STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 75917 (Completion Date 04/15/2026) and 72948 (Completion Date 02/23/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2026 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-2474-2-d, WAC 388-78A-2474-2-e, WAC 388-78A-2474-3

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

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

Sincerely,

Jamie Singer

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 an unannounced on-site follow-up on 02/13/2026 of:

MIRABELLA
116 FAIRVIEW AVENUE NORTH
SEATTLE, WA 98109

This document references the following SOD dated: 02/23/2026

The following sample was selected for review during the unannounced on-site visit: 2 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2034	Compliance Determination # 72948
Plan of Correction	MIRABELLA	Completion Date
Page 2 of 3	Licensee: MIRABELLA	02/23/2026

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

02/25/2026
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.

Administrator (or Representative)

3/11/2026
Date

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

(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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 4 of 4 sampled staff members (Staff D, E, F, and G) completed the required 12 hours of continuing education (CE). This placed 42 residents in the ALF at risk of not receiving proper care and services from staff who did not meet training requirements.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-112A-0611 Who is an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (iii) A certified nursing assistant;

Statement of Deficiencies	License #: 2034	Compliance Determination # 72948
Plan of Correction	MIRABELLA	Completion Date
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Review of staff records showed that the ALF hired Staff D (Nursing Assistant Certified ((NAC)) on 05/22/2024. Review of Staff D's record showed that they had not completed the 12 hours of CE credits between their birth dates, 11/16/2024 and 11/16/2025 or after.

Review of staff records showed that the ALF hired Staff E (NAC) on 08/22/2022. Review of Staff E's record showed that they had not completed the 12 hours of CE credits between their birth dates, 06/30/2024 and 06/30/2025 or after.

Review of staff records showed that the ALF hired Staff F (NAC) on 05/11/2022. Review of Staff F's record showed that they had not completed the 12 hours of CE credits between their birth dates, 03/02/2024 and 03/02/2025 or after.

Review of staff records showed that the ALF hired Staff G (NAC) on 01/21/2014. Review of Staff G's record showed that they had not completed the 12 hours of CE credits between their birth dates,12/14/2024 and 12/14/2025 or after.

In an interview, on 02/18/2026 at 11:15 AM, Staff G (Human Resources Director) confirmed that Staff D, E, F, and G did not complete the required 12 hours CE training between their birthdates or after.

This is an uncorrected deficiency WAC 388-78A-2474(2)(e)(3) previously cited on 11/03/2025 and 01/13/2026.

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) 4/1/2026 .

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

Administrator (or Representative) — Date: 3/11/2026

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

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 an unannounced on-site follow-up on 12/30/2025 of:

MIRABELLA
116 FAIRVIEW AVENUE NORTH
SEATTLE, WA 98109

This document references the following SOD dated: 01/13/2026

The following sample was selected for review during the unannounced on-site visit: 9 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2034	Compliance Determination # 70854
Plan of Correction	MIRABELLA	Completion Date
Page 2 of 7	Licensee: MIRABELLA	01/13/2026

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.

Jim Sherman
Residential Care Services

01-23-2026
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.

Administrator (or Representative)

2/3/2026
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;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

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 1 of 1 sampled resident (Resident 1) who received insulin (a hormone that is used to lower blood sugar) injections from non-licensed staff. This placed Resident 1 at risk for medication errors and for compromised health conditions.

Findings included...

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

assistants (NAs) and Home Care Aides (HCAs) working in certain settings to perform certain tasks--such as administer insulin injections--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 (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least every two weeks for the first four weeks, and may be more frequent. (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). (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least every two weeks for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

In an interview, on 12/30/2025 at 9:20 AM, Staff I (Assisted Living and Memory Care Nurse Manager) stated that the ALF provided ND services for residents. Staff I stated that they had been the ALF's Registered Nurse Delegator (RND).

Records review showed that the ALF admitted Resident 1 on [redacted]/2015 with multiple diagnoses including [redacted] and [redacted]. Review of a Service Plan Report (equivalent to Negotiated Service Agreement), dated 12/03/2025, showed that Resident 1 required ND services for insulin injections.

Review of the December 2025 electronic Medication Administration Records (eMARs) showed that Resident 1 had been prescribed to take Lantus (a long-acting insulin- a medication that lowers blood sugar) injections at 8:00 PM daily. Review of the eMARs showed the Lantus injections had been initialed as completed and administered by Medication Technicians (MT), including Staff K (MT).

Review of the ND documentation, dated 11/03/2025, showed that Staff I had delegated the nursing task of Resident 1's insulin injections to Staff K and the first delegation training was on 11/03/2025. There was no other ND document showing that the ALF's RND had conducted the required nursing visits, at least every two weeks in the first four weeks for the required delegation training, to review Staff K's performance for insulin injections after 11/03/2025.

Statement of Deficiencies	License #: 2034	Compliance Determination # 70854
Plan of Correction	MIRABELLA	Completion Date
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In an interview, on 12/30/2025 at 1:50 PM, Staff I confirmed that there was no other ND document showing that they had conducted the required nursing visits, at least every two weeks in the first four weeks for the required delegation training, to review Staff K's performance for insulin injections after 11/03/2025.

This is an uncorrected deficiency previously cited on 11/03/2025.

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) 2/3/2026 .

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

Administrator (or Representative) — Date: 2/3/2026

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

(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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 3 of 3 sampled staff members (Staff A, B and C) had completed the required first aid training, and 4 of 4 sampled staff (Staff E, F, G, and H) completed the required 12 hours of continuing education. This placed 41 residents in ALF at risk of not receiving proper care and services from staff who did not complete training requirements.

Findings included...

Statement of Deficiencies	License #: 2034	Compliance Determination # 70854
Plan of Correction	MIRABELLA	Completion Date
Page 5 of 7	Licensee: MIRABELLA	01/13/2026

FIRST AID CARD TRAINING

NOTE: Washington Administrative Code (WAC) 388-112A-0720 What are the CPR and first-aid training requirements? (2) Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

Review of staff records showed that the ALF hired Staff A (Caregiver) on 10/01/2025. Review of Staff A's record showed no first aid certification.

Review of staff records showed that the ALF hired Staff B (Caregiver) on 11/26/2025. Review of Staff B's record showed no first aid certification.

Review of staff records showed that the ALF hired Staff C (Caregiver) on 10/29/2025. Review of Staff C's record showed no first aid certification.

12 HOURS CONTINUING EDUCATION

NOTE: WAC 388-112A-0611 Who is an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year: (i) A certified home care aide (HCA);

Review of staff records showed that the ALF hired Staff E (Nursing Assistant- Certified ((NAC)) on 05/11/2022. Review of Staff E's record showed that they had not completed the 12 hours of continuing education (CE) credits between their birthdate from 03/02/2024 through 03/02/2025.

Review of staff records showed that the ALF hired Staff F (NAC) on 01/21/2014. Review of Staff F's record showed that they had not completed the 12 hours of CE credits between their birthdates from 12/14/2024 through 12/14/2025.

Review of staff records showed that the ALF hired Staff G (NAC) on 07/17/2024. Review of Staff G's record showed that they had not completed the 12 hours of CE credits between their birthdates from 03/29/2024 through 03/29/2025.

Review of staff records showed that the ALF hired Staff H (NAC) on 09/27/2023. Review of Staff H's record showed that they had not completed the 12 hours of CE credits

between their birthdates from 04/16/2024 through 04/16/2025.

In an interview, on 12/30/2025 at 2:30 PM, Staff J (Assisted Living / Memory Care Manager/Administrator) stated that they would provide documentation of first aid certification for Staff A, B and C and CE credits for Staff E, F, G, and H by 01/02/2026 at 5:00 PM.

As of 01/06/2025, the Department received none of the requested documents from the ALF.

This is an uncorrected deficiency under WAC 388-78A-2474(2)(d)(e) previously cited on 11/03/2025.

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) 2/3/2026 .

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

Administrator (or Representative) — Date: 2/3/2026

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 2 staff members (Staff B and C) completed the required two step tuberculosis (TB) skin test. This placed 41 residents at risk of exposure to a communicable disease from staff members whose TB status was unknown to the ALF.

Findings included...

Statement of Deficiencies	License #: 2034	Compliance Determination # 70854
Plan of Correction	MIRABELLA	Completion Date
Page 7 of 7	Licensee: MIRABELLA	01/13/2026

NOTE: Washington Administrative Code (WAC) 388-78A-2480 Tuberculosis—Testing—Required. (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

NOTE: WAC 388-78A-2481 Tuberculosis—Testing method—Required. The assisted living facility must ensure that all tuberculosis testing is done through either: (1) Intradermal (Mantoux) administration with test results read: (a) Within forty-eight to seventy-two hours of the test;

Record review showed the ALF hired Staff B (Caregiver) on 11/26/2025. Record review showed Staff B did not complete the two-step TB skin testing.

Record review showed the ALF hired Staff C (Caregiver) on 10/29/2025. Record review showed Staff C did not complete the two-step TB skin testing.

In an interview, on 12/30/2025 at 2:30 PM, Staff I (Assisted Living Memory Care Nurse Manager) confirmed that Staff B and Staff C did not complete the two-step TB skin testing.

This is an uncorrected deficiency previously cited on 11/03/2021.

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) 2/3/2026 .

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

Administrator (or Representative) 2/3/2026 Date

Plan of Correction

Agency Name Mirabella Seattle	**Citation Date 11/3/2025**
Submitted by Patricia Wagner	**Date of POC Submission**
	2/3/2025
☐ **Complaint Citation** x☐ **Certification Citation**	

Citation: (list WAC) **WAC 388-78A-2320 Intermittent Nursing Services Systems**	
What *initial or immediate actions* were taken to address concerns affecting clients?	1. Completed review of Nurse Delegation services in AL and MC. 2. Binder of delegated services made of AL and MC in compliance with Washington State law, listing medications and treatments that will be delegated to Med Techs. 3. Instructions for delegated services placed in binder. 4. 90-day supervision checks will be implemented and create schedule for med techs to be observed. 5. Quarterly review and as needed for a change of condition or medications/treatments.
How will you apply the correction to all clients you support?	1. 90 Day supervision of Med Techs will occur to ensure medications and treatments are being delivered correctly. 2. Quarterly in-service med-tech meetings to update them on processes, procedures, and to train on e-mars. 3. Med Delegation added to move in check list for new residents Consents to be collected for residents from families/poa on all move ins.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Patricia Wagner Lynette Bolger
Date by which lasting correction will be achieved	February 2, 2026

Citation: (list WAC) **WAC 388-78A-2320 Intermittent Nursing Services Systems**	
Additional Information	Enter any additional information you believe is pertinent such as if you intend to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Nicole Vreeland, Field Manager
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600
Fax: (360) 725-3208
VreelNL@dshs.wa.gov

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name Mirabella Seattle	**Citation Date 11/3/2025**
Submitted by Patricia Wagner	**Date of POC Submission**
	2/3/2025
☐ **Complaint Citation** x☐ **Certification Citation**	

Citation: (list WAC) **WAC 388-78A-2474 Training and Home Care Aide Certification Requirements.**	
What *initial or immediate actions* were taken to address concerns affecting clients?	1. Complete review by AL/MC Manager and Human Resources of all staff for First Aide/CPR, Dementia, Mental Health, Food Handler's Card, Annual CEUs. 2. Create and implement employee paperwork/certification check list to ensure all certifications are present at orientation. 3. Orientation and annual training plan created in Relias and sent to all staff to ensure compliance. 4. Complete training for staff who are out of compliance. 5. Monthly review of CEUs and reminders to all staff to complete.
How will you apply the correction to all clients you support?	1. New Hire paperwork check-list will ensure that HR and AL/MC manager have the same information and can have staff attend trainings they are missing. 2. New Hire training will begin with two days of Relias training to ensure staff are up to date with continuing education.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Patricia Wagner Evelyn Calderon Gail Carter-Lindberg Lynette Bolger
Date by which lasting correction will be achieved	March 15, 2026

Citation: (list WAC) **WAC 388-78A-2474 Training and Home Care Aide Certification Requirements.**	
Additional Information	Enter any additional information you believe is pertinent such as if you intend to submit an IDR

Submit to RCS within 10 calendar days of receipt of letter to:

Nicole Vreeland, Field Manager
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600
Fax: (360) 725-3208
VreelNL@dshs.wa.gov

Send copy to DDA Resource Manager or Residential Program Specialist for your region.

Plan of Correction

Agency Name Mirabella Seattle	**Citation Date 11/3/2025**
Submitted by Patricia Wagner	**Date of POC Submission**
	2/3/2025
☐ **Complaint Citation** x☐ **Certification Citation**	

Citation: (list WAC) **WAC 388-78A-2484 Tuberculosis Two Step Skin Testing**	
What *initial or immediate actions* were taken to address concerns affecting clients?	1. TB test dates added to new hire paperwork so HR, AL/MC Manager, and AL/MC Nurse Manager aware of dates and time of completion. 2. TB audit complete on staff members. Staff members current on TB testing.
How will you apply the correction to all clients you support?	1. AL/Nurse Manager will ensure that all two step TB tests are completed on all current employees to ensure staff are cleared to work.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Patricia Wagner Evelyn Calderon Gail Carter-Lindberg Lynette Bolger
Date by which lasting correction will be achieved	March 1, 2026
Additional Information	Enter any additional information you believe is pertinent such as if you intend to submit an IDR

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 # 66729
Plan of Correction	MIRABELLA	Completion Date
Page 1 of 24	Licensee: MIRABELLA	11/03/2025

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 on 10/06/2025 and 10/08/2025 of:
MIRABELLA
116 FAIRVIEW AVENUE NORTH
SEATTLE, WA 98109

The following sample was selected for review during the unannounced on-site visit: 8 of 41 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2034	Compliance Determination # 66729
Plan of Correction	MIRABELLA	Completion Date
Page 2 of 24	Licensee: MIRABELLA	11/03/2025

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.

Jessica Seigen
Residential Care Services

11/3/2025
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.

Administrator (or Representative)

11/31 2025
Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to use an appropriate tool to assess the special needs related to dementia (a group of symptoms that affects memory, thinking, and interferes with daily life) for 1 of 1 sampled resident (Resident 1), failed to assess a mobility issue of 1 of 1 sampled resident (Resident 1), and failed to complete full Assessments within 14 days of move-in date for 2 of 2 sample residents (Residents 4 and 8). This failure placed Residents 1, 4 and 8 at risk for not receiving proper care and services due to lack assessed care needs.

Findings included..

NOTE: Washington Administrative Code (WAC) 388-78A-2100 (2) The assisted living facility must: (b) Complete an assessment specifically focused on a resident's identified problems and related issues: (ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2025 with multiple diagnoses. Review of a note from a physician's visit, dated 05/21/2025, showed that Resident 1 had short-term memory loss which was, "frustrating for them."

Review of the Assisted Living (AL) Level of Care Evaluation (equivalent to a Full Assessment), dated 02/24/2025, under the section on Cognition and Judgment, showed no documentation as to whether the ALF had assessed Resident 1's cognition using an appropriate tool.

In an interview, on 10/08/2025 at 2:30 PM, Staff A (AL and Memory Care (MC) Manager/Administrator) stated that the ALF should have assessed any residents diagnosed with [redacted] using a special dementia assessment tool, called a Mini Mental State Exam (MMSE - a screening test tool that can be used to systematically and thoroughly assess mental status).

In an interview, on 10/08/2025 at 2:40 PM, Staff G (AL and MC Nurse Manager) confirmed there was no MMSE for screening Resident 1's memory loss.

Review of the 05/21/2025 note from the physician's visit showed that Resident 1's representative noted they had been experiencing increasing difficulty with mobility. The note showed that Resident 1 had transitioned from using a cane to a walker to aid their mobility.

Observation and interview, on 10/08/2025 at 10:10 AM, showed a walker in Resident 1's apartment. Resident 1 stated that they had been using it for walking, especially outside

of the apartment due to their unsteady balance.

Review of Resident 1's active record showed no assessment indicating that they required to use a walker as a mobility device for safety purposes.

In an interview, on 10/08/2025 at 2:40 PM, Staff G confirmed that the ALF had not assessed Resident 1's mobility issues to determine that Resident 1 required a walker as an assistive device for their ambulation.

RESIDENT 4
Record review showed the ALF admitted Resident 4 on [redacted]/2024 with care needs related to multiple diagnoses including [redacted]. Review of the undated Resident Characteristic Roster (RCR), showed Resident 4 required maximum assistance with activities of daily living (ADLs- a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.).

Record review showed the ALF completed a pre-admission Assessment for Resident 4 on 10/06/2024. Record review showed there was no full Assessment completed for Resident 4.

RESIDENT 8
Review of the RCR, showed the ALF admitted Resident 8 on [redacted]/2025 with care needs related to [redacted] that required moderate assistance with ADLs.

Record review showed the ALF completed a pre-admission Assessment for Resident 8 on 07/11/2025. Records showed there was no full Assessment completed for Resident 8.

In an interview, on 10/08/2025 at 2:50 PM, Staff A and Staff G acknowledged that the full Assessments were not completed for Residents 4 and 8.

Statement of Deficiencies	License #: 2034	Compliance Determination # 66729
Plan of Correction	MIRABELLA	Completion Date
Page 6 of 24	Licensee: MIRABELLA	11/03/2025

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) 11/21/2025 .12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) [signature] Date 11/13/2025

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 r sks 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;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

(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

(b) Based on standard policies and procedures in the assisted living facility provided that they are consistent with the reasonable accommodation requirements of state and federal law.

(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 necessary to meet the care needs for 9 of 12 sampled residents (Residents 1, 2, 3, 4, 5, 6, 9, 10 and 12). This placed Residents 1, 2, 3, 4, 5, 6, 9, 10 and 12 at risk for not having their care needs and risk for compromising their health conditions.

Findings included...

RESIDENT 1
Records review showed that the ALF admitted Resident 1 on [redacted]/2025 with multiple diagnoses inc uding [redacted].

Review of the August, September, and October 2025 electronic Medication Administration Records (eMARs) showed that Resident 1 had been prescribed to take citalopram (an antidepressant, used to treat depression) at 8:00 PM daily. The eMARs showed that Medication Technicians (MTs) were instructed to monitor behav·or related to depression. But there was no information as to what specific behavior MTs would monitor.

Review of a Service Plan Report (SPR, equivalent to NSA), dated 03/06/2025, under the section on Behavior, showed, "No monitoring for behavioral episodes or No behavioral episodes." The SPR showed that Resident 1 had not taken psychotropic medications (any substance, including antidepressants, that affects the brain and alters a person's mood, awareness, thoughts, feelings, or behavior).

In an interview, on 10/08/2025 at 2:40 PM, Staff G (Assisted Living (AL) and Memory Care (MC) Nurse Manager) confirmed that there was no plan for Resident 1's behavior management in the SPR.

RESIDENT 2
Records review showed that the ALF admitted Resident 2 on [redacted]/2025 with multiple medical diagnoses, and that Resident 2 was admitted into hospice (care provided to the terminally i l) care on 08/08/2025.

In an interview, on 10/07/2025 at 10:40 AM, Staff M (Caregiver) stated that the ALF caregivers had previously provided Resident 2 with showers due to their weakness, but currently, a hospice agency had been providing showers

In an interview, on 10/08/2025 at 10:20 AM, Resident 2 stated that they required assistance with showering. When asked who would provide showers, Resident 2 stated, "a hospice bath aide has been giving showers twice a week."

Review of Resident 2's active records showed no plan indicating that Resident 2 would be receiving hospice services, including bathing assistance, and there was no alternate plan for when the hospice bath aide would not be there to provide the services.

In interviews, on 10/08/2025 at 02:40 PM, Staff G confirmed there was no SPR showing that Resident 2 had been receiving hospice services, including bathing assistance, and there was no alternate plan should the hospice bath aide not be able to provide services.

Records review showed that Resident 2 had a diagnosis of [redacted]. Review of the AL Level of Care Evaluation (ALLCE, equivalent to a Full Assessment), dated 02/20/2025, showed that Resident 2 required staff to administer medications.

Review of the August, September, and October 2025 eMARs showed that Resident 2 had been prescribed to take Eliquis (anticoagulant used to help prevent strokes or blood clots n people who have A-Fib) twice a day.

Review of Resident 2's active records showed no plan for how to monitor or address the risks associated with long-term daily anticoagulation therapy, including signs of unusual bruising, bleeding, or symptoms of internal bleeding.

In an interview, on 10/08/2025 at 2:40 PM, Staff G confirmed there was no plan to monitor Resident 2's condition related to using the anticoagulant.

RESIDENT 3
Records review showed that the ALF admitted Resident 3 on [redacted]/2018 with multiple medical diagnoses including [redacted]. Review of the undated Resident Characteristic Roster (RCR), showed Resident 3 required moderate assistance with activities of daily living (ADLs - a term used in healthcare to refer to people's daily self-care activities such as bathing, grooming, ambulation, etc.).

Review of a Progress Note (PN), dated 09/24/2025, showed Staff K (Licensed Nurse ((LN)) documented that Resident 3 complained of right ankle pain. The PN showed a ruptured blister on Resident 3's medial side of the right heel, and left heel had thickened skin related to irritation from her shoes. The PN showed the LNs continued to do dressing changes to Resident 3's right heel. On 10/06/2025, the PN showed a new skin tear to Resident 3's left shin area related to venous insufficiency (a condition that

damaged the leg veins and causes blood to pool in the legs).

Review of the Service Plan Report (SPR – equivalent to NSA), dated 05/29/2025, under Skin Care Preferences, showed no information addressing Resident 3's wounds and interventions to prevent further skin injuries.

Review of the SPR, dated 05/29/2025, showed Resident 3 was at a high risk for fall. The SPR did not include fall prevention for Resident 3 to mitigate fall incidents.

RESIDENT 4
Records review showed that the ALF admitted Resident 4 on [redacted]/2025 with multiple diagnoses, including [redacted]. Review of the Assisted Living Level of Care Evaluation (ALLCE - equivalent to a Full Assessment), dated [redacted]/2024, showed Resident 4 required maximum assistance with ADLs including medication management

Review of SPR, dated 03/11/2024, under Behavior section, showed Resident 4's had behavior issues including yelling at staff, crying, and swearing. However, there were no behavioral interventions for staff to follow related to Resident 4's identified behavior or should Resident 4 show symptoms of decompensation (is the deterioration of mental health functioning).

Record review, showed Resident 4 had a diagnosis of a [redacted] and [redacted].

Observation and interview, on 10/08/2025 at 9:04 AM, showed Resident 4 was in bed, with a wedge support to her left arm. Resident 4 demonstrated that the wedge support had a little sling for her left hand to prevent contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility.). Resident 4 was observed with a urinary device called PureWick system (a non-invasive female external catheter connected to a collection canister used to manage incontinence).

Review of Resident 4's SPR, dated 11/08/2024, under Mobility and Device, showed no information or care needs related to the wedge support for her left arm. The SPR under Toileting Devices /Preference, did not include information or care needs on how facility staff assisted Resident 4 or what to observe and report related to the PureWick system.

Review of an Assessment, dated [redacted]/2025, showed Resident 4 was assessed at maximum risk for fall and had fallen 20 times since admission to the ALF.

Review of the SPR, dated 11/07/2024, showed Resident 3 was a "Maximum safety risk" due to fall incidents. However, SPR showed no fall prevention plans or interventions to mitigate falls.

In an interview, on 10/08/2025 at 8:20 AM, Staff P (Medication Technician) stated that Resident 4's family member supplied medications including Vitamin D (supplement), Quinol CoQ10 (supplement that supports heart health and energy production), and fluoxetine (used to treat major depressive disorder).

Review of Resident 4's SPR, showed no information that a family member (FM) provided some medications, and no alternate plan should the FM was unable to provide Resident 4's medications.

RESIDENT 5
Records review showed that the ALF admitted Resident 5 on [redacted]/2025 with multiple diagnoses, including [redacted]. Review of an SPR, dated 02/03/2025, showed that Resident 5 required staff to administer medications.

Review of the August, September, and October 2025 eMARs showed that Resident 5 was prescribed to take a Mounjaro (used to control blood sugar levels in certain people with type 2 diabetes) injection weekly. The eMARs showed multiple notations stating that Collateral Contact 1 (CC1 - Resident 5's Representative) had given the injections.

In an interview, on 10/14/2025 at 10:09 AM, CC1 stated that they had been giving the Mounjaro injection to Resident 5 every Monday.

Review of the SPR, dated 02/03/2025, showed no plan indicating that CC1 had been administering Mounjaro injections to Resident 5, and no alternate plan should CC1 not be available to administer injections to Resident 5. The SPR also did not include any plans for diabetic management, including monitoring signs and symptoms of Resident 5's conditions of hyperglycemia (high BS in the body, happens when the body has too little insulin or when the body can't use insulin properly) and hypoglycemia (low BS in the body, happens when blood sugar levels are too low, usually less than 70 milligrams per deciliter).

In an interview, on 10/08/2025 at 2:40 PM, Staff G confirmed that Resident 5's SPR did not have plans for diabetic management, including the family administering Mounjaro injections and its alternate plan.

Review of the August, September, and October 2025 eMARs showed that Resident 5 was prescribed to take vitamin D (supplement) every other day

Observation and interview, 10/08/2025 at 9:30 AM, showed a bottle of vitamin D in a medication cart in the Memory Care Unit. Staff H (Medication Technician (MT)) stated that CC1 had been supp ying vitamin D that was an over-the-counter (OTC) medication.

Review of Resident 5's SPR, dated 02/03/2025, showed no plan indicating that CC1 would provide vitamin D, and no alternate plan if CC1 was not available to supply vitamin D to Resident 5.

RESIDENT 6
Records review showed that the ALF admitted Resident 6 on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted]. Review of the RCR, showed Resident 6 required maximum assistance w th ADLs.

Review of Resident 6's SPR, dated 03/20/2025, showed that Resident 6 required the use of a wheelchair for mobility and was independent with transfers. Under the section Fall Risk, the SPR showed Resident 6 was at high risk of fall and had two falls in the past three months.

Review of Progress Notes, dated [redacted]/2025, showed Resident 6 had a significant fall injury from a fall, was transported to the hospital, and returned to the ALF on [redacted]/2025

Review of the hospital's After Visit Summary, dated [redacted]/2025, showed diagnoses of [redacted], and [redacted].

Observation of Resident 6 in the activity room, on 10/07/2025 at 10:00AM, showed presence of facial bruising.

Review of Resident 6's SPR, showed no care plan to prevent falls and no interventions for staff to follow.

RESIDENT 9
Records review showed that the ALF admitted Resident 9 on [redacted]/2024 with multiple diagnoses including [redacted].

In an interview, on 10/07/2025 at 08:28 AM, Staff H (MT) stated that Resident 9 had been eating a pureed diet for their chewing condition, and they required assistance with

feeding.

Observation and interview, on 10/08/2025 at 8:30 AM, showed that Resident 9 was served a pureed diet. During the observation, a caregiver was feeding Resident 9.

Review of a SPR, dated 02/05/2024, showed that Resident 9 did not have difficulty chewing or swallowing. The SPR showed that Resident 9 would not require staff assistance with eating, and Resident 9 would eat independently.

In an interview, on 10/08/2025 at 2:40 PM, Staff G confirmed that there was no other SPR showing Resident 9 requiring a pureed diet due to their chewing condition, or staff assistance with eating.

RESIDENT 10
Records review showed that the ALF admitted Resident 10 on [redacted]/2015 with multiple diagnoses including [redacted] Review of Resident 10's SPR, dated 07/05/2024, showed no documented plan for diabetic management, including monitoring the signs and symptoms of Resident 10's diabetic conditions of hyperglycemia and hypoglycemia.

In an interview, on 10/08/2025 at 2:40 PM Staff G confirmed that Resident 10's SPR d d not include a plan for diabetic management.

RESIDENT 12
Record review showed the ALF admitted Resident 12 on [redacted]/2024 with multiple diagnoses. Review of the undated RCR, showed Resident 12 required moderate assistance with ADLs including medication management.

In interview, during a medication pass, on 10/07/2025 at 8.30 AM, Staff P stated that there were eight medications for Resident 12 that were provided by and brought to the facility by a FM.

Review of the SPR, dated 12/16/2024, showed no alternate plan should the FM was unable to provide Resident 12's medications.

In an interview, on 10/26/2025 at 2:50 PM, Staff A (AL and MC Manager) and Staff G (AL and MC Nurse Manager) acknowledged that there were no individual plans in the SPR related to the care needs for Residents 1, 2, 3, 4, 5, 6, 9, 10 and 12.

This deficiency was previously cited on 04/18/2024.

Statement of Deficiencies	License #: 2034	Compliance Determination # 66729
Plan of Correction	MIRABELLA	Completion Date
Page 13 of 24	Licensee: MIRABELLA	11/03/2025

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) [redacted] . 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) [signature] Date 11/13/2025

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to ensure proper and safe installation of side bed rails (SBR) for 1 of 1 sampled resident (Resident 1) and 1 of 1 non-sampled resident (Resident 11). This failure placed Residents 1 and Resident 11 at risk for serious bodily harm, including death from entrapment from a bed mobility device.

Findings included ..

Review of the United States Food and Drug Administration (FDA) website, on 10/06/2025, showed the FDA developed a document regarding SBR use in health care facilities titled, "A Guide to Bed Safety." The document outlined the importance of frequent assessments to monitor a resident's physical and mental status, monitoring high risk residents, and ensuring safe installation of SBRs. The document outlined risks of using side rails including strangulation, suffocation, bodily injury, or death when a person could get caught, an increased fall risk if not used properly, and feelings of isolation and unnecessary restriction and being prevented from completing activities of daily living.

Review of the FDA website, on 10/06/2025, showed specific measurements for SBR safety in a posting titled, "Overview of the U.S. food and drug administration's potential zones of bed entrapment." The overview specified the following information:

ZONE 1: Within the Rail - any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space, less than 4 34 inches (").

ZONE 3: Between the Rail and the Mattress - this area is the space between the inside surface of the bed rail and the mattress, and if too big it can cause a risk of head entrapment. FDA recommended space: less than 4 34"

ZONE 4: Under the Rail at the Ends of the Rail - a gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment. FDA recommended space is less than 2 38".

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2025 with multiple d agnoses. Review of the Residents Characteristics Roster, updated on 10/07/2025, showed that Resident 1 had not been identified as using an SBR.

Observation and interview, on 10/08/2025 at 10:10 AM, showed an up-side-down U-shape SBR on the right side of the bed in Resident 1's apartment. Observation showed an open space/gap within the SBR measuring 11" in length and 21" high. Observation showed that a gap from the mattress to the SBR measured 7". The SBR was not securely attached to the bed frame, and when it was pulled outward, the gap increased to 9". There was no protection from the gap in the SBR. Resident 1 stated that they had not used it and said, " I don't know what it was exactly for?"

In an interview, on 10/08/2025 at 11:50 AM, Staff N (Caregiver) stated that they had known that Resident 1 had a device on the bed but did not know it was considered as being a "Side Bed Rail".

Review of an Assisted Living (AL) Level of Care Evaluation (ALLCE - equivalent to a Full Assessment), dated 02/24/2025, and a Service Plan Report (SPR - equivalent to a Negotiated Service Agreement), dated 03/06/2025, under the section on Bed Mobility Assistance, showed that Resident 1 would not require any assistance with bed mobility. Neither the ALLCE nor the SPR showed that Resident 1 would use a SBR for bed mobility.

In an interview, on 10/08/2025 at 12:30 PM, Staff G (AL and Memory Care Nurse Manager) stated that they had not known Resident 1 had a SBR and confirmed that there was no evaluation for the SBR per the ALF's regulatory requirements. Staff G stated that the SBR was not a safe device for Resident 1.

RESIDENT 11
Review of the Residents Characteristics Roster, updated 10/07/2025, showed that the ALF admitted Resident 11 on [redacted]/2025. The RCR had not identified Resident 11 as having a SBR.

In an interview, on 10/08/2025 at 11:50 AM, Staff N stated that Resident 11 had a SBR since they moved in.

Observation with Staff G, on 10/08/2025 at 12:21 PM, showed a SBR on the left side of the bed in Resident 11's apartment. Observation showed an open space/gap within the SBR measuring 18" in length and 7" high. Staff G stated that no one reported to them that Resident 11 had a SBR, and said, "It would not meet regulatory standards as a safe SBR."

In an interview, on 10/08/2025 at 2:40 PM, Staff G confirmed that there was no evaluation for the SBR as a safe bed mobility device.

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) ~~1/16/2026~~ 12/18/2025.

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) Date 11/13/2025

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;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

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 4 of 4 sampled residents (Residents 5 and 10) who received insulin injections and/or blood sugar checks from non-licensed staff, and for Residents 6 and 8 who received treatments and medication administration from non-licensed staff. This placed Residents 5, 6, 8, and 10 at risk for compromised health status.

Findings included...

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

Review of ALF's undated Disclosure of Services (DOS), showed the ALF allowed nursing assistants to administer oral, topical medications, and eye, ear, and nose drops under the delegation of a registered nurse.

In an interview, on 10/06/2025 at 9:20 AM, Staff A (Assisted Living (AL) and Memory Care (MC) Manager/Administrator) stated that the ALF had been providing ND services for residents. When asked who the RN delegator (RND) was, Staff A named Staff G (AL and MC Nurse Manager) as being the RND.

RESIDENT 5
Record review showed that the ALF admitted Resident 5 on [redacted]/2025 with multiple medical diagnoses including [redacted]. Review of a Service Plan Report (SPR - equivalent to a Negotiated Service Agreement), dated 02/03/2025, showed that Resident 5 required ND service for insulin (used to treat high blood sugar) injections.

Review of Resident 5's August, September, and October 2025 electronic Medication Administration Records (eMARs) showed that Resident 5 had a physician order for BS checks twice daily, before breakfast and dinner. Review of the eMARs showed BS checks had been initialed as completed by Medication Technicians (MTs).

In an interview, on 10/08/2025 at 08:55 AM, Staff H (MT) stated that MTs had been manually checking Resident 5's BS at 6:00 AM and 4:30 PM.

Review of the ND documents showed no information indicating that the ALF had ever delegated to MTs the nursing task of checking Resident 5's BS.

In an interview, on 10/08/2025 at 10:50 AM, Staff G stated that they were new to the ALF and had not delegated any ND tasks to any MTs. Staff G confirmed there was no additional ND document for Resident 5.

RESIDENT 6
Records review showed that the ALF admitted Resident 6 on [redacted]/2022 with multiple medical diagnoses including [redacted] and [redacted]. Review of Resident 6's Service Plan Report (SPR – equivalent to Negotiated Service Agreement), dated 02/06/2025, showed Resident 6 required staff to administer medications.

Records review, dated 07/12/2025, showed Resident 6 was prescribed diclofenac (used to relieve pain associated with osteoarthritis and arthritis) gel to apply to knee four times a day for 14 days. Review of the July and August 2025 electronic Medication Administration Record (eMAR), showed diclofenac gel was administered and initialed by Staff H (MT), Staff I (MT), and Staff O (MT).

On 09/09/2025, Resident 6 was prescribed Nystatin powder (a topical antifungal used to treat yeast infection) to apply to reddened body folds under both breasts and abdominal folds three times a day. Review of the September and October 2025 eMARs showed Nystatin powder was administered and initialed by Staff E (MT), Staff H (MT), Staff I (MT), Staff J (MT), Staff O (MT), Staff Q (MT), and Staff R (MT).

In an interview, on 10/08/2025 at 9:30 AM, Staff H stated that they had been administering medications for Resident 6.

Review of the ND documents for Resident 6, dated 02/05/2025, showed no information indicating that the RND had delegated to seven MTs the nursing task of administering the prescribed topical medications. Oral medications that had been delegated, did not show documentation that the RND reevaluated the ability of the MTs to safely administer medications every 90-days according to ND requirements

RESIDENT 8
Records review showed that the ALF admitted Resident 9 on [redacted]/2025 with care needs related to multiple diagnoses including [redacted]. Review of the Assessment, dated [redacted]/2025, showed Resident 8 required medication administration by staff.

Review of Resident 8's August, September, and October 2025 eMARs, showed multiple prescribed medications including Restasis (used to treat chronic dry eye disease) to instill one drop into both eyes five days a week for bilateral vitreous degenerat on (a condition affecting the eye that causes floaters or spots in vision). The eMARs showed Restasis eye drops were initialed by Staff H, Staff J, Staff P, and Staff R to indicate they administered the eye drops to Resident 8.

Review of the ND documents, dated 07/11/2025, showed the RND delegated nursing tasks to MTs for Resident 8. These ND documents did not include documentation that the RND reevaluated the abil'ty of the MTs to safely administer medications every 90 days according to ND requirements.

In an interview, on 10/08/2025 at 10:50 AM, Staff G (AL and MC Nurse Manager) acknowledged the lack of additional ND document for Residents 6 and Resident 8

RESIDENT 10
Record review showed that the ALF admitted Resident 10 on [redacted]/2015 with multiple diagnoses inc'uding [redacted]. Review of a SPR, dated 07/05/2024, showed that Resident 10 required ND services for insulin injections.

Review of the August, September, and October 2025 eMARs showed that Resident 10 had been prescribed to take Lantus (a long-acting insulin) injections at 8:00 PM daily and Ozempic (used to control blood sugar levels and to reduce the risk of a heart attack, stroke, or death in people with type 2 diabetes) injections every Monday. Review of the eMARs showed Resident 10 had a physician's order for BS checks three times a week. Review of the eMARs showed the Lantus and Ozempic injections and BS checks had been initialed as completed by MTs.

In an interview, on 10/07/2025 at 11:00 AM, Staff H (MT) stated that they had been

manually checking Resident 10's BS three times a week and had administered Resident 10's Ozempic injections.

In an interview, on 10/07/2025 at 1:50 PM, Staff O (MT) stated that when working as a MT at the MC Unit, they had administered Lantus injections to Resident 10.

Review of the ND documentation showed that a previous RND had delegated the nursing task of Resident 10's insulin injections to MTs on 07/04/2024 There was no other ND document showing that the ALF had conducted the required nursing visits to review MTs' performance for insulin injections after 07/04/2024.

Review of the ND documents, dated 07/04/2024, showed that the previous RND had not delegated the nursing task of Resident 10's BS check to any of the MTs.

In an interview, on 10/07/2025 at 10:50 AM, Staff G confirmed there was no additional ND document indicating that the ALF had been following the ND requirements since 07/04/2024.

This deficiency was previously cited on 04/18/2024.

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) 11/18/2026 . 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) 11/13/2026 Date

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

(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:

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that 2 of 3 sampled staff members (Staff B and C) had completed the required cardiopulmonary resuscitation (CPR) and first aid training, and 1of 1 sampled staff (Staff E) completed the required 12 hours of continuing education. This placed 41 residents in ALF at risk of not receiving proper care and services from staff who did not complete training requirements.

Findings included...

CARDIOPULMONARY RESUSCITATION (CPR) AND FIRST AID CARD

NOTE: WAC 388-112A-0720 What are the CPR and first-aid training requirements? (2) Assisted living facilities. (a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

Review of staff records showed that the ALF hired Staff B (Caregiver) on 05/07/2025. Review of Staff B's record showed no CPR certificate.

Review of staff records showed that the ALF hired Staff C (Caregiver) on 03/12/2025. Review of Staff D's record showed no first aid certificates.

12 HOURS CONTINUING EDUCATION

NOTE: WAC 388-112A-0611 Who is an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described in this section. (a) The following long-term care workers must complete 12 hours of continuing education by their birthday each year. (i) A certified home care aide (HCA);

Review of staff records showed that the ALF hired Staff E (Medication Technician) on 06/08/2022. Review of Staff E's record showed that they had not completed the 12 hours of continuing education (CE) credits between their birthdates, 02/17/2024 and 02/17/2025.

In an interview, on 10/07/2025 at10:30 AM, Staff K (Human Resources Director) confirmed that Staff B and C did not complete the required CPR/first aid training and there was no 12 hours CE training for Staff E between their birthdates.

This deficiency was previously cited on WAC 388-78A-2474(2)(d) on 04/18/2024.

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) 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) Date 11/13/2025

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students, and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Washington State name and date of birth background inquiry (BGI) for 1 of 2 sampled staff (Staff E) were renewed before the two-year expiration. This placed 41 residents at risk of receiving care from staff whose criminal background history was unknown.

Findings included...

Review of records for Staff E (Medicat on Technician), hired on 06/08/2022, showed their BGI was completed on 06/06/2022. Records showed Staff E had no BGI done before the two year expiration of 06/06/2024.

In an interview, on 10/07/2025 at 10:30 AM, Staff L (Human Resources Director) acknowledged that the BGIs for Staff E should have been completed on 06/06/2024.

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) 12/12026. 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) 11/13/2025 Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 3 staff members (Staff B) completed the required one step tuberculosis (TB) skin test (TST). This placed 41 residents at risk of exposure to a communicable disease from staff members whose TB status was unknown to the ALF.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2480 Tuberculosis—Testing—Required. (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

Record review showed the ALF hired Staff B (Caregiver) on 05/07/2025. Record review showed Staff B had a documented negative interferon-gamma release assay (IGRA) blood test result on 05/04/2024. Record review showed that the ALF did not perform a one-step TST for Staff B following a documented history of a negative blood test result within three days of employment

In an interview, on 10/07/2025 at 10:30 AM, Staff A (Assisted Living Memory Care Manager/ Administrator) confirmed the lack of a one-step TB skin test for Staff B.

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) ~~11/18/2025~~ 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative)

11/13/2025
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete the two-step skin test screening for tuberculosis (TB) for 1 of 3 sampled staff members (Staff D). This placed 41 residents at risk of exposure to a communicable disease.

Findings included...

Review of staff records showed that the ALF hired Staff D (Facility Services Director) on 04/15/2025. Staff D's record showed a one-step negative TB skin test done on 04/18/2025 but did not complete the 2nd step TB skin test.

In an interview, on 10/07/2025 at 10:45 AM, Staff A (Assisted Living Memory Care Manager/ Administrator) acknowledged the ALF did not meet the required TB skin test timely for Staff D. Staff A stated that they should be overseeing staff records for compliance with the regulations.

Statement of Deficiencies	License #: 2034	Compliance Determination # 66729
Plan of Correction	MIRABELLA	Completion Date
Page 24 of 24	Licensee: MIRABELLA	11/03/2025

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) ~~11/18/2025~~ 12/18/2025

Jamie Singer confirmed amended POC date with Provider on 11/19/2025

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

Administrator (or Representative) [signature] Date 11/13/2025