STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505264	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere at Pacific Ridge	3625 East B Street Tacoma, WA 98404

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 29644 Based on observation, interview and record review, the facility failed to provide the required care planned supervision to prevent accidents/falls for 3 of 5 residents (Resident 1, 2 and 3) reviewed for two person assists with transfers. Resident 1 experienced harm when they received care while in bed without two staff assistance which resulted in a fall and shoulder fracture. This failure placed residents at risk for falls, injury and and diminished quality of life. Findings included . <Resident 1> According to the 07/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 was alert and oriented, was dependent on staff to roll left and right in bed, dependent on staff for a chair to bed transfers and had one non injury fall since the previous MDS. Review of the Activities of Daily Living (ADL) Care Plan (CP), showed Resident 1 was totally dependent on staff for repositioning and turning in bed, two person maximum assist (initiated 12/13/2023). Review of the risk of falls CP revised showed Resident 1 had a non injury fall from the bed on 12/24/2023 and was a two person assist for cares in bed to prevent rolling out (initiated 01/02/2024). Review of the Nursing Assistant documentation for support provided to assist Resident 1 to roll left and right showed only one person assist was provided on one to two shifts daily from 06/16/2024 through 07/04/2024, and on 07/06/2024. Review of the facility 07/06/2024 incident investigation showed that at 11:15 AM the facility was notified of an incident involving Resident 1 and Staff D, Nursing Assistant Certified (NAC). Staff D was providing incontinence care alone. Resident 1 turned toward Staff D in an attempt to assist the staff providing the care, however rolled over too far and slid down the bed between the frame and Staff D. Staff D attempted to prevent Resident 1 from rolling off the bed by grabbing Resident 1's right arm, however could not stop the rolling and lowered Resident 1 to the floor. Review of the Emergency Department After Visit Summary dated 07/06/2024 showed Resident 1 was diagnosed with a closed fracture of the proximal end of the right humerous (the largest bone of the upper extremity, the upper arm bone). (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes dated 07/08/2024 showed Resident 1 had a sling on with bruises and swollen shoulder. Resident 1 was medicated for pain with some effectiveness. During an interview on 07/10/2024 at 11:33 AM, Resident 1 stated staff were changing me and I had to roll to the side and I rolled out of bed. They caught me with my arm so I got a fractured shoulder. During an interview on 07/10/2024 at 11:47 PM, Staff C, Interim Director of Nursing, stated that Staff D had been provided one on one training to read and follow the plan of care, and completed a skills competency prior to returning to work on the floor. During an interview on 07/19/2024 at 12:15 PM, Staff D stated prior to the incident, they were giving care while waiting for someone to assist them and Resident 1 rolled towards them and slipped out of bed. Staff D stated they instinctively grabbed Resident 1's arm to try to keep them from falling and then lowered Resident 1 to the floor. On 07/19/2024 at 12:21 PM Staff D and Staff E, NAC, were observed to provide care to Resident 1. Resident 1 was observed to lift their pelvis up and Staff D placed a clean incontinence product underneath the resident. When asked why they had rolled the resident during the incident, Staff D stated it was how they changed Resident 1. Resident 1 stated, I don't do that anymore. Staff E stated to Resident 1, I didn't know you could lift your hips. While applying a splint, Staff E started to roll Resident 1 who stated, I can't roll and I can't. Staff D stated Resident 1 gets very nervous now. Staff E reassured Resident 1 as they carefully turned the resident towards staff D. Resident 1 yelled out, Ouch, my shoulder ouch, it hurts real bad! The staff waited and let the resident take a break before transferring the resident into a wheelchair using a mechanical lift. The resident's bed was an alternating air mattress, which the staff did not adjust prior to moving or transferring the resident. During an interview on 07/19/2024 at 1:13 PM, Staff B, Director of Nursing, stated the level of assistance a resident requires was determined by assessments by the admitting nurse or by therapy. Staff B stated they expected the Nursing Assistant to check the care plan at the beginning of the shift, prior to providing care. Staff B stated prior to providing care, the staff were expected to set air mattresses to firm or transfer depending on the mattress. <Resident 2> According to the 05/24/2024 Significant Change MDS Resident 2 was assessed with moderate cognitive impairment, required substantial assistance to roll left and right, was dependent on staff for chair to bed transfers and had two non injury falls since the previous MDS. Review of the 02/26/2024 ADL CP showed Resident 2 required two person moderate assist for transfers. Review of the Nursing Assistant documentation for support provided to assist Resident 2 in a chair/bed to chair transfer, showed only one person assist was provided on one to two shifts on 06/25/2024, 06/26/024, 06/29/2024 through 07/03/2024, 07/05/2024 through 07/09/2024, 07/11/2024 through 07/19/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/19/2024 at 10:47 AM Resident 2 was observed asleep in bed. On 07/19/2024 at 12:41 PM, Resident 2 was observed up in a wheelchair in the dining room eating lunch. On 07/19/2024 at 12:41 PM, Resident 2 did not know who had assisted them out of bed. When asked how many staff assisted them, Resident 2 replied, One as far as I know. On 07/19/2024 at 12:52 PM, Staff F, Nursing Assistant, stated they had assisted Resident 2 up for lunch, by themselves. Staff F stated they were not aware that Resident 2 was a two person assist for transfers. <Resident 3> According to the 04/17/2024 Quarterly MDS, Resident 3 was assessed as dependent on staff for rolling left and right. Review of the 02/08/2023 high risk for falls CP showed Resident 3 was a two person assist for cares in bed to prevent rolling out. The 04/22/2023 ADL CP showed the resident required a mechanical lift for transfers by two staff. Review of the Nursing Assistant documentation for support provided to assist Resident 3 to roll left and right showed only one person assist was provided on one to two shifts daily from 06/16/2024 through 07/02/2024, and on 07/04/2024 through 07/09/2024. On 07/19/2024 at 11:11 AM, Resident 3 was observed in bed with one Nursing Assistant present assisting the resident to wash their face and hands. During an interview Resident 3 stated that staff used two people to assist them with transfers using a mechanical lift, but only used one person, sometimes two, when they assisted the resident to change their briefs. REFERENCE: WAC 388-97-1060(3)(g).