| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505183 | A. Building<br>B. Wing | 05/07/2025 |

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| Avalon Healthcare - Tacoma | 7411 Pacific Avenue<br>Tacoma, WA 98408 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644<br><br>Based on interviews and record review the facility failed to assess residents with a history of Substance Use Disorder (SUD) for associated risks, develop comprehensive individualized care plans and implement interventions to ensure the safety for 5 of 5 sampled residents (Residents 1, 2, 3, 4 & 5) reviewed for SUD related emergencies. Failure of the facility placed residents with a history of SUD at risk of delayed treatment for overdoses, reduced effectiveness of prevention strategies and placed other residents at risk of a diminished quality of life.<br><br>Findings included .<br><br>Review of the Quality of Care Accident Hazards/Supervision Policy and Procedures dated ,d+[DATE] showed the facility recognized the high-risk nature of the facility population and setting, that efforts to minimize risk to residents included individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Specifically for Residents with Substance Use Disorder (SUD) the procedure guidelines indicated Residents would be evaluated for a history of SUD following admission, the facility coordinated with the resident/resident representative and collaborated to develop appropriate care plan interventions to address associated risks. Facility addressed SUD related emergencies as appropriate. This may include, but is not limited to CPR (Cardiopulmonary Resuscitation), administration of opioid reversing agents, and EMS (Emergency Medical Services) notification.<br><br><Resident 1><br><br>Review of electronic health records (EHR) showed Resident 1 had mood and anxiety disorder diagnoses, a history of polysubstance abuse and homelessness. Resident 1 admitted to the facility for medical management, wound care and rehabilitation.<br><br>Review of Resident 1's History of SUD Care Plan (CP), initiated [DATE] and revised [DATE], showed an intervention to observe Resident 1 for possible signs and symptoms of substance use: substance related odor, needle marks, sudden or unexplained change in behavior or mood, slurred speech, altered gait or impaired coordination, unexplained drowsiness or altered level of consciousness, substance use, following leaves of absence, and following in-facility visitations.<br><br>Review of a nursing note, dated [DATE] 8:00 AM, showed Resident 1 had visitors coming in and out of the facility late in the night.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a nursing note, dated [DATE] 5:35 AM, showed Resident 1 continued to have visitors coming in and out of the facility all night, sometimes other residents joined them in the room.<br><br>Review of a Social Services Note, dated [DATE] 5:03 PM, showed Staff D, Social Services Coordinator, and the Administrator went to Resident 1's room to ask the resident if they were dealing drugs in the facility. The resident stated they were not dealing drugs, that they were using drugs a few years ago and was trying very hard to stay off of them, because they died a couple times, but the people they were with were able to save them.<br><br>Review of Resident 1's EHR showed no assessment or increased monitoring of Resident 1 as care planned.<br><br>Review of a Social Services Note, dated [DATE] 6:03 PM, showed Staff D and the Administrator went to the resident's room and asked that if the visitor was visibly obtunded, that Resident 1 ask the person to leave the facility. They informed Resident 1 that the visitor could return when they were not under the influence of substances.<br><br>Review of Resident 1's EHR showed no assessment or increased monitoring of Resident 1 as care planned.<br><br>Review of a Practitioner Note, dated [DATE] 9:32 AM, showed Resident 1 reported ongoing cocaine use, consuming approximately 0.5 grams every other week for a month by intranasal administration. Resident 1 exhibited awareness of the detrimental effects of cocaine, but continued usage.<br><br>According to progress notes on [DATE] at approximately 2:15 PM Resident 1 and a visitor were found unresponsive in Resident 1's room. Staff notified emergency medical services and implemented life saving interventions including administration of Narcan (treatment to reverse opioid overdose) and breathing assistance. The resident was transported to the hospital and stabilized.<br><br>Review of the investigation, dated [DATE], showed the facility did not identify when Resident 1 returned to the facility, when the visitor arrived, or when Resident 1 was last seen by staff to verify the intervention for assessment and increased monitoring occurred as planned.<br><br>Review of the investigative summary, dated [DATE], showed No other residents were involved and therefore statements from other residents were not taken. Review of a written statement by Staff H, Certified Nursing Assistant, showed they were in a room obtaining vitals when a visitor came and called for a nurse. Staff H walked out of the room and the visitor told them Resident 1 was unresponsive on the bed and turning blue. Staff H ran to Resident 1's room, then called for other nurses.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:23 PM, Resident 2 stated they mind their own business, but everyone should have known Resident 1 was using as they had so much traffic in their room. Resident 2 stated they were the one who found Resident 1. Resident 2 said there was a visitor, a girl from down the street, that wanted to see Resident 1. Resident 2 and the visitor went to Resident 1's room. The privacy curtain was pulled, the wheelchair pulled up to the bed as usual. The visitor saw another person on the floor, went around the curtain, saw Resident 1, began yelling and hitting Resident 1 on the chest. Resident 2 said they both yelled for a nurse, the Nursing Assistant came in and then someone brought in the crash cart and EMS took Resident 1 out on a stretcher. Review of Resident 2's EHR showed no documented monitoring for potential psychosocial harm related to their involvement in the incident involving Resident 1.<br><br>During an interview on [DATE] at 1:01 PM, Staff D stated they found white powder in a Ziploc bag in Resident 1's jackets. Staff D stated there had been rumors of Resident 1 using because of people visiting for a minute and then leaving, which looked like dealing. Staff D stated earlier in the day they had gone to talk to Resident 1 with Staff A, Administrator. Resident 1 denied using drugs at that time and denied having things in their room they were not supposed to have. When asked why they did not search Resident 1's room, Staff D stated Resident 1 would not give permission.<br><br><Resident 2><br><br>Review of Resident 2's [DATE] admission record showed diagnoses of opioid abuse with unspecified opioid-induced disorder, cannabis use, and other psychoactive substance abuse.<br><br>Review of a medical follow up note, dated [DATE], regarding Resident 2's medical issues, included Polysubstance abuse with positive toxicology screen status post initiation of methadone [DATE]. The documented plan was to continue methadone and provide education and counseling on harmful effects of drug abuse.<br><br>Review of a Nursing Note, dated [DATE] 10:58 AM, showed Resident 2 was observed to be drowsy and sleepy, with a possible overdose suspected. Narcan was administered per the physicians order, resulting in the resident becoming alert. Following administration, the resident exhibited agitation, shouting, vomiting, defecating, and cursing. Medics were called, and the resident was transferred to emergency room for further evaluation.<br><br>Review of a Nursing Note, dated [DATE] 10:38 AM, showed Resident 2 returned to the facility with a diagnosis of accidental fentanyl overdose. The resident was educated on the importance of medication safety and adherence to prescribed treatment. The documented plan was continue to Assess for withdrawal symptoms and report any abnormalities to the physician immediately, Provide emotional support and reassurance to the resident and Document any changes in behavior or physical condition.<br><br>Review of a Activities/Recreation note, dated [DATE], showed Resident 2 was often outside visiting with people and not in the facility very often.<br><br>Review of a Social Services Quarterly Note, dated [DATE], written by Staff E, Social Services Assistant, showed that Resident 2 was cognitively intact, diagnosed with psychoactive substance abuse, currently taking methadone. Care plans were reviewed, and resident remained at baseline through the quarter.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 11:04 AM, Staff F, Resident Care Manager, stated Resident 2 had a history of falling out of their wheelchair. Staff F recalled earlier in the week Resident 2 scared them to death as it took a lot to wake the resident up. When Staff F offered Narcan the resident yelled and cussed at them. When they left work, Resident 2 was at the bus stop sleeping.<br><br>Review of a Nursing Note, dated [DATE] 4:37 PM, showed Staff F was notified by the provider that Resident 2 was sedated and to check on them. Staff F called out their name multiple times each time becoming louder for a total of 4 times and they didn't respond, Staff F got closer and had to touch Resident 2's shoulder while very loudly calling their name. They sat up and was angry, Staff F then asked Resident 2 to stay awake or get into bed so they would not fall again, they said ok. Staff F returned a few minutes later to find Resident 2 with their head bent down, provider advised if they continued to pass out, that he would need to have Narcan if he couldn't stay alert or was very difficult to arouse. When Staff F explained that to Resident 2, the resident became very angry yelling at them.<br><br>During an interview on [DATE] at 2:23 PM Resident 2 stated the facility staff administered Narcan when they were sleeping and they had no drugs in their system. Another time a nurse woke them up threatening to use Narcan. Resident 2 stated they told the doctor at the facility they would take a drug test. Resident 2 stated they were on a Methadone program since they had been at the facility. Resident 2 stated they see others (with SUD) outside of the facility and they do not want to end up like that, they want to change for their family. When asked what their understanding regarding the use of illicit drugs in the facility Resident 2 replied, It's not acceptable. Resident 2 stated they had not been told that, they just assumed it.<br><br>Review of Resident 2's admission Care Plan, with revisions including [DATE], showed no SUD CP, and no care plan interventions to address associated risks.<br><br><Resident 3><br><br>Review of Resident 3's [DATE] admission record showed diagnoses of opioid abuse with unspecified opioid-induced disorder, and other psychoactive substance abuse.<br><br>Review of a Medical Doctor 30 day visit note, dated [DATE], showed Resident 3 denied any cravings for substance use and was currently compliant with Suboxone (a medication to treat dependence on opioid drugs). Resident 3 was worried about what happens when they come off Suboxone. The plan documented was a referral to an addiction clinic post discharge from the Nursing Facility.<br><br>Review of a Activities/Recreation Quarterly Note, dated [DATE], showed Resident 3 independently went out into the community to socialize with friends outside of the facility.<br><br>Review of a Social Services Quarterly Note, dated [DATE], showed Resident 3 was cognitively intact, with diagnoses of Psychoactive Substance Abuse, Uncomplicated and Opioid use, Unspecified with Unspecified Opioid-<br><br>Induced Disorder, currently taking (a medication to treat Opioid Use Disorder) to manage symptoms. Resident 3 remains at baseline throughout the quarter. Will continue to monitor mood and behavior. Care plans and behavior monitors were reviewed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on [DATE] at 2:33 PM, Resident 3 stated they had a history of opioid drug use and they had been through rehab, and attended 12-step meetings to save their marriage when they were on cocaine. Resident 3 stated they were friends with all their exes, noting that drug use has always got in the way. Resident 3 proceeded to explain they had chronic pain, then sighed and stated, I kinda use that as an excuse . Resident 3 stated, I'm worried that I will use again, my trigger is my anger and added they were at the facility to fight it off. When asked about drug use in the facility Resident 3 stated, I don't think it should be done by any means.<br><br>Review of Resident 3's Care Plan initiated at admission, last revised [DATE], showed no SUD CP, and no care plan interventions to address associated risks.<br><br><Resident 4><br><br>Review of a Social Services Note, dated [DATE] 9:55 AM, written by Staff D showed they were approached by the unit manager who showed them a sandwich bag that had two small baggies with small crystals in them. The unit manager stated they were found on the resident. The resident stated they did not know what was in the baggies, but someone on the street asked them to hold on to it and give it to another person.<br><br>Review of a Social Services Note, dated [DATE] 10:21 AM, showed the non emergency line was called to have an officer go to the facility and pick up the substance.<br><br>Review of Resident 4's CP showed a [DATE] intervention that Resident 4 exits the building unsupervised and goes off property multiple times during the day using their electric wheelchair (w/c). After they return, on some occasions, they have an strong odor of marijuana around them. On these occasions, Resident 4 was noted to be calmer and more relaxed than usual. On these occasions policies have been reiterated against drug use.<br><br>An at risk CP, revised [DATE], showed Resident 4 was at risk of injury due to leaving the facility in their power chair, and associating with unhoused people with active drug use. Two interventions were listed; Allow Resident 4 to make decisions about treatment regime, to provide sense of control, and Educated Resident 4 of the possible outcomes of not complying with treatment or care.<br><br>In an interview on [DATE] at 1:39 PM, Staff G, Staff Development, stated the other day Resident 4 was heard saying, I'm so high and boasting to another resident about doing drugs out in the parking lot with friends. Staff G stated they notified the nurse and cautioned them regarding administering medication to Resident 4.<br><br>In an interview on [DATE] at 2:49 PM, when asked about the earlier incident, Resident 4 recalled the interaction and stated they had bought some marijuana because they were out. Resident 4 stated they smoked marijuana everyday, and denied sharing with others, No, that's my stuff. Resident 4 stated they locked the marijuana in their safe and they were the only one who had the key. When asked about drug use in the facility, Resident 4 stated, I don't use it in the building, I smoke it down the street from the facility.<br><br><Resident 5><br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the MD 30 day visit note, dated [DATE], showed Resident 5 had a history of polysubstance use disorder who presented to the local hospital with altered mental status, with reports of recent meth use. Resident 5 was admitted to the nursing facility to continue with medical treatment and therapy.<br><br>Review of the Social Services Quarterly Evaluation, dated [DATE], Resident 5 was assessed with severe cognitive impairment, and a history of psychoactive substance abuse.<br><br>Review of EHR progress notes showed Resident 5 had a frequent visits with their girlfriend in the facility. Progress notes dated [DATE] showed Resident 5 left the facility with their girlfriend and did not notify the facility when they planned to return.<br><br>Review of Resident 5's care plan, initiated [DATE] and revised [DATE], showed no SUD CP, and no care plan interventions to address associated risks.<br><br>During an interview on [DATE] at 10:38 AM, Staff C, Regional Nurse Consultant, stated the facility identified Residents 2, 3, and 5 go out into the community and have access to drugs, so they all had orders for Narcan and to hold narcotics.<br><br>During an interview on [DATE] at 11:04 AM Staff F said they did not know of any resident who were actively using drugs, they had suspicions Resident 2 and Resident 3 were because their visitors were street people.<br><br>During an interview on [DATE] at 1:01 PM, Staff D stated there was no specific assessment the facility used that addressed SUD. Staff D stated when they spoke to the residents they denied use. Staff D stated they heard rumors of Resident 2 and Resident 3 using (illicit drugs), but they had no proof. When asked who developed the SUD CPs, Staff D stated that nursing staff and/or Staff I, MDS (Minimum data Set - an assessment tool) nurse did if the resident was admitted with a diagnosis.<br><br>During an interview on [DATE] at 1:28 PM, Staff I stated if a resident had a specific diagnosis from a physician then they added it to the care plan. Staff I stated they were relatively new at the facility, acknowledged although they were working on it, they had not yet revised the care plans for all residents.<br><br><SUD Policy><br><br>Review of Resident 1's History of Substance Use Disorder (SUD) Care Plan (CP), initiated [DATE] and revised [DATE], showd a goal that Resident 1 would not experience an overdose associated with SUD. Interventions included educate Resident 1 regarding facility policies pertaining to substance use and possession of illegal substances.<br><br>Review of Resident 1's EHR showed no documentation to support Resident 1 was educated regarding the facility policies pertaining to substance use and possession of illegal substances as directed in their plan of care. Similar findings were noted for Residents 2, 3, 4, and 5.<br><br>In an interview on [DATE] at 1:51 PM Staff J, Admission Nurse, stated they did not review the resident handbook, or facility rules with admission paperwork.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on [DATE] at 1:54 PM, Staff K, Admission Director, stated they reviewed the Admission Agreement with Residents on admission, but did not review policies regarding drug use with the residents.<br><br>In an interview on [DATE] at 2:10 PM, Staff A, Administrator stated they would try to find documentation to support residents were notified of facility expectations, none were provided.<br><br>Reference WAC [DATE] (3)(g) |