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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505264 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/04/2024 |
| NAME OF PROVIDER OR SUPPLIER Avamere at Pacific Ridge | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644</p> <p>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 sample residents (Resident 1, 2 & 3) reviewed for two person assists with transfers. Resident 1 experienced harm when they received care without two staff assistance which resulted in a fall, hospitalization and diagnosis of a traumatic brain injury (TBI). This failure placed residents at risk for falls, injury and a diminished quality of life.</p> <p>Findings included .</p> <p><Resident 1></p> <p>According to the 07/22/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 required substantial to maximal assistance with standing, transfers, toileting hygiene, and was dependent for lower body dressing.</p> <p>Review of the Self-Care Performance Deficit Care Plan (CP), dated 07/16/2024, showed Resident 1 required extensive assistance of two staff to dress, for toileting and with transfers.</p> <p>Review of the Nursing Assistant documentation, dated 09/05/2024 through 09/24/2024, showed only one person assistance was provided on one to two shifts daily with toileting hygiene on 20 of 20 days, with toileting on 17 of 20 days, and with bed to chair transfers on 18 of 20 days.</p> <p>Review of a Nursing Care Note, dated 09/24/2024 at 7:56 PM, showed Resident 1 fell on to the floor and sustained a large laceration to their right eyebrow. 911 was called for transport to the Emergency Department.</p> <p>Review of the Fall Scene Investigation Report, dated 09/24/2024, showed Resident 1 was receiving care from Staff C, Certified Nursing Assistant (CNA) when they fell . There were no other staff present at the time of the fall. Resident 1 was being transferred by one staff.</p> <p>Review of the Incident Report, dated 09/24/2024, showed Staff C was transferring Resident 1 from their wheelchair into bed. Resident 1 stood up and as Staff C pulled up Resident 1's pants. Resident 1 slipped from Staff C's hold, fell forward and hit their head on the floor. The resident was assessed with a 3.5 centimeter (cm) laceration (cut or tear) to their right eyebrow.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>According to the facility investigation Staff C was interviewed on 09/27/2024 and prior to the incident, Staff C did not know Resident 1 required two person extensive assist with Activities of Daily Living (ADLs).</p> <p>During an interview on 10/04/2024 at 10:28 AM, Staff B, Interim Director of Nursing, stated Staff C should have but did not get assistance of another staff to provide care to Resident 1.</p> <p>Review of hospital records showed Resident 1 was in the hospital from 09/24/2024 until 09/27/2024, where the resident was diagnosed with a TBI as medical imaging showed subdural hematoma (SDH - blood pools between the brain and the skull) on the left and right side of the resident's head. Additionally, Resident 1 had bruising and swelling to their right eyelid and a 6 cm laceration over their right brow which required stitches.</p> <p>Review of the Nursing Assistant documentation, dated 09/27/2024 through 10/04/2024, after return from the hospital, showed only one person assist was provided on one to two shifts daily with toileting hygiene on 7 of 8 days, with toileting on 2 of 8 days, and with bed to chair transfers on 4 of 8 days.</p> <p>On 10/04/2024 at 12:30 PM, Resident 1 was observed up in a wheelchair, eating lunch. Resident 1 was unable to answer questions asked regarding the incident.</p> <p>During an interview on 10/04/2024 at 1:07 PM, Staff B, stated a peace sign posted on a resident's doorway indicated the resident required two person assist with transfers and/or ADLs. Staff B stated Resident 1 required two person assist for transfers, for care, and cleaning and should have a peace sign posted.</p> <p>On 10/04/2024 at 11:02 AM, 12:30 PM, 1:05 PM Resident 1's room was observed without a peace sign.</p> <p><Resident 2></p> <p>According to the 08/15/2024 Quarterly MDS Resident 2 was assessed as dependent on staff for toileting hygiene and required substantial/maximal assistance for chair to bed transfers.</p> <p>Review of the 02/26/2024 Self-Care Performance Deficit CP and Kardex showed Resident 2 required two person assist for stand pivot transfer with gait belt.</p> <p>On 10/04/2024 at 11:02 AM, Resident 2's room was observed with a peace sign posted. At 11:14 AM, Resident 2 was observed in bed. At 11:34 AM, Resident 2 was observed seated up in a wheelchair. In an interview at that time, Resident 2 stated one staff assisted them up.</p> <p>On 10/02/2024 at 11:36 AM, Staff D, CNA, stated that they were assisted by Staff E, CNA, to get Resident 2 out of bed. Review of the Nursing Assistant documentation showed Staff D documented transferring Resident 2 with one person assist on 10/03/2024, but two person assist on 10/04/2024.</p> <p>On 10/02/2024 at 11:41 AM, Staff E stated Staff D changed Resident 2 and then summoned Staff E who assisted Staff D to transfer Resident 2 into the wheelchair. Staff E stated the Kardex stated Resident 2 was a one person stand pivot transfer, but they tried to do two person assist to be safe.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Further review of the Nursing Assistant documentation, dated 09/05/2024 through 10/04/2024, showed only one person assist was provided with bed to chair transfers on one to two shifts daily on 17 of 30 dates.</p> <p><Resident 3></p> <p>Resident 3 admitted to the facility on [DATE]. Review of the 10/02/2024 Self-Care Performance Deficit CP and Kardex showed Resident 3 required two person assist for bed mobility and transfers.</p> <p>Review of Nursing Care Notes, dated 10/02/2024 at 9:36 PM and 10/04/2024 at 1:16 AM, showed nursing staff documented Resident 3 needed one person assist with full ADLs, transfers and toileting.</p> <p>Review of Nursing Assistant documentation, dated 10/03/2024, showed only one staff person assisted with transfers.</p> <p>On 10/04/2024 at 11:02 AM, Resident 3's room was observed with a peace sign posted.</p> <p>During an interview on 10/04/2024 at 11:17 AM, Resident 3 stated they thought that two staff should assist them with mobility, but depending on the shift, sometimes there was only one assistant.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p> |