| 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 | 03/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avalon Healthcare - Tacoma | 7411 Pacific Avenue<br>Tacoma, WA 98408 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a newly-admitted resident received care and treatment in accordance with professional standards of practice including assessment, basic care tasks, and pain management, for 1 of 3 residents (Resident 1) reviewed for quality of care and services. This failure resulted in the resident not having basic care needs assessed, addressed or documented upon their admission and placed the resident at risk for pain and discomfort, unmet needs, and diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, for end-of-life care. On 02/202026 at 4:40 PM, a Collateral Contact (CC-1) stated they had visited with the resident while they were in the hospital, prior to their admission to the facility, and took them out and around the hospital in a wheelchair. CC-1 said they came to the facility shortly after the resident had arrived on the day of their admission. When they arrived, CC-1 described Resident 1 as groaning, restless, and being ?a complete 180' from when they were still at the hospital. CC-1 said they observed Resident 1 in a bed that was alongside a wall and the mattress was tilted up with pillows. CC-1 said it looked like Resident 1 was stuck on their back and they could not get out of bed. CC-1 said they were told by facility staff that Resident 1 was restless and agitated and had been trying to get out of bed. On 03/06/2026 at 1:50 PM, Staff C, a Registered Nurse, stated when Resident 1 came in, they were very restless. They were worried about the resident falling off the bed so they put a mattress on the floor next to the bed. Staff C also had a Certified Nursing Assistant (CNA) sit with the resident. Staff C said Resident 1 had orders for medications, but the pharmacy did not have any scripts (prescriptions), which were usually sent by e-fax from the hospital to the pharmacy. When asked if they were able to do an assessment, get vital signs or anything, Staff C frowned and shook their head side to side and said no, the resident was too restless. Staff C said some caregivers from where the resident used to live came in and talked to the resident, who seemed to recognize them and calmed down a little. Staff C said there was a manager on duty who came in to help with the admission but the resident had already been sent out. Staff C said it was a Saturday and they had 19 other patients and they were supposed to do an admission. Staff C said, I'm only one person. On 03/06/2026 at 2:35 PM, Staff D, a Certified Nursing Assistant, said they remembered when Resident 1 admitted and said the resident was very restless, would not make eye contact, and was very confused. Staff D said the resident kept taking off their hospital gown, and staff would put it back on him. Staff D said Resident 1 kept trying to get up, and a mattress had been put alongside the bed so they would not hurt themselves. When asked if they were on a 1:1 with the resident, Staff D said they did it for awhile and then traded off with other staff, just to make sure the resident did not hurt themself. On 03/06/2026 at 2:52 PM, Staff E, Medical Records staff, said there were no additional documents or records to be scanned into or added into Resident 1's chart. Staff E said they do not keep a hard chart anymore. When asked, Staff indicated if it was not in the electronic record, they did not have it. On 03/06/2026 at 2:58 PM, Staff F, a Registered Nurse, said they were the Manager on Duty the weekend Resident 1 admitted . Staff F said they were working remotely to put the meds into the medical record when staff called to say the resident was very agitated, crawling out of bed and such. Staff F said the next thing they heard was that the<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Hospice nurse had arrived and they sent the resident out to the hospital. Staff F said they did not know why the ordering physician did not just order a one-time dose of medications. Review of facility admission and discharge records showed Resident 1 was in the facility on 02/14/2026 from 11:30 AM to 1:58 PM, for approximately 2.5 hours. Review of Resident 1's record consisted of a Nursing Note, dated 02/14/2026 at 1:02 PM, and a Social Services Note, dated 02/16/2026 that documented Resident 1's guardian declined a bed hold. The 02/14/2026 1:02 PM nursing note documented the resident had arrived at 11:00 AM and appeared to be restless, under distress, and tried to get off the stretcher. Nursing documented the resident was non-verbal, restless, and tried to get out of bed and a CNA was assigned to sit with the resident. Nursing documented that a Hospice nurse arrived, who contacted the Hospice physician, who ordered the resident to be sent out to the hospital. Review of the record did not show a weight, vital signs, evaluations or assessments, including skin assessment, pain assessment, or consent for the resident's bed to be positioned against the wall. No documentation of 1:1 monitoring and no documentation of what care was provided to the resident and the resident's response was included in the record. On 03/06/2026, Staff B, a Registered Nurse and the facility Director of Nursing Services, could not locate vital signs, an admission nursing assessment, skin assessment, baseline care plan, documentation of 1:1 care provided. When asked, Staff B said that did not meet the expectations of care provided to newly-admitted residents. Reference WAC 388-97-1060(1)-(3) |