1 was taken to the hospital.

Review of the NSA, dated 03/11/2024, under behavior section, showed no approaches or interventions for staff to follow for Resident 1's agitative mood, physical aggression or other behavioral changes.

In an interview, on 03/20/2024 at 3:30 PM, Staff B (Assisted Living and Memory Care Nurse Manager) confirmed that the NSA lacked behavioral interventions for Resident 1.

Observation and interview, on 03/18/2024 at 11:05 AM, showed Resident 1 walking with a walker, outside his room with a private caregiver (PCG 1). Interview, at 03/18/2024 at 11:10 AM, PCG 1 stated he was assigned to Resident 1 from 10:00 AM through 4:00 PM to walk with him and be his companion and another [PCG 2] would come from 4:00 through 9:00 PM.

Interview, on 03/19/2024 at 10:40 AM, Staff A (Assisted Living & Memory Care Manager) stated PCG 3 drove Resident 1 to doctor's appointments and oversaw his overall care. Staff B stated PCG 3 also consult to Resident 1's doctors.

Interview, on 03/19/2024 at 11:00 AM, PCG 3 confirmed she oversaw Resident 1's well-being and drove him to doctors' appointments.

Review of the NSA, dated 03/11/2024, showed no information of the ALFs' staff or PCGs' roles and responsibilities, and no alternate plans for if the PCGs were unavailable.

RESIDENT 3

Records review showed that the ALF admitted Resident 3 on [REDACTED]/2021 with multiple medical diagnoses including [REDACTED] [REDACTED] [REDACTED]. Review of Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 11/30/2023, showed that Resident 3 required two-person maximum assistance with bathing. The SI showed that Resident 3 had been receiving hospice (end of life care) care and services, including bathing services, from a hospice agency.

In interviews, on 03/18/2024 at 02:18 PM, Staff E (Caregiver) stated that Resident 3 had been receiving bathing assistance three times a week from a hospice bath aide.

Review of Resident 3's SI, dated 11/30/2023, showed no alternate plan should the hospice

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bath aide not be able to provide services.

In an interview, on 03/20/2024 at 2:55 PM, Staff B (Nurse Manager) acknowledged that there was no other SI for Resident 3, including a back-up plan for when the hospice bath aide would not be able to provide bathing services.

RESIDENT 5

Records review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple diagnoses, including [REDACTED] and [REDACTED].

Review of the January, February, and March 2024 electronic Medication Administration Records (eMARs) showed that Resident 5 had been prescribed to take mirtazapine (an antidepressant, used to treat depression) at 8:00 PM daily.

Review of a Primary Care Outpatient Clinic Note, dated 01/18/2024, showed that Resident 5 had a history of two suicide attempts, the first in 2017 and the second in October 2023.

Records review showed that Resident 5 admitted to the ALF from a Skilled Nursing Facility (SNF). The SNF's discharge orders, dated 01/22/2024, showed that staff were required to monitor Resident 5's behavior of suicidal ideations and lack of appetite.

Review of Resident 5's SI, dated 01/22/2024, the Behavior section showed, "NO MONITORING for behavioral episodes or NO behavioral Episodes" and "[Resident 5] NOT Taking Psychotropic Medications." The SI showed no plan to instruct care staff what to do if Resident 5 exhibited suicidal ideation or mental decompensation.

Records review showed that Resident 5 had been prescribed to take Eliquis (a blood thinning medication to help prevent strokes or blood clots in people who have A-Fib) twice a day.

Review of Resident 5's SI, dated 01/22/2024, showed no plan for caregivers to monitor signs and symptoms of bleeding due to Eliquis treatment. There was no intervention for what staff needs to do if Resident 5 exhibited a bleeding condition.

In an interview, 03/20/2024 at 2:50 PM, Staff B acknowledged that there was no additional service plan for Resident 5.

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED]/2015 with multiple

bath aide not be able to provide services.

In an interview, on 03/20/2024 at 2:55 PM, Staff B (Nurse Manager) acknowledged that there was no other SI for Resident 3, including a back-up plan for when the hospice bath aide would not be able to provide bathing services.

RESIDENT 5

Records review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple diagnoses, [REDACTED] and [REDACTED].

Review of the January, February, and March 2024 electronic Medication Administration Records (eMARs) showed that Resident 5 had been prescribed to take mirtazapine (an antidepressant, used to treat depression) at 8:00 PM daily.

Review of a Primary Care Outpatient Clinic Note, dated 01/18/2024, showed that Resident 5 had a history of two suicide attempts, the first in 2017 and the second in October 2023.

Records review showed that Resident 5 admitted to the ALF from a Skilled Nursing Facility (SNF). The SNF's discharge orders, dated 01/22/2024, showed that staff were required to monitor Resident 5's behavior of suicidal ideations and lack of appetite.

Review of Resident 5's SI, dated 01/22/2024, the Behavior section showed, "NO MONITORING for behavioral episodes or NO behavioral Episodes" and "[Resident 5] NOT Taking Psychotropic Medications." The SI showed no plan to instruct care staff what to do if Resident 5 exhibited suicidal ideation or mental decompensation.

Records review showed that Resident 5 had been prescribed to take Eliquis (a blood thinning medication to help prevent strokes or blood clots in people who have A-Fib) twice a day.

Review of Resident 5's SI, dated 01/22/2024, showed no plan for caregivers to monitor signs and symptoms of bleeding due to Eliquis treatment. There was no intervention for what staff needs to do if Resident 5 exhibited a bleeding condition.

In an interview, 03/20/2024 at 2:50 PM, Staff B acknowledged that there was no additional service plan for Resident 5.

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED]/2015 with multiple

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medical diagnoses. Review of Resident 6's SI, dated 01/16/2024, showed that Resident 6 required one-person moderate assistance with bathing.

Observation and interview, on 03/20/2024 at 10:13 AM, showed Collateral Contact 1 (CC1 - a Private Caregiver) present in Resident 6's apartment. Resident 6 stated that they had hired CC1 as their private caregiver (PCG). CC1 stated that they had been providing shower assistance for Resident 6 twice a week, on Wednesdays and Fridays.

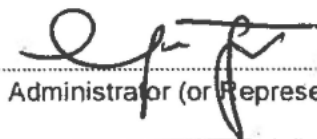
Review of Resident 6's SI, dated 01/16/2024, showed no information Resident 6 was receiving showering assistance from a PCG. The SI showed no alternate plan should the PCG not be able to provide services.

In an interview, on 03/20/2024 at 2:55 PM, Staff B acknowledged that there was no back-up plan for when the PCG would not be able to provide care and services for Resident 6.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/2/2024

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.



Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69 41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

medical diagnoses. Review of Resident 6's SI, dated 01/16/2024, showed that Resident 6 required one-person moderate assistance with bathing.

Observation and interview, on 03/20/2024 at 10:13 AM, showed Collateral Contact 1 (CC1 - a Private Caregiver) present in Resident 6's apartment. Resident 6 stated that they had hired CC1 as their private caregiver (PCG). CC1 stated that they had been providing shower assistance for Resident 6 twice a week, on Wednesdays and Fridays.

Review of Resident 6's SI, dated 01/16/2024, showed no information Resident 6 was receiving showering assistance from a PCG. The SI showed no alternate plan should the PCG not be able to provide services.

In an interview, on 03/20/2024 at 2:55 PM, Staff B acknowledged that there was no back-up plan for when the PCG would not be able to provide care and services for Resident 6.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date)_____.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative)

Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

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Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 2 of 2 sampled resident (Resident 6), who required a Licensed Nurse to administer insulin (used to lower blood sugar) injections and Resident 1, who required staff assistance with medication management. This resulted in Residents 1 and 6 not receiving their medications as prescribed and placed them at risk for compromised health conditions.

Findings included...

NOTE: Washington Administrative Code (WAC) WAC 388-78A-2450 Staff (1) Each assisted living facility must provide sufficient, trained staff persons to: (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement.

Review of the ALF's policy for "Medication and Treatment", dated 09/2023, under the section on Medication Administration showed, "Documentation of the Medication Administration Records (MARs) will be completed by the following process: the staff member administering the medication will sign the MAR."

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED]/2015 with multiple disabling diagnoses, including [REDACTED] ([REDACTED]). Record review showed Resident 6 had a physician's order for Lantus (a long-acting insulin) injection at bedtime daily. Review of Resident 6's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 09/21/2023, showed Licensed Nurses (LN) would administer insulin injections per the physician's orders.

Review of the February and March 2024 electronic Medication Administration Records (eMARs) showed that on 02/09/2024, 02/16/2024, 02/23/2024, and 03/01/2024, the column for a signature showing Resident 6's Lantus injections was left blank, indicating they had not received Lantus injections on those days.

In an interview, on 03/20/2024 at 1:20 PM, Staff N (Medication Technician (MT)) stated that MTs would not administer Lantus injections for Resident 6. Staff N stated that usually, a LN was working at the Memory Care in the evening, and they asked the LN to inject insulin for Resident 6.

Review of the ALF's staffing schedules for February and March 2024 showed that on 02/09/2024, 02/16/2024, 02/23/2024, and 03/01/2024 there was no LN scheduled to work in the evening. There was no one scheduled to administer Lantus insulin for Resident 6.

Review of a physician's order, dated 03/04/2024, showed that the physician decreased the dosage of Lantus from 35 units to 30 every evening. Review of the March 2024 eMARs

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems to promote safe medication services for 2 of 2 sampled resident (Resident 6), who required a Licensed Nurse to administer insulin (used to lower blood sugar) injections and Resident 1, who required staff assistance with medication management. This resulted in Residents 1 and 6 not receiving their medications as prescribed and placed them at risk for compromised health conditions.

Findings included...

NOTE: Washington Administrative Code (WAC) WAC 388-78A-2450 Staff (1) Each assisted living facility must provide sufficient, trained staff persons to: (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement.

Review of the ALF's policy for "Medication and Treatment", dated 09/2023, under the section on Medication Administration showed, "Documentation of the Medication Administration Records (MARs) will be completed by the following process: the staff member administering the medication will sign the MAR."

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED]/2015 with multiple disabling diagnoses, including [REDACTED] ([REDACTED]). Record review showed Resident 6 had a physician's order for Lantus (a long-acting insulin) injection at bedtime daily. Review of Resident 6's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 09/21/2023, showed Licensed Nurses (LN) would administer insulin injections per the physician's orders.

Review of the February and March 2024 electronic Medication Administration Records (eMARs) showed that on 02/09/2024, 02/16/2024, 02/23/2024, and 03/01/2024, the column for a signature showing Resident 6's Lantus injections was left blank, indicating they had not received Lantus injections on those days.

In an interview, on 03/20/2024 at 1:20 PM, Staff N (Medication Technician (MT)) stated that MTs would not administer Lantus injections for Resident 6. Staff N stated that usually, a LN was working at the Memory Care in the evening, and they asked the LN to inject insulin for Resident 6.

Review of the ALF's staffing schedules for February and March 2024 showed that on 02/09/2024, 02/16/2024, 02/23/2024, and 03/01/2024 there was no LN scheduled to work in the evening. There was no one scheduled to administer Lantus insulin for Resident 6.

Review of a physician's order, dated 03/04/2024, showed that the physician decreased the dosage of Lantus from 35 units to 30 every evening. Review of the March 2024 eMARs

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showed that the 35 units of Lantus order was discontinued on 03/04/2024 at 4:13 PM, however the new dosage of Lantus not started until 03/05/2024. The March 2024 eMARs showed no signature indicating that Resident 6 received any Lantus injection on 03/04/2024.

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2022 with multiple disabling diagnoses including [REDACTED] ([REDACTED]). Review of Resident 1's Negotiated Service Agreement, dated 02/19/2024, showed staff were to administer his medications.

Review of a Physician Progress Note, dated 03/13/2024, showed an order to increase propranolol (used to treat high blood pressure - BP) from 20 milligrams (mg) once a day to 20mg twice a day. The order included instructions to check Resident 1's BP daily "for the next week" and notify the physician immediately for BP greater than 170/100.

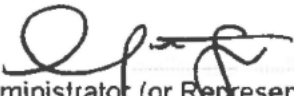
Review of the March 2024 electronic Medication Administration Record (eMAR) showed the new order of Propranolol 20 mg twice a day was not transcribed. Resident 1 did not receive the second daily dose of propranolol 20 mg from 03/14/2024 through 03/20/2024. There was no documentation Resident 1's BP was taken as ordered.

In an interview, on 04/10/2024 at 1:00 PM, Staff B stated, "Looking at our eMAR, we are still giving [Resident 1] propranolol once a day not twice a day. That is totally my fault, I will follow-up with doctor."

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/2/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.


Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a

showed that the 35 units of Lantus order was discontinued on 03/04/2024 at 4:13 PM, however the new dosage of Lantus not started until 03/05/2024. The March 2024 eMARs showed no signature indicating that Resident 6 received any Lantus injection on 03/04/2024.

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2022 with multiple disabling diagnoses including [REDACTED] ([REDACTED]). Review of Resident 1's Negotiated Service Agreement, dated 02/19/2024, showed staff were to administer his medications.

Review of a Physician Progress Note, dated 03/13/2024, showed an order to increase propranolol (used to treat high blood pressure - BP) from 20 milligrams (mg) once a day to 20mg twice a day. The order included instructions to check Resident 1's BP daily "for the next week" and notify the physician immediately for BP greater than 170/100.

Review of the March 2024 electronic Medication Administration Record (eMAR) showed the new order of Propranolol 20 mg twice a day was not transcribed. Resident 1 did not receive the second daily dose of propranolol 20 mg from 03/14/2024 through 03/20/2024. There was no documentation Resident 1's BP was taken as ordered.

In an interview, on 04/10/2024 at 1:00 PM, Staff B stated, "Looking at our eMAR, we are still giving [Resident 1] propranolol once a day not twice a day. That is totally my fault, I will follow-up with doctor."

Plan/Attestation Statement

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative)

Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a

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staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for any negative outcomes when 2 of 2 sampled resident (Residents 1 and 5) refused their medication. This placed Residents 1 and 5 at risk for compromised mental health condition.

Findings included...

Review of the ALF's Medication Administration -Licensed Nurse and Medication-Aide Policy and Procedure, dated 09/2023, stated, "(7) If resident refuses to take a medication, leave and re-approach after a few minutes. If the resident continues to refuse, document in the e-MAR or the electronic Medication Administration Record. (8) A licensed nurse is to notify the resident's physician immediately for refusal of high risk drugs and other refusals or problems with medications. Certified Medication Aides will notify licensed nurse for refusal of high risk drugs. This notification should be documented, as well as any new orders that may be received."

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2022 with multiple disabling diagnoses. Review of the Negotiated Service Agreement (NSA), dated 02/19/2024, showed Licenses Nurses (LNs) and Certified Medication Aides /Technicians were to administer medications to Resident 1.

Review of the March 2024 electronic Medication Administration Record (eMAR) showed Resident 1 refused the following medications:

Amlodipine (used to treat high blood pressure) 1 tablet daily at 8:00 AM Resident 1 refused on 03/14/2024 and 03/15/2024.

Aspirin 81 milligram (mg) daily (for prophylaxis blood thinner) refused on 03/14/2024, 03/015/2024 and 03/18/2024.

Atorvastatin 40 mg (used to treat high cholesterol) refused on 03/14/2024.

Calcium Carb 600 mg 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024.

staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician or evaluate for any negative outcomes when 2 of 2 sampled resident (Residents 1 and 5) refused their medication. This placed Residents 1 and 5 at risk for compromised mental health condition.

Findings included...

Review of the ALF's Medication Administration -Licensed Nurse and Medication-Aide Policy and Procedure, dated 09/2023, stated, "(7) If resident refuses to take a medication, leave and re-approach after a few minutes. If the resident continues to refuse, document in the e-MAR or the electronic Medication Administration Record. (8) A licensed nurse is to notify the resident's physician immediately for refusal of high risk drugs and other refusals or problems with medications. Certified Medication Aides will notify licensed nurse for refusal of high risk drugs. This notification should be documented, as well as any new orders that may be received."

RESIDENT 1

Review of a Resident Information (RI) form showed the ALF admitted Resident 1 on [REDACTED]/2022 with multiple disabling diagnoses. Review of the Negotiated Service Agreement (NSA), dated 02/19/2024, showed Licenses Nurses (LNs) and Certified Medication Aides /Technicians were to administer medications to Resident 1.

Review of the March 2024 electronic Medication Administration Record (eMAR) showed Resident 1 refused the following medications:

Amlodipine (used to treat high blood pressure) 1 tablet daily at 8:00 AM Resident 1 refused on 03/14/2024 and 03/15/2024.

Aspirin 81 milligram (mg) daily (for prophylaxis blood thinner) refused on 03/14/2024, 03/015/2024 and 03/18/2024.

Atorvastatin 40 mg (used to treat high cholesterol) refused on 03/14/2024.

Calcium Carb 600 mg 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024,

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03/16/2024 and 03/18/2024.

Cerovite Senior Multi-Vit (supplement) 1 tablet daily refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Ceterizine 10 mg 1 tablet daily (used for allergy) refused on 03/14/2024, 03/15/2024, and 03/18/2024.

Irbesartan 150 mg tablet daily (used for high blood pressure) refused on 03/14/2024 and 03/18/2024.

Isosorbide Mono ER 30 mg 1 tablet daily (used for coronary heart disease) refused on 03/14/2024 and 03/18/2024.

Mirtazapine 7.5 mg 1 tablet at bedtime (used for depression) refused on 03/14/2024.

Potassium Chloride ER 20 MEQ 1 tablet daily (used for potassium supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Propranolol 20mg 1 tablet daily (used for high blood pressure) refused on 03/14/2024, 03/15/2024, and 03/18/2024.

Tamsulosin 1 capsule daily (used for benign prostatic hypertrophy) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Vitamin C 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Vitamin D 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Review of Resident 1's records showed no documentation the physician was notified when Resident 1's refused medication. There was no documentation the ALF evaluated for outcome following medication refusals.

In interview, on 03/18/2024 at 2:30 PM, Staff I (Registered Nurse) stated that if a resident refused their medications three times in a week, as reflected in the eMAR, they should fax the physician. Staff I stated that the Medication Aides (MAs) would also report to LNs when a resident refused their medications, then LN were to notify the physician by fax.

RESIDENT 5

Records review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple diagnoses including [REDACTED] ([REDACTED]). Review of Resident 5's Special Instructions (SI - equivalent to combination of a Full Assessment and Negotiated Service Agreement), dated 01/22/2024, showed Resident 5 required staff to administer medications.

Review of the February and March 2024 electronic Medication Administration Records (eMARs) showed that Resident 5 had been prescribed mirtazapine (an antidepressant, used to treat depression) at bedtime daily.

Review of the February and March 2024 eMARs showed that Resident 5 on refused to take their mirtazapine on 10 days in February 2024, and again on 03/17/2024.

Review of Resident 5's active records showed no documentation as to whether MTs had

03/16/2024 and 03/18/2024.

Cerovite Senior Multi-Vit (supplement) 1 tablet daily refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Ceterizine 10 mg 1 tablet daily (used for allergy) refused on 03/14/2024, 03/15/2024, and 03/18/2024.

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Isosorbide Mono ER 30 mg 1 tablet daily (used for coronary heart disease) refused on 03/14/2024 and 03/18/2024.

Mirtazapine 7.5 mg 1 tablet at bedtime (used for depression) refused on 03/14/2024.

Potassium Chloride ER 20 MEQ 1 tablet daily (used for potassium supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Propranolol 20mg 1 tablet daily (used for high blood pressure) refused on 03/14/2024, 03/15/2024, and 03/18/2024.

Tamsulosin 1 capsule daily (used for benign prostatic hypertrophy) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Vitamin C 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Vitamin D 1 tablet daily (supplement) refused on 03/14/2024, 03/15/2024, 03/16/2024 and 03/18/2024.

Review of Resident 1's records showed no documentation the physician was notified when Resident 1's refused medication. There was no documentation the ALF evaluated for outcome following medication refusals.

In interview, on 03/18/2024 at 2:30 PM, Staff I (Registered Nurse) stated that if a resident refused their medications three times in a week, as reflected in the eMAR, they should fax the physician. Staff I stated that the Medication Aides (MAs) would also report to LNs when a resident refused their medications, then LN were to notify the physician by fax.

RESIDENT 5

Records review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple diagnoses including [REDACTED] ([REDACTED]). Review of Resident 5's Special Instructions (SI - equivalent to combination of a Full Assessment and Negotiated Service Agreement), dated 01/22/2024, showed Resident 5 required staff to administer medications.

Review of the February and March 2024 electronic Medication Administration Records (eMARs) showed that Resident 5 had been prescribed mirtazapine (an antidepressant, used to treat depression) at bedtime daily.

Review of the February and March 2024 eMARs showed that Resident 5 on refused to take their mirtazapine on 10 days in February 2024, and again on 03/17/2024.

Review of Resident 5's active records showed no documentation as to whether MTs had

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notified a LN about Resident 5's mirtazapine refusal. There was no documentation to indicate that the ALF evaluated Resident 5's condition and notified the physician about Resident 5's continued pattern of refusing mirtazapine. There were no physician's directions for how to address Resident 5's medication refusal. The ALF did not follow its own policy for Medication Refusal.

In an interview, on 03/20/2024 at 2:40 PM, Staff B (Nurse Manager) acknowledged that there was no documentation to show the ALF notified the physician or evaluated for negative outcomes about Resident 5's medication refusal.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/2/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.



Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement safe Nurse Delegation (ND) services for 2 of 2 sampled residents (Residents 3 and 4) who received medication administration from non-licensed staff. This placed Residents 3 and 4 at risk for compromised health status.

Findings included...

NOTE: The Nurse Delegation Program, under Washington State law, allows nursing

notified a LN about Resident 5's mirtazapine refusal. There was no documentation to indicate that the ALF evaluated Resident 5's condition and notified the physician about Resident 5's continued pattern of refusing mirtazapine. There were no physician's directions for how to address Resident 5's medication refusal. The ALF did not follow its own policy for Medication Refusal.

In an interview, on 03/20/2024 at 2:40 PM, Staff B (Nurse Manager) acknowledged that there was no documentation to show the ALF notified the physician or evaluated for negative outcomes about Resident 5's medication refusal.

Plan/Attestation Statement

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative)

Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

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(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement safe Nurse Delegation (ND) services for 2 of 2 sampled residents (Residents 3 and 4) who received medication administration from non-licensed staff. This placed Residents 3 and 4 at risk for compromised health status.

Findings included...

NOTE: The Nurse Delegation Program, under Washington State law, allows nursing

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assistants (NAs) and Home Care Aides (HCAs) working in certain settings to perform certain tasks--such as administer medications--normally performed only by licensed nurses. A Registered Nurse (RN) must teach and supervise the nursing assistant, as well as provide nursing assessments of the patient's condition.

NOTE: Washington Administrative Code (WAC) 246-840-930 Criteria for delegation, includes the following subsections:

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record

(m) Supervision shall occur at least every ninety days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent.

(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

In an interview, on 03/18/2024 at 9:20 AM, Staff A (Assisted Living and Memory Care Manager) stated that the ALF had been providing ND services for residents. When asked who the RN delegator (RND) was, Staff A said, "Staff B (Nurse Manager) is".

Records review showed that the ALF admitted Resident 3 on [REDACTED] 2021 and Resident 4 on [REDACTED] /2022, both with multiple medical diagnoses including [REDACTED] ([REDACTED]). Review of the Resident 3 and 4's Special Instructions (SI, equivalent to a combination of a full assessment and a Negotiated Service Agreement), both dated 11/30/2023, showed that Residents 3 and 4 required staff to administer medications.

Review of the January, February, and March 2024 electronic Medication Administration Records (eMARs) showed that Residents 3 and 4 had been prescribed multiple medications.

In an interview, on 03/20/2024 at 11:55 AM, Staff J (Medication Technician ((MT)) stated that they had been administering medications for Resident 3 and Resident 4.

Review of the RN Delegated Task Assessment (RNDTA) showed the RND delegated nursing tasks to three MTs for Resident 3 on 07/12/2023 and 12/01/2023, and Resident 4 on 07/13/2023 and 12/01/2023. These RNDTAs did not show documentation that the RND supervised and evaluated the ability of the three MTs to safely administer medications.

assistants (NAs) and Home Care Aides (HCAs) working in certain settings to perform certain tasks--such as administer medications--normally performed only by licensed nurses. A Registered Nurse (RN) must teach and supervise the nursing assistant, as well as provide nursing assessments of the patient's condition.

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(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

In an interview, on 03/18/2024 at 9:20 AM, Staff A (Assisted Living and Memory Care Manager) stated that the ALF had been providing ND services for residents. When asked who the RN delegator (RND) was, Staff A said, "Staff B (Nurse Manager) is".

Records review showed that the ALF admitted Resident 3 on [REDACTED]/2021 and Resident 4 on [REDACTED]/2022, both with multiple medical diagnoses including [REDACTED] (a [REDACTED]). Review of the Resident 3 and 4's Special Instructions (SI, equivalent to a combination of a full assessment and a Negotiated Service Agreement), both dated 11/30/2023, showed that Residents 3 and 4 required staff to administer medications.

Review of the January, February, and March 2024 electronic Medication Administration Records (eMARs) showed that Residents 3 and 4 had been prescribed multiple medications.

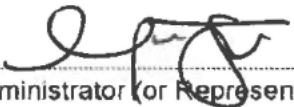
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Review of the RN Delegated Task Assessment (RNDTA) showed the RND delegated nursing tasks to three MTs for Resident 3 on 07/12/2023 and 12/01/2023, and Resident 4 on 07/13/2023 and 12/01/2023. These RNDTAs did not show documentation that the RND supervised and evaluated the ability of the three MTs to safely administer medications

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every 90-days per the ND requirements.

In an interview, on 03/18/2024 at 11:40 AM, Staff B stated that since November 2023, they had been responsible for the ND programs. Staff B stated that all ND documents had been filed in the ND binders. Staff B stated that there were no additional ND documents.

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) <u>6/2/2024</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>4/23/2024</u> Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to wash their hands or don gloves during meal preparation. This failure placed 37 of 37 residents at risk for food borne illness.

Findings included...

NOTE: Washington Administrative Code (WAC) 246-215-02305 Hands and arms—Cleaning procedure (FDA Food Code 2-301.12). (1) Except as specified in subsection (4) of this section, food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under WAC 246-215-05210 and Part 6, Subpart C of this chapter.

Review of the undated Residents' Characteristics Roster showed that the ALF provided care and services for 37 residents. The ALF served meals to 18 residents on the 2nd floor Memory Care unit, and 19 residents on the 3rd floor Assisted Living section.

Observation and interview, on 03/20/2024 between 11:50 PM and 12:25 PM, showed Staff W (Nutritional Services Aide) transporting a hot food cart and entering the 3rd floor

every 90-days per the ND requirements.

In an interview, on 03/18/2024 at 11:40 AM, Staff B stated that since November 2023, they had been responsible for the ND programs. Staff B stated that all ND documents had been filed in the ND binders. Staff B stated that there were no additional ND documents.

Plan/Attestation Statement

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Administrator (or Representative)

Date

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(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to wash their hands or don gloves during meal preparation. This failure placed 37 of 37 residents at risk for food borne illness.

Findings included...

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Observation and interview, on 03/20/2024 between 11:50 PM and 12:25 PM, showed Staff W (Nutritional Services Aide) transporting a hot food cart and entering the 3rd floor

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kitchen. Staff W opened the hot cart and transferred the food onto steam table without washing their hands. With bare hands, Staff W proceeded to take an alcohol swab, wiped the thermometer stem, started taking food temperatures from the cubed potatoes to the spinach, then to the cauliflower, and couscous without wiping the thermometer stem. When questioned by the Department Representative (DR), Staff W stated, "I wiped it off at the beginning." Afterward, Staff W started wiping the thermometer stem before taking each food temperatures. Without handwashing, Staff W proceeded to open drawers removing bread knives and ladles. Staff W placed the bread knives onto a chopping board and the ladles into each food canisters at the steam table. Staff W did not clean or sanitize their hands between touching surfaces including opening refrigerator.

In an interview, on 03/20/2024 at 12:35 PM, Staff V (Nutritional Services Manager) stated their expectation was for staff to wash their hands first, prior to doing any task in the kitchen. The DR's kitchen observation was mentioned to Staff V regarding the lack of handwashing by Staff W. Staff V stated, "I have always emphasized the importance of hand washing, and this would be another training for everyone."

Plan/Attestation Statement

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.



Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-2350 Coordination of health care services.

(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to integrate and communicate relevant information with a Primary Care Provider (PCP) for the care of 2 of 2 sampled residents (Residents 5 and 6). This placed Residents 5 and 6 at risk for not receiving proper care and compromised their health conditions.

Findings included...

kitchen. Staff W opened the hot cart and transferred the food onto steam table without washing their hands. With bare hands, Staff W proceeded to take an alcohol swab, wiped the thermometer stem, started taking food temperatures from the cubed potatoes to the spinach, then to the cauliflower, and couscous without wiping the thermometer stem. When questioned by the Department Representative (DR), Staff W stated, "I wiped it off at the beginning." Afterward, Staff W started wiping the thermometer stem before taking each food temperatures. Without handwashing, Staff W proceeded to open drawers removing bread knives and ladles. Staff W placed the bread knives onto a chopping board and the ladles into each food canisters at the steam table. Staff W did not clean or sanitize their hands between touching surfaces including opening refrigerator.

In an interview, on 03/20/2024 at 12:35 PM, Staff V (Nutritional Services Manager) stated their expectation was for staff to wash their hands first, prior to doing any task in the kitchen. The DR's kitchen observation was mentioned to Staff V regarding the lack of handwashing by Staff W, Staff V stated, "I have always emphasized the importance of hand washing, and this would be another training for everyone."

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Administrator (or Representative)

Date

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(7) When coordinating care or services, the assisted living facility must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to integrate and communicate relevant information with a Primary Care Provider (PCP) for the care of 2 of 2 sampled residents (Residents 5 and 6). This placed Residents 5 and 6 at risk for not receiving proper care and compromised their health conditions.

Findings included...

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RESIDENT 5

NOTE: Washington Administrative Code 388-78A-2060 - Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility: (1) Medical history; (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons; (4) Significant known behaviors or symptoms that may cause concern or require special care; (6) Level of personal care needs.

Record review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple medical diagnoses.

Record review showed that Resident 5 moved from a Skilled Nursing Facility (SNF). Review of a physician's discharge order from the SNF, dated 01/22/2024, showed that staff were required to clean a skin tear on the left shin with normal saline, apply antibiotic ointment, and then apply a band aid and change it every three days and as needed.

Record review showed no documentation of assessing, evaluating, or treating Resident 5's skin tear from admission date of [REDACTED]/2024 through 02/04/2024.

Review of a Progress Note (PN), dated 02/05/2024, showed that Staff H (Licensed Nurse) documented that Resident 5 had an open area on their left shin. The PN showed Resident 5 notified Staff H that wound had been there when they moved into the ALF. Another PN, dated 02/07/2024, showed that Staff H received a new physician's order for a treatment to the open area on the left shin.

Review of Resident 5's active record showed no pre-admission assessment was completed noting Resident 5's skin condition. Review of Resident 5's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 01/22/2024, showed no information about Resident 5's skin tear or physician's orders for treatment on the left shin.

In an interview, on 03/20/2024 at 11:20 AM, Staff B (Nurse Manager) stated that there was no pre-admission assessment completed for Resident 5.

Records review showed no documentation to show that the ALF had carried out the physician's order for the skin tear when Resident 5 moved into the ALF. Records review showed Resident 5 had not received any wound care until 02/07/2024.

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED] 8/2015 with multiple diagnoses including [REDACTED].

Review of Resident 6's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 01/17/2024,

RESIDENT 5

NOTE: Washington Administrative Code 388-78A-2060 - Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility: (1) Medical history; (3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons; (4) Significant known behaviors or symptoms that may cause concern or require special care; (6) Level of personal care needs.

Record review showed that the ALF admitted Resident 5 on [REDACTED]/2024 with multiple medical diagnoses.

Record review showed that Resident 5 moved from a Skilled Nursing Facility (SNF). Review of a physician's discharge order from the SNF, dated 01/22/2024, showed that staff were required to clean a skin tear on the left shin with normal saline, apply antibiotic ointment, and then apply a band aid and change it every three days and as needed.

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Review of Resident 5's active record showed no pre-admission assessment was completed noting Resident 5's skin condition. Review of Resident 5's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 01/22/2024, showed no information about Resident 5's skin tear or physician's orders for treatment on the left shin.

In an interview, on 03/20/2024 at 11:20 AM, Staff B (Nurse Manager) stated that there was no pre-admission assessment completed for Resident 5.

Records review showed no documentation to show that the ALF had carried out the physician's order for the skin tear when Resident 5 moved into the ALF. Records review showed Resident 5 had not received any wound care until 02/07/2024.

RESIDENT 6

Records review showed that the ALF admitted Resident 6 on [REDACTED]/2015 with multiple diagnoses including [REDACTED].

Review of Resident 6's Special Instructions (SI - equivalent to a combination of a Full Assessment and Negotiated Service Agreement), dated 01/17/2024,

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showed that Licensed Nurses (LNs) would measure Resident 6's blood sugar (BS) levels.

Review of the February 2024 electronic Medication Administration Records (eMARs) showed that the ALF staff had a physician's order to measure Resident 6's BS every Sunday, Tuesday, and Thursday at 6:00 AM. The eMARs showed that beginning on 07/10/2022, the order instructed staff to call the physician if Resident 6's BS levels were greater than 250 or less than 70.

Review of the eMARs showed Resident 6's BS levels were lower than 70 on 02/08/2024, 02/11/2024, 02/13/2024, and 02/29/2024.

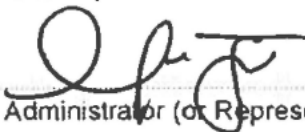
Review of Resident 6's active records showed no documentation as to whether the ALF notified the physician of Resident 6's BS level when it was lower than 70.

In an interview, on 03/20/2024 at 2:50 PM, Staff B (Nurse Manager) acknowledged that there was no documentation to show the ALF notified Resident 6's physician about their BS levels.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/7/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.


Administrator (or Representative)

4/22/2024
Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

showed that Licensed Nurses (LNs) would measure Resident 6's blood sugar (BS) levels.

Review of the February 2024 electronic Medication Administration Records (eMARs) showed that the ALF staff had a physician's order to measure Resident 6's BS every Sunday, Tuesday, and Thursday at 6:00 AM. The eMARs showed that beginning on 07/10/2022, the order instructed staff to call the physician if Resident 6's BS levels were greater than 250 or less than 70.

Review of the eMARs showed Resident 6's BS levels were lower than 70 on 02/08/2024, 02/11/2024, 02/13/2024, and 02/29/2024.

Review of Resident 6's active records showed no documentation as to whether the ALF notified the physician of Resident 6's BS level when it was lower than 70.

In an interview, on 03/20/2024 at 2:50 PM, Staff B (Nurse Manager) acknowledged that there was no documentation to show the ALF notified Resident 6's physician about their BS levels.

Plan/Attestation Statement

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(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

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Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 3 sampled newly hired staff members (Staff A, B, and C) received the facility orientation before having routine interaction with residents and had specialty training for dementia and mental health in a timely manner. This placed 37 of 37 residents in the ALF at risk for not receiving proper care and services from staff who did not complete training requirements.

Findings included...

FACILITY ORIENTATION

NOTE: Washington Administrative Code (WAC) 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Review of staff records showed that the ALF hired Staff A (Assisted Living and Memory Care Manager) on 06/07/2023. Staff A did not complete the facility orientation until 03/19/2024, about nine months after being hired.

Review of staff records showed that the ALF hired Staff B (Nurse Manager) on 11/01/2023. Staff A did not complete the facility orientation until 03/19/2024, about four months after being hired.

Review of staff records showed that the ALF hired Staff C (Certified Nursing Assistant/Memory Care) on 09/08/2023. Staff C did not complete the facility orientation until 03/19/2024, about six months after being hired.

In an interview, on 03/19/2024 at 9:30 AM, Staff O (Human Resources Director) Confirmed Staff A, B, and C did not have facility orientation prior to routine interaction with residents.

SPECIALTY TRAINING

NOTE: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 3 sampled newly hired staff members (Staff A, B, and C) received the facility orientation before having routine interaction with residents and had specialty training for dementia and mental health in a timely manner. This placed 37 of 37 residents in the ALF at risk for not receiving proper care and services from staff who did not complete training requirements.

Findings included...

FACILITY ORIENTATION

NOTE: Washington Administrative Code (WAC) 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training. (1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

Review of staff records showed that the ALF hired Staff A (Assisted Living and Memory Care Manager) on 06/07/2023. Staff A did not complete the facility orientation until 03/19/2024, about nine months after being hired.

Review of staff records showed that the ALF hired Staff B (Nurse Manager) on 11/01/2023. Staff A did not complete the facility orientation until 03/19/2024, about four months after being hired.

Review of staff records showed that the ALF hired Staff C (Certified Nursing Assistant/Memory Care) on 09/08/2023. Staff C did not complete the facility orientation until 03/19/2024, about six months after being hired.

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described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

NOTE: WAC 388-78A-2510 - Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

Record review of a Resident Characteristics Roster identified 27 residents with diagnoses of [REDACTED] or [REDACTED] and 8 residents with [REDACTED]. Review of sampled residents' records showed four residents with [REDACTED] diagnoses.

Record review showed Staff A did not complete the dementia and mental health specialty training.

Record review showed Staff B did not complete the dementia and mental health specialty training.

Record review showed Staff C did not complete the dementia and mental health specialty training.

In interview, dated 03/19/2024 at 3:00 PM, Staff Q (Health Services Administrator) and Staff A confirmed the specialty training for dementia and mental health should have been completed. Staff Q stated, "It fell through the cracks when the previous AL Manager left."

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, MIRABELLA is or will be in compliance with this law and / or regulation on (Date) 6/2/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.


Administrator (or Representative)

4/23/2024
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the

described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

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Record review of a Resident Characteristics Roster identified 27 residents with diagnoses of [REDACTED] or [REDACTED] and 8 residents with [REDACTED]. Review of sampled residents' records showed four residents with [REDACTED] diagnoses.

Record review showed Staff A did not complete the dementia and mental health specialty training.

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Record review showed Staff C did not complete the dementia and mental health specialty training.

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assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment,
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
- (4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to secure potentially hazardous supplies and equipment. This placed 14 of 19 ambulatory residents with cognitive impairment and wandering behaviors in the Memory Care unit (MCU) at risk harm and injury.

Findings included...

Record review of sampled residents in the MCU identified four residents with [REDACTED] diagnoses and 10 residents identified with behaviors/psychosocial issues.

Observation, on 03/18/2024 between at 10:35 AM and 11:40 AM, during a walkthrough with Staff A (Assisted Living & Memory Care Manager in the MCU showed a medication cart unlocked and left unattended in the hallway. In a public restroom located in the MCU a can of Glade mist spray was observed in an unlocked drawer with precautionary label, "Keep out of reach of children. Avoid contact with skin, eyes, and clothing."

Observation and interview, on 03/18/2024 at 10:49 AM, showed the entrance to the MCU dining room and the door to the kitchen was unlocked. Staff A stated the door should be locked until lunch. Inside the unlocked kitchen drawers were several sizes of knives and scissors. A posted sign was noted at the entrance door to the dining room, "DINING ROOM DOORS NEED TO BE LOCKED AFTER MEALS UNLESS ACTIVITIES ARE PLANNED..."

Observation, on 03/18/2024 at 10:57 AM, showed under the handwashing sink in the MCU serving area were two spray bottles of peroxide multi surface cleaner and disinfectant, and multi-surface crème cleanser with precautionary labels, "Keep out of reach of children. Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. May cause an allergic skin reaction. Toxic if inhaled. Causes burns/ serious damage to mouth, throat, and stomach. Keep container tightly closed. Avoid contact with eyes, skin, and clothing." There was also an unlabeled spray bottle containing liquid solution.

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assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
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Findings included...

Record review of sampled residents in the MCU identified four residents with [REDACTED] diagnoses and 10 residents identified with behaviors/psychosocial issues.

Observation, on 03/18/2024 between at 10:35 AM and 11:40 AM, during a walkthrough with Staff A (Assisted Living & Memory Care Manager in the MCU showed a medication cart unlocked and left unattended in the hallway. In a public restroom located in the MCU a can of Glade mist spray was observed in an unlocked drawer with precautionary label, "Keep out of reach of children. Avoid contact with skin, eyes, and clothing."

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Administrator (or Representative)

4/23/2024
Date

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