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	04/26/2024

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation and interview, the facility failed to maintain a homelike environment in resident areas for 3 of 4 halls (Halls 100, 200, and 400) when reviewed for environment. This failure placed residents at risk of decreased mood and a diminished quality of life. Findings included . Observation on 04/22/2024 showed the light fixture above the bathroom sink in rooms [ROOM NUMBERS] did not have a cover and the light bulbs were exposed. Observation on 04/26/2024 showed that the bathroom light fixtures in Rooms 110, 114 and 405 did not have a cover and the light bulbs were exposed. Observation on 04/22/2024 at 10:48 AM showed the wall in room [ROOM NUMBER] had deep gouges with flaking drywall which had accumulated on the ground. Observation on 04/22/2024 at 1:17 PM showed the corner near the bathroom of room [ROOM NUMBER] had damaged drywall which was covered by yellow and blue tape. Observation on 04/26/2024 showed that the deep gouges in room [ROOM NUMBER] and damaged drywall in room [ROOM NUMBER] continued. Observation on 04/26/2024 showed the bathroom ceiling vent cover in room [ROOM NUMBER] was missing and the inside of the vent was visible. During an interview on 04/26/2024 at 10:00 AM, Staff N, Maintenance Director, stated staff would report damage to the maintenance department for repair and the maintenance department would conduct an audit to identify needed repairs. Staff N stated light fixtures should have covers and the bathrooms of rooms [ROOM NUMBER] did not. Staff N stated damage to walls should be repaired and the damage to the wall in room [ROOM NUMBER], being covered with tape, did not meet expectation. Staff N stated the vent in the bathroom of room [ROOM NUMBER] should be covered. During an interview on 04/26/2024 at 10:17 AM, Staff A, Administrator, stated repairs were reported to maintenance through a weekly audit. Staff A stated light fixtures should have covers, wall damage should be repaired, and all vents should be covered. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-0880

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to have system and timely resolution of a grievance for 1 of 3 sampled residents (Resident 31) reviewed for grievances. Failure to ensure grievance/concerns were addressed and resolved timely had the potential to affect the resident's quality of life. Findings included . Resident 31 was admitted to the facility on [DATE] from an acute care hospital. Review of the annual comprehensive Minimum Data Set assessment, dated 10/09/2023, showed Resident 31 was admitted with diagnoses of anxiety, depression, post-traumatic stress disorder, renal insufficiency, and had intact cognitive functions. During an interview on 04/22/2024 at 11:48 AM, Resident 31 stated staff were not listening to their complaints. Resident 31 stated staff were not treating them well because their roommate had an iPad, and the volume was loud and was disturbing her. Resident 31 had reported their concern to staff, but the staff were not listening. Resident 31 stated they told staff a simple solution was to give the roommate headphones. Review of nursing progress notes from 04/17/2024 and 04/20/2024 showed Resident 31 had been upset, yelled at their roommate, and asked for headphones on two occasions. During interview on 04/24/2024 at 9:49 AM, Staff R, Administer-in-Training/Grievance Official, stated no grievance for Resident 31 had been generated and they were unaware Resident 31 had any concerns. During an interview on 04/24/2024 at 1:46 PM, Staff B, Director of Nursing Services, stated the expectation was to fill out a grievance form at the time a resident voiced a concern. Reference WAC 388-97-0460(1)(2)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written notification of the reason for transfer/discharge to the resident or responsible party for 3 of 3 sampled residents (Residents 81, 24 and 33) reviewed for hospitalization . This failure placed the residents at risk for diminished protection from being inappropriately discharged . Findings included . Resident 81 Review of Resident 81's 01/21/2024 discharge minimum data set (MDS, a required assessment tool) showed the resident discharged to the hospital on 01/21/2024 with return anticipated and the resident's MDS tracking showed Resident 81 readmitted to the facility on [DATE]. Review of Resident 81's electronic health record (EHR) showed no documentation that a written notice of transfer/discharge was provided to Resident 81 and/or a responsible party for the transfer to the hospital on 01/21/2024. During an interview on 04/23/2024 at 1:11 PM, Staff E, Social Service Director, stated they were unaware that written notices were required to be provided to residents and that they had not been. During an interview on 04/24/2024 at 12:44 PM, Staff A, Administrator, stated their expectation was that all residents received written and verbal notice of transfer/discharge. 38344 Resident 24 Review of Resident 24's 06/10/2023 discharge MDS showed the resident discharged to the hospital on 06/10/2023 with return anticipated and the resident's MDS tracking showed Resident 24 readmitted to the facility on [DATE]. Resident 24's 06/30/2023 discharge MDS showed the resident discharged to the hospital on 06/30/2023 with return anticipated and the resident's MDS tracking showed Resident 24 readmitted to the facility on [DATE]. Review of Resident 24's EHR showed no documentation that a written notice of transfer/discharge was provided to Resident 24 and/or a responsible party for the transfer to the hospital on 06/10/2023 or 06/30/2023. During an interview on 04/25/2024 at 4:54 PM Staff B, Director of Nursing Services, stated that notifications of transfers to the hospital were made verbally and there were no documented written notice of transfers completed and provided to Resident 24 for the transfers to the hospital on 06/10/2023 or 06/30/2023. Resident 33 (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of Resident 33's 10/29/2023 discharge MDS showed the resident discharged to the hospital on 10/29/2023 with return anticipated and the resident's MDS tracking showed Resident 33 readmitted to the facility on [DATE]. Review of Resident 33's EHR showed no documentation that a written notice of transfer/discharge was provided to Resident 33 and/or a responsible party for the transfer to the hospital on 10/29/2023. During an interview on 04/25/2024 at 4:44 PM, Staff B stated that Resident 33's notifications of transfers to the hospital were made verbally and there was no documented written notice of transfers completed and provided to Resident 33 for the transfer to the hospital on 10/29/2023. Reference WAC 388-87-0120(2)(a-d), -0140 (1)(a)(b)(c)(i-iii)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide a bed hold notice in writing at the time of transfer to the hospital or within 24 hours of transfer to the hospital for 2 of 3 sampled residents (Residents 81 and 33) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital and diminished quality of life. Findings included . Resident 81 Review of the medical record showed Resident 81 admitted to the facility on [DATE] and was able to make needs known. Review of a progress note dated 01/21/2024 at 6:02 AM showed Resident 81 was transported to the hospital due to a complaint of sharp chest pain. Review of the electronic health record (EHR) showed no documentation that a bed hold was offered, nor the bed hold notice had been provided to the resident or the resident's representative. During an interview on 04/23/2024 at 1:11 PM, Staff E, Social Service Director, reviewed the EHR and stated a bed hold should have been offered and a written notice provided but had not been. During an interview on 04/24/2024 at 12:44 PM, Staff A, Administrator, stated the expectation was that all residents were offered a bed hold upon transfer to the hospital and administration would follow up the next day. 38344 Resident 33 Review of Resident 33's 10/29/2023 discharge MDS showed the resident discharged to the hospital on 10/29/2023 with return anticipated and the resident's MDS tracking showed Resident 33 readmitted to the facility on [DATE]. Review of Resident 33's EHR showed no documentation that Resident 33 was offered a bed hold for the transfers/discharges on 10/29/2023. During an interview on 04/25/2024 at 4:20 PM, Staff E stated they were unable to locate documentation that a bed hold was provided to Resident 33. During an interview on 04/25/2024 at 4:44 PM, Staff B, Director of Nursing Services, stated there was no bed hold documentation for Resident 33 and there should have been. Reference WAC 388-97-0120 (4) (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	.

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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** 34567 Based on interview and record review, the facility failed to accurately assess 2 of 22 residents (Residents 72 and 5) when reviewed for accuracy of assessments. This failure placed the residents at risk of not receiving the care and services required to meet the residents' needs and inaccuracies in their care planning. Findings included . Resident 72 Review of Resident 72's admission minimum data set (MDS, a required assessment tool), dated 03/18/2024, showed the resident was admitted on [DATE] with multiple diagnoses to include heart/lung disease, diabetes and for post-surgical care for partial amputation of both right and left foot. The MDS showed the resident was able to make their needs known. During an interview on 04/22/2024 at 11:43 AM, Resident 72 stated that they had diabetes but did not receive any insulin in the facility. Review of Resident 72's medication administration record (MAR) for March 2024 and April 2024 showed the resident did not have a provider's order for insulin and had not received any insulin. Review of Resident 72's MDS Medicare 5-Day assessment showed that the resident was coded in section N to have received insulin injections during the last 7 days since admission. During an interview on 04/24/2024 at 9:20 AM, Staff G, Registered Nurse/MDS Coordinator, stated Resident 72 was no longer on insulin and that the MDS entry was an error and would now need to be modified. During an interview on 04/24/2024 at 9:31 AM, Staff B, Director of Nursing Services (DNS), stated that it was their expectation that the MDS assessment would be correct and if Resident 72 did not receive insulin in that time period, then the MDS would now need to be modified to correct the error. 49926 Review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual showed OPEN LESION(S) OTHER THAN ULCERS, RASHES, CUTS Most typically skin lesions that develop as a result of diseases and conditions such as syphilis and cancer. Resident 5 Resident 5 was admitted to the facility on [DATE]. Review of the annual comprehensive MDS showed that Resident 5 had diagnoses of diabetes, osteomyelitis (bone infection) in the sacral (lower back) area, non-pressure chronic ulcer to buttocks, Alzheimer dementia and was cognitively impaired. Section M of the MDS was checked that Resident 5 had a lesion and coded 0 for pressure ulcer. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's discharge history and physical from the last hospital admission, dated 05/26/2023, showed the resident had a pressure ulcer on the lower back. Review of a provider's progress note, dated 04/24/2024, showed chronic stage IV decubitus ulcer. Reviewed of Resident 5's outside wound provider's progress note, dated 04/18/2024, showed chronic ulcer. Observation on 04/24/2024 at 11:49 AM showed a large wound on Resident 5's sacral area over a bony area. During an interview on 04/24/2024 at 1:31 PM, Staff S, Licensed Practical Nurse/MDS Coordinator (MDSC) and Staff G, Registered Nurse/MDSC, stated Resident 5's MDS was not coded as a pressure ulcer per prior assessment. During an interview on 04/25/2024 at 12:06 PM, Staff AA, Adult Registered Nurse Practitioner (ARNP), stated that Resident 5 had a chronic ulcer. Reference WAC 388-97-1000(1)(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to ensure nursing staff were following provider's orders for medication administration for 1 of 5 sampled residents (Resident 18) reviewed for unnecessary medications. In addition, the facility failed provide a psychiatry referral per provider's recommendation for 1 of 2 sampled resident (Resident 184) when reviewed for behavioral health care needs. This failure placed the residents at potential risk of having adverse side effects, medication errors and unmet care services. Findings included . Resident 18 Resident 18 was admitted on [DATE] with diagnoses of diabetes, stroke, chronic kidney disease, anxiety, and depression. Review of the minimum data set (MDS, a required assessment tool), dated 03/18/2024, showed Resident 18 could make needs known. Review of Resident 18's provider's orders showed an order for hydralazine (used to treat high blood pressure) and to hold the medication if the systolic blood pressure was less than 120. Review of Resident 18's medication administration records showed the resident received the medication when the systolic blood pressure was less than 120 on eight of 93 administrations in March 2024 and 18 of 75 administrations in April 2024. During an interview on 04/24/2024 at 11:49 AM, Staff B, Director of Nursing Services (DNS), stated Resident 18's medicine should have been held. 34567 Resident 184 Review of the entry MDS, dated [DATE], showed Resident 184 was admitted on [DATE]. The electronic health record (EHR) showed that Resident 184 was admitted with multiple diagnoses including muscle weakness, malnutrition (state of inadequate intake of food, as a source of protein, calories, and other essential nutrients), depression, and anxiety. The provider ordered multiple psychotropic medications (affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), to include an antidepressant and antipsychotic/antianxiety medications. The resident was able to make needs known. Observation and attempted interview on 04/22/2024 at 11:04 AM showed Resident 184 laid in bed in their room. The resident appeared anxious on approach and yelled out loudly, What do you want? An attempt to communicate with the resident resulted in additional yelling and lacked constructive dialogue. The overall appearance of the resident was disheveled as they laid in bed within a darken room. The resident wore a hospital gown, their toenails were long and yellow, their long gray beard was unkempt, and their hair appeared greasy and uncombed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of multiple clinical progress notes within Resident 184's EHR showed LNs had documented the following: 04/15/2024 - Resident yelling out, difficult to console., 04/17/2024 - Resident refusing skin evaluation, moody, fearful, yell frequently, overly fearful about people, resists care and changing briefs, refused weight today, 04/22/2024 - Resident continues to refuse care and yelling to be left alone. 04/23/2024 - behavior/yelling outburst while visit with a case worker. Review of a providers clinical progress note, dated 4/15/2024, showed that a psych (psychiatry) referral would be ordered; however, review of Resident 184's EHR showed no order for a psych referral was generated. During an interview on 04/24/2024 at 12:55 PM, Staff E, Social Services Director (SSD), stated Resident 184's behavior was supposed to be tracked by the residential care manager; however, Staff E, SSD, stated that the increased behavioral issues the resident experienced would need to be addressed and that the initial preadmission screening and resident review (PASSR, an evaluation conducted to ensure nursing home residents receive appropriate [behavioral] care and services) would need to be updated to address the residents increased behaviors and diagnoses related to general anxiety disorder and major depressive disorder. During an interview on 04/24/2024 at 1:01 PM, Staff O, Adult Registered Nurse Practitioner (ARNP), stated that they were aware of Resident 187's increasing behaviors of yelling out and refusal of care; however, they stated they had documented the resident required a psych referral but the facility must have not placed the referral for psych services since it was not in the resident's order summary, but should have been. Reference WAC 388-97-160(2)(b)

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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** 34567 Based on interview and record review, the facility failed to consistently monitor and document bowel movements (BM) and implement the bowel program when needed for 2 of 3 residents (Residents 61 and 40) reviewed for bowel protocol. This failure placed the residents at risk for worsening condition, discomfort, and a decreased quality of life. Findings included . Review of a facility's policy titled, Avamere Living - Bowel Care Protocol, dated 10/2020, showed the policy of the facility was to monitor the bowel records of residents to assure that they attained a normal bowel pattern without complications. If the resident had not had a bowel movement for three consecutive days (must be medium or large), then staff were to administer the bowel protocol that the provider had ordered. Resident 61 Review of the admission minimum data set (MDS, a required assessment tool), dated 01/23/2024, showed the resident admitted on [DATE] with diagnoses to include lung disease, fracture of spine, opioid abuse (medication used to reduce moderate to severe pain) and constipation. The resident was able to make needs known. During an interview on 04/23/2024 at 8:58 AM, Resident 61 stated that they had problems with constipation at the facility. Review of Resident 61's care plan, dated 04/02/2024, showed the resident had potential for constipation related to decreased mobility and opioid use. The goal was for the resident to have a normal bowel movement (BM) at least every three days. Interventions included to follow the facility's bowel protocol for bowel management. Staff were to monitor/document/record BM pattern each day. Review of Resident 61's electronic health record (EHR), task section, for bowel documentation showed staff had documented multiple dates whereas the resident did not have a BM documented: 03/01/2024 to 03/09/2024 (nine days), 03/13/2024 to 03/16/2024 (four days) and 03/25/2024 to 03/30/2024 (six days). Review of Resident 61's medication administration record (MAR) for March 2024 showed the resident's provider had ordered multiple medications to be administered by the licensed nurse (LN) as needed for constipation: Dulcolax suppository (a medication used in the treatment of constipation) for no BM for four days, Fleets enema for constipation, Polyethylene glycol every 24 hours as needed for constipation. The documentation showed that the polyethylene was the only as needed constipation medication that was administered one time on 03/09/2024. During an interview on 04/23/2024 at 12:24 PM, Staff H, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated it was their expectation that the medication nurse checked the bowel record every shift and started the bowel protocol as ordered if the resident did not have a BM within the ordered time frame. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46148 Resident 40 Review on 04/23/2024 of Resident 40's EHR showed the resident admitted on [DATE] with diagnoses of dysthymic disorder (a fluctuating mood disorder) and right leg fracture. The resident was placed on hospice (end-of-life) care on 03/08/2024. Review of the April 2024 bowel monitor showed Resident 40 had no documented BM for six days between the dates of 04/01/2024 through 04/06/2024, and no documented BM for four days between the dates of 04/08/2024 through 04/11/2024. Review of the EHR showed no as needed bowel medications for constipation were administered between 04/01/2024 through 04/12/2024. During an interview on 04/23/2024 at 2:22 PM, Staff D, Licensed Practical Nurse (LPN), stated the nurses would go to the dashboard in the EHR and check alerts every shift for which resident required as needed bowel medications. During an interview on 04/23/2024 at 2:37 PM, Staff C, RCM/LPN, stated the facility had a bowel protocol which included to administer as needed bowel medication after three days with no BM. Staff C stated that Resident 40 should have received a as needed bowel medication after three days without a BM. During an interview on 04/23/2024 at 2:41 PM, Staff B, Director of Nursing Services, stated it was their expectation that nurses monitored the EHR dashboard during their shifts and administered bowel medications as needed. Staff B stated Resident 40 should have had an alert on the EHR dashboard for no BM on 04/04/2024, 04/05/2024, 04/06/2024 and 04/11/2024 and been administered as needed bowel medications. Reference WAC 388-97-1060 (1)

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	505264	A. Building B. Wing	04/26/2024

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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** 38344 Based on observation, interview, and record review, the facility failed to have a clear system in place to monitor and accurately document fluids consumed to ensure fluid restrictions (a diet which limits the amount of daily fluid intake) was implemented per provider's orders for 1 of 2 sampled residents (Residents 24) reviewed for fluid restrictions. These failures placed the resident at risk for medical complications, unmet needs, and a diminished quality of life. Findings included . Review of the quarterly minimum data set assessment dated [DATE] showed that Resident 24 admitted to the facility on [DATE] with diagnoses to include malnutrition (a condition when the body does not get enough nutrients/poor nutrition), dysphagia (difficulty swallowing), had a feeding tube (a tube inserted through the skin and directly into the stomach or small intestine to provide liquid food), received dialysis (treatment to filter wastes and water from the blood) services, was provided a mechanically altered diet, and was able to make needs known. Review of Resident 24's care plan, initiated 10/31/2023, showed an intervention, Dialysis Fluid Restrictions: 1200 ML. Dietary: 600 ML/day [per day] Nursing: 600 ML/day. Review of Resident 24's Kardex (directions to provide care,) dated 04/25/2024, showed, Dialysis Fluid Restrictions: 1200 ML. Dietary: 600 ML/ day Nursing: 600 ML / day and Intake (240 ML for days, 240 ML for evenings, 120 ML for NOC [night shift]. Review of the diet order, dated 02/13/2024, showed Resident 24 was prescribed a regular limited carbohydrate (CHO diet used to improve blood sugar control) with limited salt and phosphorus (a mineral found in food) diet, pureed texture (food that is smooth with no lumps like pudding), and thin liquid consistency on Monday, Wednesday, Friday lunch delivered by 12:00 PM on dialysis days related to dependence on dialysis. Review of the provider order, dated 01/05/2024, showed Resident 24 was prescribed enteral feeding of Novasource renal formula 50 ml per hour at 8:00 PM - 12:00 PM (16 hours total), with 30 ml water flushes every eight hours (before, during and after) 90 ml total water related to moderate protein-calorie malnutrition and dysphagia. Review of Resident 24's April 2024 treatment administration record (TAR) from 04/01/2024 - 04/24/2024 showed an order dated 10/31/2023 for the resident to have a fluid restriction of 1200 milliliters (ml). Dietary to provide: 600 milliliters (ml) per day and Nursing to provide: 600 ml per day two times a day at 7:00 AM - 10:00 AM and 4:00 PM - 8:00 PM related to dependence on dialysis. It also showed 300 ml's for nursing every 12 hours and to make sure intake and output were documented. Documentation showed it was initialed and completed; however, there was no documentation to show the fluid amounts provided to Resident 24. (continued on next page)

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	505264	A. Building B. Wing	04/26/2024

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic health records (EHR) on 04/25/2024 did not show documentation of monitoring Resident 24's output per provider's 10/31/2023 order. The EHR 30-day look back documentation completed by the nursing assistants showed Resident 24 had received fluid intake of 720 ml on 03/28/2024 (over the ordered fluid restriction parameters) and showed no documentation (blanks) of amount of fluid provided on either the day, evening, or night shifts on the following dates: 03/28/2024, 03/29/2024, 03/30/2024, 03/31/2024, 04/02/2024, 04/03/2024, 04/05/2024, 04/10/2024, 04/12/2024, 04/19/2024, and 04/21/2024. Observations of Resident 24's room on 04/22/2024 at 10:55 AM, 04/23/2024 at 2:44 PM, and 04/24/2024 at 10:30 AM showed a water pitcher/mug with a handle and a straw on the nightstand filled with water within easy access to Resident 24. During an interview on 04/22/2024 at 10:55 AM, Resident 24 stated they were not sure how much fluid they could drink in a 24-hour period. Observation and interview on 04/25/2024 at 10:01 AM showed a maroon plastic cup filled with 240 milliliters (ml) of coffee and a 355 ml can of soda on the overbed table. On the nightstand there was a water pitcher/mug with a handle, which had measurement lines on the side that showed it was filled with 550 ml of water. Resident 24 stated the staff put the water in the water pitcher and did not remember staff ever telling them how much they could drink each shift and did not believe they were on any fluid restrictions. During an interview on 04/25/2024 at 2:33 PM, Staff J, Certified Nursing Assistant (CNA), stated that it was their second time being assigned to take care of Resident 24 and was not sure if the resident was on fluid restrictions; however, they did see that there was a water pitcher/mug with a straw in Resident 24's room. Staff J stated the Kardex showed that Resident 24 was on fluid restrictions and was able to have 600 ml by nursing; however, they were unable to know how much fluid licensed nurses gave the resident and would have to ask. Staff J stated a resident on fluid restrictions should not be provided a water pitcher. During an interview on 04/25/2024 at 2:50 PM, Staff C, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated that regarding fluid restriction, the nursing assistants documented what fluids they provided in the EHR and the licensed nurses (LNs) documented in the medication administration records (MARs) and TARs. Staff C stated that Resident 24 should not have had a filled water pitcher of 550 ml in their room because they were on fluid restrictions of 1200 ml a day due to receiving dialysis services. Staff C stated that there was no place to record fluids consumed and/or fluids flushed/provided with medication administration in Resident 24's April 2024 MAR and TAR. Staff C stated that documentation showed Resident 24 received over the fluid parameters in a day and there should have been shift totals of fluids documented for each shift and for a 24-hour period to ensure compliance with the prescribed order and this did not meet expectations. Staff C stated that Resident 24's orders needed to be clarified with the provider and the registered dietician to enquire if enteral feedings were to be included in the fluid restriction parameters. (continued on next page)

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	505264	A. Building B. Wing	04/26/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/2024 at 3:55 PM, Staff B, Director of Nursing Services, stated that Resident 24 should not have had a water pitcher in their room due to being on fluid restrictions. Staff B stated the expectation was that the amount of fluids provided were documented in the MAR and/or TAR and fluids documented by the aids during meals should have added up to fluid restriction parameters and that did not happen for Resident 24. Staff B stated that it was not in their policy that fluid restriction included enteral feedings but perhaps it should have. Staff B stated that fluid restriction documentation was unclear and did not meet expectations and the provider and registered dietician needed to be contacted to come up with a clear system for all residents going forward related to fluid restrictions. Please refer to F693 for additional information. Reference WAC 388-97-1060 (3)(h)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38344 Based on 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 provider's orders and professional standards of practice for 2 of 2 sampled residents (Residents 11 and 24) reviewed for enteral nutrition. The facility failed to have a system in place which ensured the amount of enteral formula (liquid food products) a resident received was reconciled with the amount they were ordered to receive. This failure placed the residents at risk for inadequate nutrition, hydration, and other adverse outcomes. Findings included . Resident 11 Review of the quarterly minimum data set assessment (MDS), dated [DATE], showed that Resident 11 readmitted to the facility on [DATE] and received their nutrition through a feeding tube. Review of Resident 11's provider order dated 04/01/2024 showed orders for enteral feeding four times a day of Fibersouce HN or equivalent 450 milliliters (ml) every six hours via a syringe per feeding tube. It showed total volume to be delivered was 1800 ml., document amount infused, and to notify provider and registered dietician if Resident 11 was not tolerating the feeding. Review of Resident 11's focused care plan, revised on 02/23/2024, showed the resident was at risk for dehydration and dependent on others for fluids, had swallowing difficulties, and recommended to have nothing by mouth (NPO) and to receive fluids by tube feeding. Review of Resident 11's April 2024 treatment administration record (TAR) from 04/01/2024 - 04/23/2024 showed scheduled enteral feeding times were 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and included a spot above the time to document the amount of enteral formula provided. It showed multiple documented X, 0, blanks, and/or the amount of formula provided was below the prescribed amount ordered (no refusals were documented). It showed Resident 11 received the ordered total amount of 1800 ml once in 23 days. During an interview on 04/25/2024 at 3:30 PM, Staff C, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 11's April 2024 TAR had holes/blanks, X's, 0's, no refusals documented, and was not consistently provided the ordered amount of fluid prescribed. Staff C stated progress notes did not show documentation that the provider was consistently informed/aware that Resident 11 did not receive the ordered amount of fluid prescribed. During an interview on 04/25/2024 at 4:11 PM, Staff B, Director of Nursing Services (DNS), stated Resident 11's documentation regarding enteral feedings in the resident's electronic health record (EHR) and April 2024 TAR did not meet expectations. Resident 24 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS dated [DATE] showed that Resident 24 admitted to the facility on [DATE] with diagnoses to include malnutrition (a condition when the body does not get enough nutrients/poor nutrition), dysphagia (difficulty swallowing), had a feeding tube in place, and was able to make needs known. Review of the April 2024 TAR from 04/01/2024 - 04/23/2024 showed the following enteral feed orders dated 01/05/2024 for Resident 24 that included: 1) Novasource renal (enteral feed) 50 ml per hour at 8:00 PM - 12:00 PM (16 hours total), with 30 ml water flush every eight hours (before, during and after), 90 ml total water, related to moderate protein-calorie malnutrition and dysphagia. Documentation showed, y (that indicated, yes) with no documented amount of fluid provided. 2) Enteral feed to be OFF at 12:00 PM and showed a spot to document milliliters (ml) which were documented with an X and on 04/08/2024 and 04/13/2024 was left blank and did not show the amount of feedings that were provided. 3) An order for 30 ml water flush three times a day before, during and after enteral feed with amount of ml to be documented at 8:00 AM, 12:00 PM, and 8:00 PM and showed documented amounts of 30 ml not documented for four out of 69 opportunities. During an interview on 04/25/2024 at 3:38 PM, Staff C, RCM/LPN, stated Resident 24's April 2024 TAR from 04/01/2024 - 04/23/2024 did not meet expectations because there were no totals of enteral feedings documented to ensure adherence to provider orders and there should have been. During an interview on 04/25/2024 at 4:14 PM, Staff B, DNS, stated Resident 24 should have had enteral feed totals of fluids provided, monitored, and documented for nutritional intake per provider orders and this did not meet expectations. Reference WAC 388-97-1060 (3)(f)

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	505264	A. Building B. Wing	04/26/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assured timely acquiring, receiving, and administering of a prescribed medications) to meet the needs of 1 out of 4 sampled residents (Residents 55) reviewed for medication administration. The facility failed to consistently reconcile controlled medications in 3 of 3 medication carts (medication carts 200, 400, and 300) reviewed for medication storage. Failure to ensure timely receipt and administration of an ordered medication, placed Resident 55 at risk for medical complications and a poor quality of life, and failure to reconcile controlled medications placed residents at risk for misappropriation of their medications and the facility at risk for diversion of controlled medications. Findings included . <Pharmaceutical Services> Review of Resident 55's quarterly minimum data set assessment (MDS) dated [DATE] showed that Resident 55 readmitted to the facility on [DATE] with diagnoses to include heart failure (a condition when the heart does not pump enough blood for the body's needs), high blood pressure (pressure of blood pushing against the walls of the arteries/blood vessels that carry blood to all parts of the body), and was able to make needs known. Observation and interview on 04/23/2024 at 7:34 AM showed Staff K, Charge Nurse/Licensed Practical Nurse (CN/LPN), looked in the 200 medication cart for Resident 55's ordered medication of Macitentan (used to treat high blood pressure) and was unable to locate the medication in the cart or in the facility's medication storage rooms. Staff K stated the medication was not available at this time and would inform the provider. Review of Resident 55's progress note dated 04/23/2024 showed the medication Macitentan oral tablet 10 milligrams to be provided one time a day for pulmonary hypertension (condition that affects the blood vessels in the lungs) was not available and showed, will notify provider. Review of Resident 55's electronic health record (EHR) showed January 2024 medication administration record (MAR) had an order with a start date of 01/25/2024 for Macitentan once a day for pulmonary hypertension. Documentation showed that Resident 55 did not receive the medication five out of seven opportunities. The February 2024 MAR showed the ordered Macitentan was not provided 18 out of 29 opportunities. The March 2024 MAR showed the ordered Macitentan was not provided 29 out of 31 opportunities. The April 2024 MAR showed the ordered Macitentan was not provided 23 out of 24 opportunities. The documentation in the MARs showed that the number 9 (Other/See Nurse Notes) was documented when the medication was not provided. Review of Resident 55's progress notes from January 2024 through 04/24/2024 showed inconsistent documentation to show why Macitentan was not provided to Resident 55 and if the provider was notified. During an interview on 04/25/2024 at 9:23 AM, Staff K, CN/LPN, stated they had called the pharmacy and was informed that the pharmacy did not carry the Macitentan oral medications. (continued on next page)

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	505264	A. Building B. Wing	04/26/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/25/2024 at 10:21 AM, after reviewing Resident 24's EHR, Staff B, DNS, stated they should have had documentation to show attempts to obtain the ordered Macitentan medication from the pharmacy and the provider's response to not having the medication available. When unable to obtain the medication, staff should have asked the provider to choose an alternative medication and/or discontinue the medication and this did not meet expectations. <Reconcile Controlled Medications> Observation and interview on 04/23/2024 at 7:38 AM showed the 200-medication cart's controlled substance book number 13's signed acknowledged page dated April 2024 had no signature to show the count was reconciled by the night shift nurse and the day shift nurse on 04/23/2024. Staff K, CN/LPN, stated they did count the scheduled medications in the morning; however, they failed to sign the book to show the medication count was correct. Staff K stated the April 2024 acknowledged page showed multiple missing signatures in the controlled substance book number 13 and there should not have been. During an interview on 04/23/2024 at 7:53 AM, Staff H, Resident Care Manager/LPN (RCM/LPN), stated there should be two licensed nurses (LNs), signing the controlled substance book to ensure the count was correct at the change of shift; however, the 200 medication cart's book was missing signatures, and this did not meet expectations. Observation and interview on 04/23/2024 at 8:54 AM showed the 400-medication cart's controlled substance books numbered 3 and 4's signed acknowledged pages dated April 2024 had multiple missing signatures. Staff L, LPN, stated they forgot to sign the books in the morning. Staff L stated that both books had missing signatures at shift change and there should not have been. Observation and interview on 04/23/2024 at 2:08 PM showed the 300-medication cart's controlled substance books lettered D and E's signed acknowledged pages dated April 2024 had multiple missing signatures. Staff M, CN/LPN, stated the night shift nurse forgot to sign both books in the morning. Staff M stated both books had several missing signatures by two LNs at change of shift. During an interview on 04/24/2024 at 11:03 AM, Staff B, DNS, stated the expectation was that two nurses were to reconcile/count scheduled controlled medications and have documented signatures at every shift change to ensure the count was correct. After reviewing the controlled substance books signed acknowledged pages dated April 2024 for the 200, 400, and 300 medication carts, Staff B stated documentation showed there were several missing signatures and there should not have been. Staff B stated this did not meet expectations. Reference WAC 388-97-(1)(a)(ii) (b)(ii),(c)(ii-iv)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to ensure freedom from unnecessary pain medication for 1 of 5 sampled residents (Residents 33) reviewed for unnecessary medication use. Failure to provide non-pharmacological interventions (approaches, therapies, or treatments that do not involve drugs) prior to giving as needed pain medications placed the resident at risk for side-effects related to the medication, medical complications, and a diminished quality of life. Findings included . Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 33 readmitted to the facility on [DATE] with diagnoses to include chronic pain syndrome (long standing persistent pain), anxiety disorder, and the resident was able to make needs known. Review of Resident 33's revision dated 01/03/2024 focused actual pain care plan showed an intervention was initiated on 04/28/2021 to attempt nonpharmacological intervention prior to administering pain medications such a reposition, redirection, relaxation, etc. Resident 33 was alert and able to notify staff if they desired assistance. Review of Resident 33's April 2024 medication administration record (MAR) from 04/01/2024 - 04/13/2024 showed a provider order with a start date of 09/25/2023 for acetaminophen 650 milligrams (mg) (used to treat minor aches and pains and reduces fever) every four hours as needed for elevated temperature or pain. It showed that acetaminophen was provided for pain on 04/01/2024, 04/02/2024, 04/03/2024, 04/12/2024 and did not show that nonpharmacological interventions were provided prior to administration. This order was discontinued on 04/13/2024; however, it showed a new order with a start date of 04/13/2024 for acetaminophen tablet 650 mg every four hours as needed for elevated temperature or pain. This order showed, What nonpharmacological interventions did you attempt prior to med administration? A= repositioning, B= diversional activities, C= decrease external stimulation (i.e. turn lights off). Documentation showed that Resident 33 was provided acetaminophen on 04/23/2024; however, it did not show the letters A, B, or C documented, but instead showed, NA. Continued review of Resident 33's April 2024 MAR showed an order with a start date of 01/08/2024 to provide oxycodone HCl (used to treat moderate to severe pain) 0.5 mg every six hours as needed for pain. It showed that oxycodone HCl was provided on 04/02/2024, 04/03/2024, 04/09/2024, 04/12/2024, and 04/13/2024 and did not show that nonpharmacological interventions were provided prior to administration. This order was discontinued on 04/13/2024; however, it showed a new order with a start date of 04/13/2024 for oxycodone HCl 0.5 mg every six hours as needed for pain. This order showed, What non-pharmacological interventions did you attempt prior to med administration? A= repositioning, B= diversional activities, C= decrease external stimulation (i.e. turn lights off). Documentation showed that Resident 33 was provided oxycodone HCl on 04/18/2024 and 04/23/2024; however, it did not show the letters A, B, or C documented, but instead showed, NA. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2024 at 2:24 AM, Staff C, Resident Care Manager/Licensed Practical Nurse, stated that prior to giving a resident an as needed pain medication, the resident should be offered/provided a non-pharmacological intervention and it should be documented in the MAR. Staff C stated that Resident 33's initial orders for acetaminophen and oxycodone HCl on the April 2024 MAR should have had nonpharmacological interventions attached to the orders to be able to document that nonpharmacological interventions were offered/provided. Staff C stated that the new orders for acetaminophen and oxycodone HCl had NA documented which meant nothing and should not have been documented. During an interview on 04/25/2024 at 10:48 AM, after reviewing Resident 33's April 2024 MAR acetaminophen and oxycodone HCl as needed pain medication orders, Staff B, Director of Nursing Services, stated that the documentation did not meet expectations. Staff B stated that the nurses should have documented per orders. Reference WAC 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to consistently monitor residents' behaviors and/or medication side effects for 3 of 5 sampled residents (Residents 5, 33 and 184) when reviewed for unnecessary medications. This failure placed residents at risk of not receiving adequate mental health supports, increased behaviors, increased psychotropic use, and a diminished quality of life. Findings included . Resident 5 Review showed that Resident 5 admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder) and psychotic disorder (thoughts and perceptions are disrupted). Review of Resident 5's April 2024 behavior monitoring record (BMR) showed orders to monitor the resident's behaviors and side effects of psychotropic medications. Review showed that four of 24 days were missing entries. During an interview on 04/25/2024 at 10:48 AM, Staff C, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated that the facility monitored resident behaviors and medication side effects through the BAR. Staff C stated that Resident 5 was missing monitoring, and this did not meet expectation. 38344 Resident 33 Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 33 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), and psychotic disorder. It showed that Resident 33 received antipsychotic and antidepressant medications and was able to make needs known. Review of Resident 33's provider orders showed an order dated 02/25/2023, for fluoxetine (an antidepressant medication) one time a day for depression. An order dated 10/03/2023 for behavior monitoring due to use of an antidepressant with listed various behaviors to watch for and interventions and outcomes to document. There was an order dated 09/25/2023 for quetiapine fumarate (an antipsychotic medication) 50 milligrams (mg) two times a day and 100 mg at bedtime for bipolar disorder. An order dated 10/03/2023 for behavior monitoring due to use of an antipsychotic with listed various behaviors to watch for and interventions and outcomes to document. Orders included to monitor side effects for both antidepressant and antipsychotic medication use. (continued on next page)

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	505264	A. Building B. Wing	04/26/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 33's April 2024 medication administration record (MAR) and BMR from 04/01/2024 - 04/23/2024 showed the resident received fluoxetine and quetiapine fumarate per provider orders. The BMR showed Resident 33's orders for behavior monitoring for use of an antidepressant, antipsychotic, and adverse side effects had blanks/holes in the documentation for the following shift and dates: Day shift - 04/08/2024, 04/13/2024, and 04/14/2024 and Evening shift - 04/18/2024, 04/20/2024, and 04/21/2024. During an interview on 04/24/2024 at 2:17 PM, Staff C, RCM/LPN, stated Resident 33's April 2024 BMR had blanks/holes in the documentation and there should not have been. During an interview on 04/25/2024 at 10:45 AM, Staff B, Director of Nursing Services (DNS), stated that the expectation was that documentation in the BMRs should be complete with no holes/blanks and that Resident 33's April 2024 BMR documentation did not meet expectations. . 34567 Resident 184 Review of the entry MDS, dated [DATE], showed Resident 184 was admitted on [DATE]. The electronic health record (EHR) showed that Resident 184 was admitted with multiple diagnoses including muscle weakness, malnutrition (state of inadequate intake of food, as a source of protein, calories, and other essential nutrients), depression and anxiety. The provider ordered multiple psychotropic medications (affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), to include an antidepressant, and antipsychotic/antianxiety medications. The resident was able to make needs known. Observation and attempted interview on 04/22/2024 at 11:04 AM showed Resident 184 laid in bed within their room. The resident appeared anxious on approach and yelled out loudly, What do you want!? An attempt to continue to communicate with the resident further resulted additional loud yelling and lack constructive dialogue. The overall appearance of the resident was disheveled as they laid in bed within a darken room. The resident wore a hospital gown, their toenails were long and yellow, their long gray beard was unkempt, and hair appeared greasy and uncombed. Review of Resident 184's MAR, dated April 2024, showed providers orders for the licensed nurse (LN) to administer the following medication; venlafaxine (an antidepressant medication), and quetiapine for anxiety and major depressive disorder once a day. The provider ordered hydroxyzine (an antianxiety medication) three times a day as necessary. Review of Resident 184's care plan, dated 04/16/2024, showed the resident had the potential for alterations in mood and/or behavior related to their diagnoses of general anxiety disorder (GAD) and major depressive disorder (MDD) and that LNs were to conduct behavioral monitoring as needed and notify social service director of any decline in mood or behavior. In addition, the care plan showed resident specific behaviors included screaming, refusing care, and becoming paranoid (unreasonable, or obsessively anxious, suspicious, or mistrustful). (continued on next page)

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	04/26/2024

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.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of multiple clinical progress notes within Resident 184's electronic health record showed LNs had documented the following: 04/15/2024 - Resident yelling out, difficult to console., 04/17/2024 - Resident refusing skin evaluation, moody, fearful, yell frequently, overly fearful about people, resists care and changing briefs, refused weight today, 04/22/2024 - Resident continues to refuse care and yelling to be left alone. 04/23/2024 - behavior/yelling outburst while visit with a case worker. Review of Resident 184's BMR for April 2024 showed LNs were to document any changes related to the resident's GAD, to include yelling or easily agitated, or MDD, to include screaming, anxiousness, or self-isolating. The BMR also directed LNs to document any triggers (either internal or external stimuli that affect the individual's ability to remain in the present), and document interventions that were implemented and whether those interventions / outcomes were shown to result in an improvement, worsened or was unchanged. The April 2024 BMR showed multiple LNs' entries that were being documented as inaccurate and which did not match up with the resident's behaviors, interventions, and outcomes accordingly. During an interview on 04/24/2024 at 12:55 PM, Staff E, Social Services Director (SSD), stated that Resident 187's behavior was supposed to be tracked by the residential care manager but at this time they were not available; however, Staff E stated that the increased behavioral issues the resident was experiencing would need to be addressed and that the initial preadmission screening and resident review (PASSR, an evaluation conducted to ensure nursing home residents receive appropriate [behavioral] care and services) would need to be updated to address the residents increased behaviors and diagnoses related to GAD and MDD. During an interview on 04/24/2024 at 1:17 PM, Staff B, DNS, stated it was their expectation that Resident 187's behavior monitoring was to be documented correctly and that the initial PASRR should have been updated as it was related to the residents increasing behavioral issues. Reference WAC 388-97-1060(3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38344 Based on observation, interview, and record review, the facility failed to consistently maintain the medication refrigerator temperature logs in 2 of 2 medication rooms (medication rooms 100/200 hall and 300/400 hall) reviewed for medication storage and labeling. This failure placed the residents at risk for receiving compromised or ineffective medications. Findings included . Observation on 04/23/2024 at 11:30 AM with Staff H, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), of the 100/200 hall medication room refrigerator containing various liquid medications that included vaccines, showed April 2024 refrigerator temperature monitoring logs for AM and PM, from 04/01/2024 - 04/22/2024 with inconsistent documentation. The logs had either blanks or one temperature logged on 11 out of 22 dates. During an interview on 04/23/2024 at 11:30 AM, Staff H, RCM/LPN, stated the 100/200 hall medication room's April 2024 refrigerator temperature monitoring logs for AM and PM had blanks and one temperature logged at times and since there were vaccines stored in the refrigerator the temperatures needed to be logged twice a day. Observation on 04/23/2024 at 12:17 AM with Staff C, RCM/LPN, of the 300/400 hall medication room refrigerator containing various liquid medications that included vaccines, showed April 2024 refrigerator temperature monitoring logs for AM and PM, from 04/01/2024 - 04/22/2024 with inconsistent documentation. The logs had either blanks or one temperature logged on 18 out of 22 dates. During an interview on 04/23/2024 at 12:17 AM, Staff C, RCM/LPN, stated the 300/400 hall medication room's April 2024 refrigerator temperature monitoring logs for AM and PM had missing documentation and blanks. Staff C stated the logs needed to be completely filled out twice a day and that did not happen. During an interview on 04/23/2024 at 1:30 PM, Staff B, Director of Nursing Services, stated the expectation was that the medication refrigerator temperature logs were to be documented by night shift and day shift, twice a day, and kept in binders for each shift to document. Staff B stated the 100/200 hall and 300/400 hall medication refrigerator temperature logs for April 2024 had blanks, missing documentation, and some temperatures logged times were too close together. Staff B stated this did not meet expectations. Reference WAC 388-97-1300(1)(i)(2)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40817 Based on observation and interview, the facility failed to maintain a call light system that allowed residents to call for help from the floor of the bathroom for 2 of 4 hallways (Halls 200 and 400) when reviewed for call light system. This failure placed residents at risk of not being able to call for assistance, delayed response to a fall, injury, and a diminished quality of life. Findings included . Observation on 04/22/2024 showed the call light string in the bathrooms of rooms [ROOM NUMBER] were short and could not be reached if laying on the floor. Observation on 04/26/2024 showed that the bathroom call light sting the bathrooms of rooms [ROOM NUMBER] were short and could not be reached if laying on the floor. Observation on 04/26/2024 showed the bathroom call light in room [ROOM NUMBER] was short and could not be reached if laying on the floor. During an interview on 04/26/2024 at 10:00 AM, Staff N, Maintenance Director, stated the facility performed call light audits to ensure they were accessible to residents. Staff N stated that the call light strings in the bathrooms of Rooms 405, 406, 415, and 210 were too short and a resident on the floor would not be able to reach them. During an interview on 04/26/2024 at 10:17 AM, Staff A, Administrator, stated that the facility performed call light audits to ensure they were accessible, but was unsure whether this included the bathroom call lights. Staff A stated that call lights should be accessible and call lights that were inaccessible did not meet expectation. Reference WAC 388-97-2280 (1)(b)(c)