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	12/12/2025

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 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. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a wound was fully assessed on admission and weekly as ordered, was monitored, and changes reported as needed for 1 of 3 sampled residents (Resident 1) reviewed for wound care. This failure placed the resident at risk for pain, deterioration in condition, and diminished quality of life. Findings included .The facility's policy, Wound Management Guidelines, revised 03/31/2025, stated that on admission the admitting nurse or designee would complete a skin evaluation and document the patient's skin condition in the resident's clinical record. The policy also stated that actual pressure injuries, venous stasis ulcers, arterial ulcers, diabetic/neuropathic ulcers and open surgical wounds would have weekly documentation that included measurements and how the wound was progressing (improvement, worse, unchanged). Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, for skilled nursing care of a wound on their lower leg. The Minimum Data Set, dated [DATE], documented Resident 1 was cognitively impaired and required assistance with the activities of daily living. Hospital discharge documentation, dated 06/24/2025 documented Resident 1 was diagnosed with cellulitis on one lower leg, was stable for discharge to a skilled nursing facility for rehabilitation and wound healing, and was to have outpatient podiatry and wound care appointments. On 09/08/2025 at 11:40 AM, a collateral contact reported Resident 1's care team and representative kept pressing the facility about their concerns thinking the resident should go to the ER or get a consultation about their wound. The collateral contact said later that exact same day another doctor went and looked at the wound, and said the resident needed to go to the ER. Resident 1 left and was admitted to the hospital to have the wound surgically debrided (removal of dead, damaged or infected tissue). On 09/29/2025 at 1:03 PM, Resident 1's representative said they had concerns about the resident's wound care while at the facility and when they asked questions about it, they got shut down and told the staff knew what they were doing. Then the doctor came in the next day and Resident 1 was sent to the hospital. The representative said they were told when Resident 1 got to the hospital the smell of the wound was horrific and the resident had an infection down to the tendon, and would need surgery to take out the bad tissue and to be put on antibiotics right away. On 09/29/2025 at 12:27 PM, Staff C, a Licensed Practical Nurse (LPN), said when they did Resident 1's dressing change, they concerned about the wound and called the provider, who was there, came over and looked at the wound and sent the resident out. Staff C said while she was doing the dressing change, they had seen a white area and thought it was a tendon but was not sure. So the provider saw that and because she was having more pain, the provider said the resident should go to the hospital. When asked, Staff C said no, seeing a tendon is not normal. You should not see that. On 09/29/2025 at 1:51 PM, Staff D, an LPN and the facility wound nurse, said they had started working at the facility in July of 2025. Staff D said the previous wound nurse wanted to change shifts and Staff D offered to take over and try to help everybody out. When asked, Staff D said they were trained by following the previous wound care nurse around. Staff D said they learned how to measure wounds from a wound clinic staff who brought supplies to the facility sometimes. Staff D said if they had a concern, they would get the provider on call and have them look at the wound if they possibly could. And if it had a weird odor then they could swab it (get a sample to send to the lab for analysis). Staff D said when Resident 1 came in, they had eschar (dead tissue, black tissue) over their wound. And with the dressing changes finally that dead tissue started to come off. The wound clinic changed the dressing changes from daily to every other day or every third day, and wanted us to put this gentamicin (antibiotic) ointment on it. Once we started to notice an odor in it, we let the provider know there's an odor and we got a culture. On 09/29/2025 at 3:29 PM, Staff E, a provider (advanced registered nurse practitioner), said they try to coordinate with the facility wound nurse so they can look at residents' wounds. When asked about being able to see a tendon in a foot wound, Staff E said, if they saw a tendon, they would get a wound care consult to see if the resident needed to be on antibiotics or something, because that would be a good way to lose a foot. Review of Resident 1's admission Nursing Database, dated 06/24/2025 at 5:38 PM, documented under Skin Integrity, the resident had a skin tear and another open wound. No location, measurements or other description of the wounds was located on the admission assessment. Under the section, Daily Services, boxes for daily rehabilitation and daily wound care were marked. A document titled admission Skin Check, dated 06/24/2025 included a front and back body diagram, on which areas were circled, including circles that denoted rashes to the front and back peri areas, pitting edema (swelling that is persistent) to one lower leg, a