STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505183	A. Building B. Wing	07/30/2025

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at a palatable temperature when reviewed for kitchen. This failure placed residents at risk of reduced nutritional intake, unintended weight loss, feelings of worthlessness, and a diminished quality of life. Findings included.During an interview on 07/23/2025 at 11:45 AM, Resident 7 stated food was cold for all three meals and that morning's waffles were cold. During an interview on 07/23/2025 at 12:44 PM, Resident 7 stated the broccoli served at lunch was cold. During an interview on 07/23/2025 at 10:23 AM, Resident 14 stated the facility's food was cold all the time. During an interview on 07/24/2025 at 1:12 PM, Resident 14 stated that morning's breakfast was cold. During an interview on 07/23/2025 at 12:02 PM, Resident 3 stated the facility's food was cold and the issue had been brought up in resident council, but it had not been resolved. During an interview on 07/23/2024 at 3:15 PM, Resident 44 stated the facility's food was lukewarm, and the resident preferred warm to hot foods. During an interview on 07/23/2025 at 3:27 PM, Resident 49 stated they told their nurse their food was cold, and it was not resolved. Observation on 07/23/2025 at 12:25 PM showed facility staff serving food in the 300 Hall with the doors left ajar between trays. Observation on 07/23/2025 at 12:28 PM showed facility staff serving food in the 200 Hall with the doors left ajar between trays. Observation on 07/23/2025 at 12:30 PM showed staff serving food in the 100 Hall with the doors left ajar between trays. Review of the resident council minutes showed the resident council considered cold food to be a problem in March, April, and May 2025. Review of the resident council minutes for May 2025 showed, Still having issues w/ cold food. Explained insulated carts had been ordered. Observation on 07/29/2025 at 12:32 PM showed the food cart arrived in the 400 Hall and staff began serving. Observation showed facility staff left the cart open while serving, prepared and passed drinks while serving, and completed tray pass for 400 Hall at 12:42 PM. During an interview on 07/29/2025 at 1:37 PM, Staff R, Dietary Manager, stated the facility was aware of the residents' concern about cold food and was waiting for new food carts to arrive. Staff B stated the carts had been delivered but were the wrong size and could not be used. Review of a food cart retailer price quote for five meal delivery carts showed it was dated 05/30/2025. During an interview on 07/29/2025 at 2:49 PM, Staff A, Administrator, stated the facility was aware of the residents' concerns of cold foods as early as March 2025. Staff A stated new carts had been ordered and were looking for more staff to help until a fix could be found. Staff A stated there was a concern the issue had not been corrected from March 2025 and the facility's food temperature did not meet expectations. Reference WAC 388-97-1100 (1), (2)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNF ABN: a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare. Beneficiaries may choose to continue the services but may be financially liable) and/or a Notification of Medicare (federal health insurance program for people age [AGE] or older) Non-Coverage (NOMNC- a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) at least two calendar days before the Medicare coverage ended for 3 of 3 residents (Residents 64, 65, and 45) when reviewed for beneficiary notification. These failures placed the residents and/or their representatives at risk of not being fully informed and losing their right to an appeals process.Findings included . Resident 64Review of the electronic health record (EHR) showed Resident 64 admitted to the facility on [DATE] with diagnoses to include heart failure and encephalopathy (altered brain function or structure). Resident 64 was usually able to make needs known. According to the SNF Beneficiary Protection Notification Review (BPNR), completed by facility staff on 07/25/2025, Resident 64's Medicare services started on 04/16/2025 and ended on 05/01/2025, with Resident 64 discharging from the facility on 05/01/2025. It showed that Resident 64 was not issued a NOMNC form. During an interview on 07/28/2025 at 10:29 AM Staff C, Social Services Director (SSD) stated Resident 64 should have been provided with a NOMNC and this did not meet expectations. Resident 65Review of the EHR showed Resident 65 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood) and difficulty in walking. Resident 65 was able to make needs known. According to the BPNR, completed by facility staff on 07/25/2025, Resident 65's Medicare services started on 01/27/2025 and ended on 03/05/2025, with Resident 65 remaining in the facility after the skilled services ended. It showed that the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted and that Resident 64 was issued a NOMNC form; however, they were not issued a SNF ABN form. During an interview on 07/28/2025 at 10:33 AM, Staff C, SSD, stated Resident 65 should have been provided with a SNF ABN two days prior to discharging from part A benefits and discharging from facility. Resident 45Review of the EHR showed Resident 45 admitted to the facility on [DATE] with diagnoses to include heart failure and Alzheimer's disease (a brain disorder that worsens over time, causing problems with memory, thinking and behavior). Resident 45 was usually able to make needs known. According to the BPNR, completed by facility staff on 07/25/2025, Resident 45's Medicare services started on 03/06/2025 and ended on 05/09/2025, with Resident 45 remaining in the facility after the skilled services ended. It showed Resident 45 was not issued the SNF ABN or NOMNC forms. During an interview on 07/28/2025 at 10:36 AM, Staff C, SSD, stated Resident 45 should have been provided with a SNF ABN and a NOMNC and this did not meet expectations. During an interview on 07/28/2025 at 10:43 AM, Staff A, Administrator, stated Resident 64 should have been issued a NOMNC, Resident 65 should have been issued a SNF ABN, and Resident 45 should have been issued a SNF ABN and a NOMNC, and this did not meet their expectations. Reference WAC 388-97-0300(1)(e), (5), (6)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure overbed light cords were functional or conformed with homelike standards for 4 of 4 halls (100, 200, 300, and 400 Halls) when reviewed for environment. Failure to have functional or homelike pull cords on overbed lights placed residents at risk of falling, inability to perform activities of daily living, decreased mood, and a diminished quality of life.Findings included.Observation on 07/23/2025 at 11:57 AM showed bed 303-A had an overbed light cord made from multiple plastic bags tied together. Observation on 07/29/2025 at 2:12 PM showed bed 303-A had an overbed light cord made from multiple plastic bags tied together. Observation on 07/29/2025 at 2:20 PM showed the following rooms had an overbed light cord made from multiple plastic bags tied together: 106-A, 309-A, 404-B, 408-B. Observation on 07/29/2025 at 2:20 PM showed the following rooms had an overbed light cord shorter than three inches and were not able to be pulled while in bed: 103-A, 107-A, 205-A, and 413-A. During an interview on 07/29/2025 at 2:59 PM, Staff N, Regional Maintenance Director, stated the facility conducted rounds of rooms monthly to identify repair needs and non-maintenance staff had access to an electronic maintenance tracking system to inform the maintenance department of any needed repairs. Staff N stated overbed light cords should be four to five feet in length and residents should be able to use them while in bed. Staff N stated the observations of overbed light cords being less than three inches long or having plastic bags tied to them did not meet expectations. During an interview on 07/30/2025 at 10:17 AM, Staff A, Administrator, stated non-maintenance staff had access to an electronic maintenance tracking system to inform the maintenance department of any needed repairs. Staff A stated the overbed light cords should not be made of plastic bags and be long enough for a resident to use them while in bed. Staff A stated the observation of plastic bags and short cords did not meet expectations. Reference WAC 388-97-0880

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure beds against wall and low beds were not a physical restraint for 2 of 2 sampled residents (Residents 55 and 5) when reviewed for physical restraints. This failure placed residents at risk of inability to move about the facility, feelings of worthlessness, and a diminished quality of life. Findings included . Resident 55 Review of the electronic health record (EHR) showed Resident 55 admitted to the facility on [DATE] with diagnoses to include dementia (a progressive decline in memory, thinking, reasoning, and judgment, that interfere with daily functioning and social relationships), muscle weakness, and adult failure to thrive. Resident 55 was unable to make needs known. Observation on 07/23/2025 at 10:22 AM showed Resident 55 in bed with the bed against the wall. Observation showed Resident 55's right arm and leg were touching the wall. Observation on 07/24/2025 at 9:59 AM showed Resident 55 in bed with three pillows placed under the mattress causing it to tilt towards the wall. Resident 55 attempted to recenter themselves in the bed but slid towards the wall. Observation on 07/24/2025 at 2:25 PM showed Resident 55 in bed with three pillows placed under the mattress causing it to tilt towards the wall and the resident's right side was touching the wall. Observation on 07/25/2025 at 11:15 AM and 07/29/2025 at 8:23 AM showed Resident 55 in bed with three pillows placed under the mattress causing it to tilt towards the wall. Review of provider's orders showed no order for Resident 55's bed against the wall. Review of the care plan, initiated on 03/27/2025, showed Resident 55 had a self-care performance deficit related to malnutrition (lack of proper nutrition) and muscle weakness and was dependent on staff for repositioning and turning in bed. The care plan did not show an intervention for the bed against the wall. During an interview on 07/30/2025 at 9:50 AM, Staff B, Director of Nursing Services, stated the facility ensured a bed against the wall was not a physical restraint by completing an assessment. Staff B stated Resident 55's lack of assessment, provider's order, or care plan for a bed against the wall did not meet expectations. Staff B stated staff placing pillows under a mattress causing it to tilt towards the wall was never appropriate and could be considered a restraint. Staff B stated Resident 55's bed against the wall and pillows placed under the mattress did not meet expectations. Resident 5 Review of the EHR showed Resident 5 was admitted to the facility on [DATE] with diagnoses that included gastrostomy status (the delivery of nutrients through a feeding tube directly into stomach), heart failure, convulsions (uncontrolled jerking, loss of consciousness) and anoxic brain damage (brain damage from lack of oxygen). Resident 5 was not able to communicate their needs. Observations on 07/23/2025 at 12:45 PM and 07/28/2025 at 8:55 AM showed Resident 5 laying in a (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	low bed, the bed was placed next to the wall, and a mattress was next to the bed. Review of the EHR showed Resident 5 had no care plan related to the use of low bed and bed by the wall. Review of the EHR showed Resident 5 had no assessments or consents for the use of low bed and bed by the wall. During an interview on 07/28/2025 at 9:39 AM, Staff B, DNS, stated low bed and bed next to the wall could be considered a restraint and the process was for staff to complete evaluation and consents prior use. Staff B stated Resident 5's medical records did not meet expectations. Reference WAC 388-97-0620(1)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASARR, a mental health screening tool) assessments were accurately completed for 4 of 5 sampled residents (Residents 8, 37, 2 and 21) when reviewed for PASARRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs. Review of a document titled, Resident Assessment (PASARR) for mental disorder (MD) and intellectual disability (ID)”, dated 08/2018, showed the PASSAR screening will be completed for each resident prior to admission. In addition, a document titled “Resident Assessments PASARR screening coordination”, dated 07/2018, showed the facility will refer to the appropriate state-designated agency when a resident with mental disorder or intellectual disability experiences a significant change in status newly evident or possible serious MD or ID or related condition. Resident 8 Review of the electronic health record (EHR) showed Resident 8 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and post-traumatic stress disorder (PTSD, difficulty recovering after experiencing or witnessing a terrifying event). Resident 8 was sometimes able to communicate needs. Review of the level I PASARR dated 07/23/2025 showed Resident 8 was a current resident since 10/23/2023, had serious mental illness indicators checked, and a level II referral was required. During an interview on 07/28/2025 at 1:05 PM, Staff C, Social Services Director (SSD), stated when Resident 8 readmitted to the facility on [DATE] there should have been a level I PASARR completed at that time and this did not meet expectations. During an interview on 07/28/2025 at 1:48 PM, Staff A, Administrator, stated Resident 8's level I PASARR dated 07/23/2025 did not meet expectations because it should have been completed when the resident readmitted to the facility on [DATE]. Resident 37 Review of the EHR showed Resident 37 readmitted to the facility on [DATE], initially admitted on [DATE], and was able to make needs known. Review showed Resident 37 had diagnoses of vascular dementia (brain damage with a decline in mental abilities, severe enough to interfere with daily life, caused by multiple strokes) with other behavioral disturbance, adult failure to thrive, and history of traumatic brain injury (damage to the brain caused by an external force). Review of Resident 37's EHR showed a level I PASARR form dated 03/13/2025 that was marked “VOID” in the EHR. Review of the level I PASARR dated 03/14/2025 showed Resident 37 was a current resident since 03/13/2025, had serious mental illness indicator checked for other psychotic disorder “behavioral disturbance”, and a level II referral was required. During an interview on 07/28/2025 at 1:14 PM, Staff C, SSD, stated it looked like Resident 37's level I PASARR dated 03/13/2025 was voided and could not explain why. Staff C stated Resident 37's (continued on next page)

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	505183	A. Building B. Wing	07/30/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/14/2025 level I PASARR should have had the diagnosis of vascular dementia with other behavioral disturbance documented on the form. Staff C stated Resident 37 needed to have another level I PASARR completed to include the diagnosis of vascular dementia. During an interview on 07/28/2025 at 1:53 PM, Staff A, Administrator, stated the expectation was level I PASARRs were completed accurately prior to or on admission to the facility and Resident 37's 03/14/2025 level I PASARR did not meet expectations. Resident 2 Review of Resident 2's admission minimum data set (MDS, a required assessment tool), dated 04/17/2025, showed the resident admitted on [DATE] with multiple health conditions including heart and lung disease, hemiplegia (paralysis of one side of the body), depression, PTSD, and depression. The EHR showed the resident was able to make their needs known. Review of Resident 2's EHR on 07/24/2025 showed a level I PASARR, dated 04/16/2025, which was completed by the facility social work staff. The PASARR form showed Section 1. A documented Resident 2 had a mood disorder (depression) and PTSD. Review of Resident 2's EHR admission record (diagnoses information) had been updated on 7/11/2025 with a new diagnosis of psychotic disorder with delusions due to known physiological condition. During an interview on 07/25/2025 at 09:09 AM, Staff M, Social Service Assistant (SSA), and Staff C, Social Service Director (SSD) ,stated if Resident 2 had a newly identified behavioral health diagnosis, then the expectation would be to update Resident 2's PASARR to reflect that new mental health diagnosis. Resident 21 Review of the MDS dated [DATE] showed Resident 21 admitted on [DATE] with multiple diagnoses to include heart and lung disease, anxiety, depression and PTSD. In addition, the MDS showed the resident was able to make needs known and required substantial assistance with activities of daily living (ADLs). Review of Resident 21's EHR on 07/24/2025 showed a level I PASARR, dated 04/28/2025, completed by the facility social work staff. The PASARR form Section 1. A showed Resident 21 had an anxiety disorder diagnosis. (No depression or PTSD diagnoses were documented on the PASSAR form.) During an interview on 07/24/2025 at 2:11 PM, Staff M, SSA, stated they must have missed the qualifying behavioral health diagnoses, and the depression and PTSD diagnoses should have been documented on the initial PASARR form. In addition, Staff C, SSD, stated if Resident 21 had the initial behavioral health diagnoses than the expectation would ensure Resident 21's PASARR was correct. During an interview on 07/24/2025 at 2:19 PM, Staff A, Administrator (ADM), stated it was their expectation the additional behavioral health diagnoses were on the PASARRs and updated as directed for the residents. Reference WAC 388-97-1915 (1)(2)(a-c)

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	505183	A. Building B. Wing	07/30/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement individualized comprehensive care plans for 3 of 19 sampled residents (Residents 36, 37, and 2) whose care plans were reviewed. Failure to develop and implement care plans that were individualized and accurately reflected resident care needs related to dementia and behavioral health placed residents at risk of unmet care needs and potential negative outcomes.Review of a facility's policy titled, Comprehensive Care Plans, dated 11/2017, showed the facility interdisciplinary team (IDT) will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, physical, mental and psychosocial needs that are identified in the comprehensive assessment. Resident 36 Review of the electronic health record (EHR) showed Resident 36 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (brain disorder caused by chemical imbalances), chronic obstructive pulmonary disease (lung disease that blocks air flow and makes it difficult to breathe) and depression. Resident 36 was able to communicate needs. During an interview on 07/23/2025 at 10:06 AM, Resident 36 stated they had post-traumatic stress disorder (PTSD, a disorder that develops when a person experienced or witnessed a traumatic event) and were raped multiple times in the past. Review of the EHR showed a social service evaluation called Post-Traumatic Checklist completed on 07/07/2025. Review of Resident 36 's care plan dated 07/07/2025 showed a focus area of diagnosis of PTSD without any further specific directions or instructions for staff to follow. During an interview on 07/28/2025 at 9:43 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was for specific instructions and directions related to Resident 36 PTSD to be on the care plan. Staff B stated Resident 36's care plan for PTSD did not meet expectations. Resident 37 Review of the EHR showed Resident 37 initially admitted to the facility on [DATE] with diagnoses of dementia (a decline in mental abilities, severe enough to interfere with daily life) and adult failure to thrive. Review showed Resident 37 was hospitalized on [DATE] and readmitted on [DATE]. Resident 37 was able to make needs known. During an interview on 07/24/2025 at 3:06 PM, Resident 37 stated they could be forgetful at times. Review of the 5-day minimum data set (MDS, a required assessment tool) dated 03/19/2025 showed Resident 37 had a diagnosis of dementia. Review of the significant change in condition MDS, Section V: care area assessment (CAA) dated 04/17/2025 showed Resident 37 was triggered to have a care plan for cognitive (mental processes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	involved in acquiring knowledge and understanding) loss/dementia; however, the care plan decision was documented, “No” (not to develop/create the care plan). Review of the current care plan dated 04/22/2025 of Resident 37's focused care plan for impaired cognitive function and communication related to dementia showed it was initiated/created on 07/28/2025. During an interview on 07/30/2025 at 9:27 AM, Staff J, MDS Coordinator, stated they were unable to explain why the 04/17/2025 significant change in condition MDS decision for care planning for cognitive loss/dementia was documented “No.” Staff J stated that it should have been care planned at that time. Staff J stated Resident 37's care plan for impaired cognitive function and communication related to dementia was created on 07/28/2025 and this did not meet expectations. During an interview on 07/30/2025 at 10:20 AM, Staff B, DNS, stated Resident 37 should have had a care plan for dementia created when the diagnosis was identified and this did not meet expectations. Resident 2 Review of Resident 2's admission MDS, dated [DATE], showed the resident admitted on [DATE] with multiple health conditions including heart and lung disease, hemiplegia (paralysis of one side of the body), dementia, depression, and PTSD. The EHR showed the resident was able to make their needs known. Review of Resident 2's medication administration records (MARs) showed the resident was ordered by a provider to be administered a psychotropic medication (a treatment that affects a person's mental state) since 4/19/2025 for expression or indications of distress related to dementia with psychosis (a mental health condition characterized by a loss of contact with reality). Review of Resident 2's care plan showed no focus care plan related to dementia that provided any specific interventions for the staff to conduct the necessary care and services related to the residents' behavioral issue (dementia). During an interview on 07/28/2025 at 11:18 AM, Staff J, MDS Coordinator, stated if Resident 2 had a qualifying diagnosis of dementia, then a comprehensive care plan should have been created for this resident. During an interview on 07/28/2025 at 11:31 AM, Staff B, DNS, stated Resident 2's care plan did not have specific care and service interventions for the staff to provide care and did not meet their expectations. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide non-pharmacological interventions for 2 of 5 sampled residents (Residents 55 and 37) when reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included. Resident 55 Review of the electronic health care record (EHR) showed Resident 55 admitted to the facility on [DATE] with diagnoses to include dementia (a progressive decline in memory, thinking, reasoning, and judgment, that interfere with daily functioning and social relationships), muscle weakness, and adult failure to thrive. Resident 55 was unable to make needs known. Review of the June 2025 medication administration record (MAR) showed Resident 55 had an order for acetaminophen (an over-the-counter pain-relieving medication) as needed (PRN) and an order for nonpharmacological interventions (NPI, methods of reducing pain without medication, e.g. massage, heat, etc.). Review showed Resident 55 received acetaminophen PRN without NPI on 8 of 10 opportunities. Review of the July 2025 MAR showed Resident 55 had orders for acetaminophen PRN, oxycodone (a narcotic pain-relieving medication) PRN, and NPI. Review showed Resident 55 received acetaminophen PRN without NPI on 2 of 3 opportunities and received oxycodone without NPI on 5 of 12 opportunities. During an interview on 07/30/2025 at 9:41 AM, Staff B, Director of Nursing Services, stated the facility ensured PRN pain medications were needed by providing NPI prior to use. Staff B stated the expectation was that staff would provide NPI prior to PRN pain medications. Resident 37 Review of the EHR showed Resident 37 readmitted to the facility on [DATE] with diagnoses to include dementia and osteoarthritis (a condition that causes joint pain and stiffness). Resident 37 was able to make needs known. Review of the July 2025 MAR and the July 2025 monitors record from 07/01/2025 – 07/23/2025 showed Resident 37 had orders for oxycodone PRN for pain and orders to monitor for pain, document NPI with a code number, and number of episodes. Documentation showed Resident 37 had no NPI documented on eight days when oxycodone was provided once or twice a day. During an interview on 07/28/2025 at 1:14 PM, Staff K, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 37 should have had documentation of NPI being provided prior to giving the PRN oxycodone. Staff K stated Resident 37's documentation was inconsistent related to NPI, and this did not meet expectations. During an interview on 07/29/2025 at 2:06 PM, Staff B, DNS, stated the expectation was that prior to giving an PRN pain medication the nurse should assess for pain, location, level of pain, type of pain, offer NPI, and document in the MAR and/or the monitors records. Staff B stated Resident 37's July (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505183	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025 MAR and monitors record documentation related to pain and NPI did not meet expectations. Reference WAC 388-97-1060 (3)(k)(i)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance and follow up on an appointment for dental care services for 2 of 4 sampled residents (Residents 21 and 41) reviewed for dental services. This failure placed the residents at potential risk for continued dental problems and decreased quality of life.Findings included . Resident 21Review of the admission minimum data set (MDS, a required assessment tool) dated 04/30/2025 showed Resident 21 admitted on [DATE] with multiple diagnoses to include heart and lung disease, anxiety, and depression. The MDS showed the resident was able to make needs known and required substantial assistance with activities of daily living (ADLs). Observation and interview on 07/23/2025 at 10:14 AM showed Resident 21 laid in bed and their oral cavity showed multiple teeth deeply stained a dark brown color. When asked whether they had seen a dentist since admitting, Resident 21 stated they had bad teeth with multiple cavities and were not seen since being admitted to the facility, but needed to see one. Review of Resident 21s admission MDS dental Section L0200 dated 04/20/2025 showed the resident was assessed and documented with obvious or likely cavities or broken natural teeth. The resident was assessed with mouth or facial pain, discomfort or difficulty chewing. Review of a provider's order dated 04/24/2025 showed an order for Resident 21 to have a dental consultation and treatment as needed. Review of Resident 21's focus care plan dated 04/24/2025 showed the resident was at risk for decline in oral status related to missing carious (tooth decay or cavities) teeth. Interventions included for staff to coordinate arrangements for dental care and transportation as needed. During an interview on 07/24/2025 at 1:54 PM, Staff J, MDS Coordinator, stated they had just placed Resident 21 into the consultation binder (dental section) on 7/23/2025. (3 months after the resident's initial dental needs were assessed). Resident 41Review of the admission MDS dated [DATE] showed Resident 41 admitted on [DATE] with multiple diagnoses to include heart and lung disease, stroke, and malnutrition. The MDS showed the resident was able to make needs known and required substantial assistance with activities of daily living (ADLs). During an interview on 07/23/2025 at 11:42 AM, Resident 41 stated they had lost their lower denture plate and were supposed to see a dentist per a facility staff nurse but had not seen one. Review of Resident 41's admission MDS dental Section L0200 dated 05/08/2025 showed the resident was assessed and documented with broken or loosely fitting or partial dentures, and with no natural teeth, mouth or facial pain, discomfort or difficulty chewing, and obvious or likely cavities or broken natural teeth. Review of Resident 41's focus care plan showed the resident had oral/dental problems. During an interview on 07/25/2025 at 09:30 AM, Staff L, MDS Coordinator, stated they had identified Resident 41 required dental care and sent out an email to the facility's staff to get them onto the dental consultation list. Review of an email dated 05/08/2025 from Staff L to facility staff (Social Work staff, nursing leadership and facility administrator) showed the following: Resident 41 had no teeth and wore full upper dentures only. The upper dentures were missing one tooth. Resident 41 stated they lost their bottom dentures in November of last year. They reported trouble chewing related to having missing teeth and needed a dental consult as appropriate. During an interview on 07/25/2025 at 9:34 AM, Staff C, Social Service Director, stated they were unaware of the email and must have missed the email from the MDS staff but would get the resident onto the consultation binder so they could be seen. During an interview on 07/25/2025 at 9:36 AM, Staff B, Director of Nursing Services, stated the expectation would if the staff were aware of the residents' dental needs then a consult should have been placed into the (dental) binder so they (residents) could be seen by the dental providers. Reference WAC 388-97-1060 (2)(c), (3)(j)(vii)

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	505183	A. Building B. Wing	07/30/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use, and decrease the development of adverse side effects and antibiotic resistance for 2 of 2 sampled residents (Residents 29 and 45) when reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included . Review of the facility policy titled Antibiotic Stewardship dated 03/2019 showed the facility would follow national standards, including revised McGeers criteria, to guide treatment for infections. Review of the revised McGeers criteria dated 09/2023 showed a resident with a urinary catheter must have at least one of the following signs or symptoms:1. Fever,2. Acute change in mental status with no alternate diagnosis and leukocytosis (increased white blood cells)3. New-onset suprapubic (lower belly) pain4. Purulent discharge (thick fluid) from around the catheterand5. Have a positive urine culture (Urinary catheter specimen culture with greater than 100,000 colony count of any organism). Review of the electronic health record showed Resident 29 admitted to the facility on [DATE] with diagnoses of type 2 diabetes (when there is too much sugar in the blood) and kidney failure. The resident was able to make needs known. Review of the provider's orders showed Resident 29 had an order for amoxicillin (an antibiotic) daily for 10 days for presumed urinary tract infection (UTI), dated 06/03/2025, and the resident received all 10 doses. Review of a provider note dated 06/03/2025 showed the resident had suprapubic pain. Review of the EHR showed a urinalysis was collected on 06/04/2025 and results were returned on 06/08/2025 showing no bacterial growth, which was negative for UTI. Review of the provided infection control line listing for 06/2025 showed infection criteria was not met. Review of the EHR on 07/30/2025 showed no documentation of rationale for continued administration of the antibiotic medication. Resident 45Review of the EHR showed Resident 45 admitted to the facility on [DATE] with diagnoses of congestive heart failure and Alzheimer's disease. The resident was able to make needs known. Review of the provider's orders showed the resident received nitrofurantoin (an antibiotic) four times a day from 06/16/2025 through 06/23/2025. The resident received all 27 doses. Review of the provided infection control line listing for 06/2025 did not include this infection. Review of the lab results dated 06/14/2025 showed negative results for UTI and a 20000-49000 colony count. No documentation was found related to the rationale for continued administration of the antibiotic. During an interview on 07/29/2025 at 2:22 PM, Staff B, Director of Nursing Services, stated it was their expectation that residents who received antibiotics were assessed for appropriate criteria and should have documented rationale for continued treatment if criteria was not met. No associated WAC

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer, educate, and obtain consent for pneumococcal vaccines for 2 of 5 sampled residents (Residents 31 and 45) when reviewed for immunizations. These failures denied residents the opportunity to make an informed decision regarding receiving immunizations and placed the residents at risk for communicable diseases. Findings included .Resident 31Review of the electronic health record (EHR) showed Resident 31 admitted to the facility on [DATE] with diagnoses of stroke (when blood flow is cut off from parts of the brain) and weakness. The resident was not able to make needs known. Review of the EHR showed no documentation Resident 31 was assessed for the need for pneumococcal vaccine and no documentation the resident or their representative was educated or offered the vaccine. Resident 45Review of the EHR showed Resident 45 admitted to the facility on [DATE] with diagnoses of congestive heart failure and Alzheimer's disease. The resident was able to make needs known. Review of the EHR showed no documentation Resident 45 was assessed for the need for pneumococcal vaccine and no documentation the resident or their representative was educated or offered the vaccine. During an interview on 07/29/2025 at 10:45 AM, Staff B, Director of Nursing Services, stated the facility had not assessed all residents for pneumococcal vaccination status or offered the vaccines to all residents as needed and should have. Reference WAC 388-97 -1340 (1), (2), (3)

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	505183	A. Building B. Wing	07/30/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure psychotropic medications (any drug that affects the brain activities associated with mental process and behavior) were regularly monitored and had documented adverse side effects and effectiveness for 1 of the 5 sampled residents (Resident 49) when reviewed for unnecessary medication use. This failure placed the residents at risk of unnecessary medication use, side effects without interventions, and diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 49 was admitted to the facility on [DATE] with diagnoses of major depression, anxiety, diabetes (high blood sugar) and insomnia. The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 49 was cognitively intact. Observation on 07/25/2025 at 10:41 AM showed Resident 49 was in their room with a staff member providing one on one supervision. Review of the EHR showed Resident 49 was taking scheduled psychotropic medications including an antipsychotic (a class of medication primarily used to manage psychosis) and antidepressant (a class of medication used to treat depression, anxiety) medications.Review of the EHR showed Resident 49 did not have documentation about monitoring of adverse side effects and behaviors related to the use of the antidepressant and antipsychotic medication. During an interview on 07/28/2025 at 9:33 AM, Staff B, Director of Nursing Services, stated the expectations were for nurses to monitor and document behaviors and adverse side effects in the EHR, and lack of documentation for Resident 49 did not meet expectations. Reference WAC 388-97-0610 (1)(a), 1060 (3)(k)(i)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bed hold notices in writing at the time of transfer to the hospital or within 24 hours of transfer to the hospital for 2 of 2 sampled residents (Residents 37 and 29) when reviewed for hospitalization. This failed practice placed the residents at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital.Findings included… Resident 37 Review of the electronic health record (EHR) showed Resident 37 initially admitted to the facility on [DATE] with diagnoses of dementia, adult failure to thrive, and alcoholic cirrhosis of the liver (liver damage leading to scarring and liver failure). Resident 37 was able to make needs known. Review of the EHR showed Resident 37 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. There was no documentation to show Resident 37 was offered a bed hold for their transfer/discharge to the hospital. During an interview on 07/29/2025 at 1:32 PM, Staff C, Social Services Director (SSD), stated they should have attempted to contact Resident 37 at the hospital to offer the bed hold and documented the response and/or any failed attempts to contact the resident and that did not happen. During an interview on 07/29/2025 at 1:47 PM, Staff A, Administrator, stated there should have been a completed bed hold form, or a progress note regarding offering a bed hold and any attempts to contact Resident 37 for their 03/23/2025 transfer to the hospital. Staff A stated that this did not meet their expectations. Resident 29 Review of the EHR showed Resident 29 admitted to the facility on [DATE] with diagnoses of type 2 diabetes (when there is too much sugar in the blood), heart failure, and kidney failure. The resident was able to make needs known. Review of the EHR showed Resident 29 was discharged to the hospital on [DATE] and returned to the facility on [DATE] to a different room. Review of the EHR showed no documentation that a bed hold was offered to Resident 29 at the time of transfer. During an interview on 07/28/2025 at 10:03 AM, Staff C, SSD, stated a bed hold should have been offered to Resident 29 but it was not. During an interview on 07/28/2025 at 10:53 AM, Staff A, stated it was their expectation bed holds be offered to residents who are transferred to the hospital. Reference WAC 399-97 -0120 (4)

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	505183	A. Building B. Wing	07/30/2025

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a significant change of condition for 1 of 3 sampled residents (Resident 58) reviewed for significant change. Failure to identify the need for significant change of condition assessment minimum data set (MDS, a required assessment tool) placed the residents at risk for unidentified/unmet care needs, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 58 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (progressive disease that destroys memory and other important brain functions), diabetes (high blood sugar) and depression. Review of the EHR showed Resident 58 started hospice (end of life care) services on 02/20/2025. Review of the MDS schedule showed an annual MDS on 12/31/2024 and a quarterly MDS on 04/02/2025 that did not address hospice services. During an interview on 07/28/2025 at 9:44 AM, Staff B, Director of Nursing Services, stated Resident 58 should have had a change of condition MDS after initiation of hospice services. Staff B stated a lack of change of condition MDS for Resident 58 did not meet expectations. Reference WAC 388-97-1000(3)(b)

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	505183	A. Building B. Wing	07/30/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate assessment for 2 of 19 sampled residents (Residents 37 and 29) when reviewed for accuracy of assessments. These failures placed the residents at risk of unmet care needs, inaccurate information in the resident's medical record, and a diminished quality of life. Findings included .Resident 37 Review of the electronic health record (EHR) showed Resident 37 readmitted to the facility on [DATE] with diagnoses of dementia (a decline in mental abilities, severe enough to interfere with daily life), adult failure to thrive, and alcoholic cirrhosis of the liver (liver damage leading to scarring and liver failure). Resident 37 was able to make needs known. Review of Resident 37's EHR showed a “Hospice Certification and Plan of Care,” order dated 04/11/2025. It showed that hospice care services were being provided and documented per the provider's order. Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 37 was not receiving hospice care services. During an interview on 07/30/2025 at 9:07 AM, Staff J, MDS Coordinator, stated Resident 37 was receiving hospice care services and their 07/10/2025 quarterly MDS should have been coded for hospice care. During an interview on 07/30/2025 at 10:10 AM, Staff B, Director of Nursing Services (DNS), stated Resident 37's 07/10/2025 quarterly MDS coding for hospice care was inaccurate and did not meet expectations. Resident 29 Review of the EHR showed Resident 29 admitted to the facility on [DATE] with diagnoses of type 2 diabetes (when there is too much sugar in the blood) and kidney failure. The resident was able to make needs known. Review of the EHR showed Resident 29 required dialysis (when waste is filtered from the blood with a machine) three days a week from 05/12/2025 to 07/29/2025. Review of the MDS dated [DATE] showed the resident was not receiving dialysis. During an interview on 07/28/2025 at 9:45 AM, Staff J, MDS coordinator, stated Resident 29 should have been marked yes, indicating the resident received dialysis during their stay, but was not. During an interview on 07/28/2025 at 10:10 AM, Staff B, DNS, stated it was their expectation the MDS assessment for Resident 29 included their dialysis services. Reference WAC 388-97 -1000 (1)(b)

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	505183	A. Building B. Wing	07/30/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were timely revised on a change in resident status for 2 of 19 sampled residents (Residents 48 and 37) when reviewed for revision of care plan. This failure placed residents at risk for unmet care needs, inaccurate care plans, and a diminished quality of life. Findings included .Resident 48 Review of the electronic health record (EHR) showed Resident 48 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, diabetes (high blood sugar), heart failure and end stage renal disease with dialysis (treatment that removes waste products and excess fluids from the blood when the kidneys are unable to complete these functions). Resident 48 was able to communicate their needs. During an interview on 07/23/2025 at 9:41 AM, Resident 48 stated they were on a fluid restriction of 40 ounces a day. Review of the care plan focus area of oral intake, initiated 09/20/2023, showed Resident 48 was on a 1000 milliliters (mls) fluid restriction. Review of EHR showed Resident 48 had a discontinued provider order for fluid restriction on 07/18/2025. During an interview on 07/28/2025 at 9:37 AM, Staff B, Director of Nursing Services (DNS), stated the care plan should have been updated after the order was discontinued for the fluid restriction. Staff B stated Resident 48's care plan regarding fluid consumption did not meet expectations. Resident 37 Review of the EHR showed Resident 37 readmitted to the facility on [DATE], initially admitted on [DATE], and was able to make needs known. Review showed Resident 37 had diagnoses of vascular dementia (brain damage with a decline in mental abilities, severe enough to interfere with daily life, caused by multiple strokes) with other behavioral disturbance, adult failure to thrive, and history of traumatic brain injury (damage to the brain caused by an external force). Review of current provider's orders on 07/24/2025 showed Resident 37 was not prescribed psychotropic medications (drugs that affect the way the brain works). Review of the current care plan, dated 04/22/2025, showed Resident 37 used psychotropic medications (medications which affect the mind) and was at risk for falls related to psychoactive drug use and antianxiety medication. During an interview on 07/30/2025 at 10:20 AM, Staff B, DNS, stated care plans were to be revised quarterly, annually and with a change in condition. Staff B stated if a problem or issue was identified or resolved, the care plan should be revised as soon as possible. Staff B stated psychotropic medication use was documented in Resident 37's current care plan; however, Resident 37 was no longer receiving psychotropic medications, and the care plan did not reflect the resident's status and needed to be revised. Staff B stated this did not meet expectations. (continued on next page)

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	505183	A. Building B. Wing	07/30/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC [PHONE NUMBER]20(2)(c)(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were provided an activity program for 1 of 3 sampled residents (Resident 55) when reviewed for activities. This failure placed the resident at risk for boredom, feelings of worthlessness, and a diminished quality of life. Findings included.Resident 55Review of the electronic health care record (EHR) showed Resident 55 admitted to the facility on [DATE] with diagnoses to include dementia (a progressive decline in memory, thinking, reasoning, and judgment, that interfere with daily functioning and social relationships), muscle weakness, and adult failure to thrive. Resident 55 was unable to make needs known. Observation on 07/23/2025 at 10:23 AM showed Resident 55 laid in bed eyes open with their television (TV) off and angled away from the bed. Resident 55 pointed at the TV and stated, Look. Observations on 07/24/2025 at 9:56 AM and 2:27 PM and 07/25/2025 at 11:14 AM showed Resident 55 laid in bed eyes open with their TV off and angled away from the bed. Review of the care plan, initiated 03/27/2025, showed Resident 55 was dependent on staff for activities and was unable to attend outside room activities. Review of an Activities Recreation Quarterly/Annual Review, dated 05/16/2025, showed Resident 55 liked to watch their television in their room. During an interview on 07/25/2025 at 12:25 PM, Staff O, Activity Assistant, stated Resident 55 sometimes had their TV on. Staff O stated they did not think Resident 55 could turn on their own TV or re-angle it toward the bed. During an interview on 07/25/2025 at 12:34 PM, Staff P, Activity Director, stated they conducted an activity evaluation to determine what activities residents enjoyed and they would be provided in the residents' room if they were not able to attend in-person activities. Staff P stated Resident 55 enjoyed watching the news and would request it be put on. Staff P stated Resident 55's TV was unplugged, and this did not meet expectations. During an interview on 07/25/2025 at 1:07 PM, Staff A, Administrator, stated the certified nursing assistants were responsible for ensuring residents had their TVs on if that was their preferred activity. Staff A stated the observations of Resident 55's TV off, angled away from the bed, and unplugged did not meet expectations. Reference WAC 388-97-0940 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505183	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop a collaborative comprehensive care plan involving hospice care (end of life care and services) for 2 of the 2 sampled residents (Resident 37 and 55) when reviewed for hospice. This failure placed residents at potential risk for unmet needs and a diminished quality of life.Findings included . Review of the facility's policy titled, Administration hospice, dated July 2018, showed, The facility and the hospice will establish a coordinated plan of care which identifies the specific services/functions each provider is responsible for performing.” Resident 37 Review of the electronic health record (EHR) showed Resident 37 readmitted to the facility on [DATE] with diagnoses of dementia (a decline in mental abilities, severe enough to interfere with daily life), adult failure to thrive, and alcoholic cirrhosis of the liver (liver damage leading to scarring and liver failure). Resident 37 received hospice care services and was able to make needs known. Review of Resident 37's EHR showed a “Hospice Certification and Plan of Care,” order dated 04/11/2025. Review showed a hospice and palliative care coordination of care document dated 04/11/2025 signed and dated by hospice and a facility staff member on 04/11/2025. Review of the current care plan dated 04/22/2025 of Resident 37's focused care plan for hospice services showed it was initiated/created on 07/24/2025. Review showed it did not include hospice location or a point of contact person, and did not specifically show or identify specific services/functions that would be provided by hospice. During an interview on 07/30/2025 at 9:07 AM, Staff J, Minimum Data Set Coordinator, stated Resident 37 had been receiving hospice services since 04/11/2025; however, the hospice care plan was initiated/created on 07/24/2025 and this did not meet their expectation for a timely care plan. Staff J stated Resident 37's hospice care plan was missing the location of hospice and who to contact and needed to be revised to integrate hospice care services information. During an interview on 07/30/2025 at 10:10 AM, Staff B, Director of Nursing Services (DNS), stated Resident 37's hospice care plan created on 07/24/2025 did not meet expectations because it should have been initiated/created when the order was obtained. Staff B stated Resident 37's hospice care plan should have included information from the “hospice coordination of care” to make it a more collaborative plan of care. Resident 55 Review of the EHR showed Resident 55 admitted to the facility on [DATE] with diagnoses including dementia, malnutrition, anorexia and adult failure to thrive. The resident was not able to make needs known. Review of the EHR showed the resident was admitted to hospice services on 05/09/2025 and a hospice plan of care/coordination of care was received by the facility on 05/12/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 55's plan of care showed the care plan for hospice services was not integrated into their plan of care until 07/24/2025. During an interview on 07/28/2025 at 10:27 AM, Staff B, DNS, stated the facility should have created a care plan that integrated the hospice services into it but did not until 07/24/2025 and it should have been done sooner. Reference WAC 388-97 -1060 (1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions to prevent/heal pressure injuries were provided for 1 of 2 sampled residents (Resident 2) when reviewed for pressure injury. This failure placed the resident at risk of inability to heal pressure injury, worsening pressure injury, and a diminished quality of life. Findings included .Resident 2Review of the electronic health record showed Resident 2 admitted to the facility on [DATE] with diagnoses to include hemiplegia (paralysis or severe weakness on one side of the body), psychotic disorder with delusions, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Resident 2 was unable to make needs known. Observation on 07/23/2025 at 11:54 AM showed Resident 2 in bed laying on their back with two inflatable boots on the nightstand. Observations on 07/23/2025 at 11:54 AM, 07/24/2025 at 9:30 AM and 2:24 PM, 07/29/2025 at 8:21 AM, and 07/30/2025 at 9:23 AM showed Resident 2 laid on their back in bed and had an air mattress which was set to 660 to 750 pounds (lbs.), lights were flashing on the extra firm and low pressure indicators, and the control unit emitted a loud whirring sound. Review of the care plan, initiated 04/11/2025, showed Resident 2 had a stage three pressure injury to their right foot and a small open area to the left buttock. Interventions included to avoid positioning the resident on their back, float heels (a positioning technique in patient care where the heels are lifted or suspended to prevent pressure injuries), and a pressure relieving mattress. During an interview on 07/30/2025 at 9:25 AM, Staff K, Registered Nurse/Resident Care Manager, stated the facility ensured pressure injury prevention/healing interventions were provided by doing wound care rounds to ensure treatments were provided. Staff K stated they did rounds of resident rooms to ensure pressure reliving devices, such as air mattresses, were functioning properly. Staff K stated the observations of Resident 2's heels not being floated did not meet expectations. During an interview on 07/30/2025 at 9:30 AM, Staff B, Director of Nursing Services, stated facility staff would check on what things were not performed the previous day, and it would be addressed with the floor nurse. Staff B stated air mattresses would alarm if they were not functioning properly to alert staff. Staff B stated Resident 2's air mattress controlling unit had been pushed against the wall, was set to 660 to 775 lbs., and should be set to 174 lbs. Staff B stated their expectation was Resident 2's air mattress was set to the correct setting and their inflatable boot applied. Reference WAC 388-97-1060 (3)(b)

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	505183	A. Building B. Wing	07/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents did not have access to weapons for 1 of 3 sampled residents (Resident 38) when reviewed for accident hazards. This failure placed residents at risk of being assaulted, avoidable injury, and a diminished quality of life. Findings included .Resident 38Review of the electronic health record showed Resident 38 admitted to the facility on [DATE] with diagnoses to include heart disease, dementia (a progressive decline in memory, thinking, reasoning, and judgment, that interfere with daily functioning and social relationships), unspecified psychosis (a mental health condition characterized by a loss of contact with reality), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Resident 38 was able to make needs known. Observation on 07/23/2025 at 9:46 AM showed a piece of rebar (a steel reinforcing rod in concrete) next to Resident 38's sink. Observation on 07/23/2025 at 11:47 AM, 07/24/2025 at 2:32 PM, 07/25/2025 at 11:08 AM, and 07/29/2025 at 9:37 AM showed a piece of rebar next to Resident 38's sink and a baton sticking out from the bedside table drawer which was left ajar. Review of the care plan, initiated on 03/06/2023, showed Resident 38 was at risk for potential alteration in mood/behaviors due to bipolar disorder and unspecified psychosis, had ineffective coping skills, and poor impulse control. Review of an incident report, dated 06/25/2025, showed Resident 38 had an altercation with another resident, called the other resident an expletive, and threatened to pulverize them. During an interview on 07/30/2025 at 9:30 AM, Staff B, Director of Nursing Services, stated the facility ensured residents were not a danger to others by investigating root cause after an altercation and determining an intervention to ensure they were safe. Staff B stated residents with behavioral issues should not have access to weapons. Staff B stated their expectation was facility staff would observe Resident 38's rebar and baton, and intervene as needed. Reference WAC 388-97-1060 (3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure accurate monitoring and documentation for fluid restrictions for 1 of 3 sampled residents (Resident 29) when reviewed for hydration. This failure placed residents at risk for medical complications related to hydration and a diminished quality of life.Review of the electronic health record showed Resident 29 admitted to the facility on [DATE] with diagnoses of type 2 diabetes (when there is too much sugar in the blood) and kidney failure and was receiving dialysis services (when the blood if filtered through a machine to remove waste). The resident was able to make needs known. Review of the provider orders showed an order dated 05/10/2025 for a fluid restriction of 2000 milliliters (ml) daily. There was no documentation of the amount of fluid received from nursing /dietary and the daily total was not calculated and documented in the EHR. During an interview on 07/28/2025 at 9:43 AM, Staff K, Registered Nurse/Resident Care Manager (RN/RCM), stated the facility should divide the fluids between dietary and nursing and calculate the totals at the end of the day. During an interview on 07/28/2025 at 10:15 AM, Staff B, Director of Nursing Services, stated they were aware the fluid restriction orders were not clear, Resident 29's fluid restrictions should have been clarified, and this did not meet expectations. Reference WAC 388-97 -1060 (3)(i)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with providers orders and professional standards of practice for 1 of 1 sampled resident (Resident 5) when reviewed for enteral nutrition. This failure placed the resident at risk for infection, malnutrition, and diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 5 was admitted to the facility on [DATE] with diagnoses that included gastrostomy status (the delivery of nutrients through a feeding tube directly into the stomach or small intestine), heart failure, convulsions (uncontrolled jerking, loss of consciousness) and anoxic brain damage (brain damage from lack of oxygen). Resident 5 was not able to communicate their needs. Review of Resident 5's quarterly minimum data set (MDS, a required assessment tool), dated 06/30/2025, showed Resident 5 was dependent on staff for activities of daily living (ADL) including nutrition. Observation on 07/23/2025 at 12:19 PM, showed Resident 5 was in their bed receiving a feeding formula via tube in the stomach. The feeding formula was in a bag hanging on a pole next to the bed. The feeding formula was dated 07/21/2025 at 3:00 AM. Next to the feeding formula bag was a hanging water bag with no date. The machine infusing the feeding formula was running at 70 milliliters (ml) per hour and showed to have infused 494 ml. The bag providing fluids to Resident 5 was undated and not labeled on 07/24/2025 and 07/25/2025. Observation and interview on 07/28/2025 at 2:25 PM showed Resident 5 was in bed running tube feeding formula and the bed was low to the floor and flat. Staff Q, Licensed Practical Nurse, stated the head of the bed should be elevated to prevent aspiration (breathing material into the lungs). Observation on 07/30/2025 at 8:18 AM showed Resident 5's water bag was dated 07/28/2025 at 10:32 PM. During an interview on 07/30/2025 at 9:02 AM, Staff B, Director of Nursing Services, stated the fluid/water bag and formula bag were to be changed every day during night shift. Staff B stated observations of Resident 5's bags of water and formula, and being flat in bed when receiving formula, did not meet expectations. Reference WAC 388-97-1060 (3)(f)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide prompt follow up on provider's referral for dental care services for 1 of 4 sampled residents (Resident 44) reviewed for dental services. This failure placed Resident 44 at potential risk for continued dental problems, unmet needs, and a diminished quality of life.Findings included. Review of the facility's policy titled, Dental Services, dated November 2017 showed, Dental services are available to residents, including, but not limited to examination, oral prophylaxis [actions taken to prevent disease] and emergency dental care to relieve pain and infection. Review showed, If any resident is unable to pay for dental services, the facility should attempt to find alternative funding sources or delivery systems so that the resident may receive the services needed to meet their dental needs and maintain his/her highest practicable level of wellbeing. Review of the electronic health record (EHR) showed Resident 44 admitted to the facility on [DATE] with diagnoses of diabetes (too much sugar in the blood), high blood pressure, and depression. Resident 44 was able to communicate needs. Observation and interview on 07/23/2025 at 3:28 PM showed Resident 44 with missing and broken upper and lower teeth. Resident 44 stated they wanted to see a dentist to pull out their teeth so they could have dentures. Review of the admission minimum data set (MDS, a required assessment tool) dated 07/15/2025 showed Resident 44 had obvious or likely cavities or broken natural teeth. Review of the order dated 04/17/2025 showed Resident 44 may have dental, vision and eye health, hearing, and podiatry consults as needed. Review of the focus care plan initiated on 04/18/2025 showed, The resident has oral/dental health problems. It showed Resident 44 had a goal to be free of infection, pain or bleeding in the oral cavity by review date/target date of 10/13/2025. Review of the dental visit/consult form dated 05/19/2025 showed Resident 44 had red/irritated gums and broken and missing upper and lower teeth. It showed the dentist made a referral for x-rays, evaluation, and extraction of all teeth. Review showed the dentist recommended hygiene cleaning and documented to talk to family and Resident 44 wanted extractions. Review of the EHR showed no documentation of a scheduled follow up dental appointment after the 05/19/2025 referral was made by the dentist. During an interview on 07/29/2025 at 10:03 AM, Staff M, Social Services Assistant, stated Resident 44 had a dental consultation on 05/20/2025 and needed a follow up appointment for teeth extraction; however, they were unable to locate documentation of a scheduled dental appointment at that time for Resident 44. Staff M stated they still needed to talk to the family. Staff M stated Resident 44 should have had dental issues followed up on sooner and this did not meet expectations. During an interview on 07/29/2025 at 10:18 AM, Staff A, Administrator, stated Resident 44's 05/20/2025 dental referrals/recommendation should have been followed up on prior to now and this did not meet expectations. Reference WAC 388-97-1060 (1), (3)(j)(vii)

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	505183	A. Building B. Wing	07/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to maintain an infection prevention and control program by completing and analyzing infection control data, identifying trends, and completing follow-up activities in response to those trends for 3 of 3 sampled months (April, May, June 2025) when reviewed for infection control. This failure placed the residents at risk for communicable diseases, poor clinical outcomes, and a decreased quality of life. Findings included.Review of the facility policy titled Infection Preventions and Control Program dated 08/2022 showed the surveillance log will include the pathogen and the infection preventionist will use the information to identify trends to minimize further spread and the information would be used to implement changes and/or education to address the trends. Review of the facility infection control line listing documentation for 04/2025, 05/2025 and 06/2025 showed no identified organisms were included in the data. No monthly summary was completed showing the data was analyzed or trends identified and there were no interventions to address the trends. During an interview on 07/29/2025 at 2:22 PM, Staff B, Director of Nursing Services, stated they were aware of the missing tracking, trending, and interventions, and this did not meet their expectations. Reference WAC 388-97-1320 (2)(a)(c)

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	505183	A. Building B. Wing	07/30/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to have an emergency call light system in place that allowed a resident to call for help from their bathroom for 1 of 4 hallways (300 hallway) when reviewed for call light system. This failure placed the resident at risk of not being able to call for assistance, delayed response to a fall, injury, and a diminished quality of life.Findings included . Observations on 07/24/2025 at 9:31 AM and 07/25/2025 at 10:43 AM showed the bathroom in room [ROOM NUMBER] had no emergency call light system. During an interview on 07/24/2025 at 9:31 AM, Resident 1, who resided in room [ROOM NUMBER], stated they used the bathroom and had not noticed that there was no call light in the bathroom. During an interview on 07/25/2025 at 10:49 AM, Staff B, Director of Nursing Services, stated there was not an emergency call light in room [ROOM NUMBER]'s bathroom and there should be. During an interview on 07/25/2025 at 10:49 AM, Staff A, Administrator, stated their expectation was all resident bathrooms had an emergency call light within reach for residents to use. Staff A stated they had not been aware that the bathroom in room [ROOM NUMBER] did not have an emergency call light. Staff A stated it somehow got missed during weekly environmental room rounds. Reference WAC 388-97-2280 (1)(b)(c).