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	04/23/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when medications were not administered per physician orders for 1 of 3 residents (Resident 1) reviewed for medication management. Resident 1, who was newly placed on an anticoagulant (blood thinning) medication to treat multiple blood clots, experienced harm when the facility failed to administer the medication resulting in pain, increased swelling, and required inpatient treatment at the hospital. This failure placed residents at risk for medical complications, unintended health consequences, and a diminished quality of life. Findings included .The facility's policy entitled Medication and Treatment Orders, approved 11/2025, stated that orders for medications and treatments will be consistent with principles of safe and effective order writing, and that orders for anticoagulants will be prescribed only with appropriate clinical and laboratory monitoring, and that the attending physician must periodically record in the progress notes the results of the laboratory monitoring and review for potential complications. Resident 1 was admitted to the facility on [DATE] with multiple diagnoses to include heart disease, congestive heart failure, end stage renal disease, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia (low blood levels of oxygen), and required the use of supplemental oxygen, and had a blood clot in one lower leg diagnosed in February 2026, and a blood clot in one of their upper arms diagnosed in March 2026. Review of Resident 1's electronic health record showed the resident discharged from the hospital to the facility on [DATE] with orders for Coumadin (also known as warfarin, an anticoagulant for prevention and treatment of blood clots) to be given daily for treatment of a deep vein thrombosis (DVT (blood clot)) in their upper arm as well as their lower leg. Review of Resident 1's electronic health record at the facility showed that on 03/26/2026 the resident's Coumadin was discontinued. Review of the resident's record did not include a reason the medication was discontinued, or the substitution of a different medication to treat the resident's blood clots. On 03/30/2026 the provider documented they saw the resident for evaluation of missed warfarin doses, noted the resident had not received warfarin for 5 days, and that nursing had reported increased right foot swelling. The provider noted a change in the resident's condition in that they had worsened breathing and leg swelling, and documented a concern for recurrent blood clot formation and complications given the missed doses of warfarin for 5 days and Resident 1's history of large DVT/PE (pulmonary embolus, a blood clot that affects the lungs). The provider ordered the resident to be sent to the hospital for reevaluation, reinitiation of intravenous (IV) anticoagulation medication and transition back to the warfarin. Review of 03/30/2026 hospital documentation showed the resident was sent to the hospital emergency room for evaluation of worsening left arm pain and swelling. Hospital pharmacy staff contacted the facility and found out Resident 1 did not receive the Coumadin (warfarin) since they last discharged from the hospital on [DATE]. The resident was evaluated and admitted for treatment of the blood clot and restarted on the warfarin as well as the IV anticoagulant medication. Review of facility investigation documentation initiated on 03/30/2026, documented the facility identified a system breakdown when the medication was discontinued and not resumed, and also noted that no doses of the anticoagulant medication had been given since the resident was readmitted . The investigation noted that after the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	medication was discontinued, no replacement or revised anticoagulation order was entered following the discontinuation, resulting in an interruption of therapy. The investigation also noted that there was no documented follow-up or clarification after the discontinuation to ensure anticoagulation was resumed despite the resident having an active diagnosis of DVT that required ongoing treatment. On 04/23/2026 at 12:18 PM, Staff B, a Registered Nurse and the interim Director of Nursing Services, stated that residents who were on coumadin were to be discussed during clinical morning meetings. When asked about new orders, and particularly orders anticoagulant therapy, Staff B said either the providers could put them in or the nurses would put them in and the resident care managers (RCMs) would cross-verify the orders. Staff B said their expectation is for residents on anticoagulant therapy to receive medications as ordered and for their treatment to be monitored and follow-up provided. On 04/23/2026 at 12:54 PM, Staff A, the facility Administrator, acknowledged the facility had identified a breakdown in communication regarding Resident 1's medication therapy. Refer to WAC 388-97-1060(3)(k)(iii).