

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 03/27/2025
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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on interview and record review, the facility failed to have signed consent prior to administering mood altering medication for 1 of 5 sampled residents (Resident 66) when reviewed for unnecessary medications use. This failure placed the resident or their legal representatives at risk of receiving medication without knowledge to make informed decision regarding the use of the medication, adverse side effects, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 66 was admitted to the facility on [DATE] with diagnoses to include major depression, altered mental status, and dementia (brain function impairment with memory and judgment loss). Resident 66 was not able to communicate needs.</p> <p>Review of the medication administration record for the month of March 2025 showed an order dated 02/28/2025 for Divalproex (mood stabilizer medication) twice a day. Resident 66 was administered the medication 03/01/2025 through 03/26/2025 for violent behavior.</p> <p>Review of the Resident 66's EHR showed no consent was completed or in place for the use of Divalproex.</p> <p>During an interview on 03/27/2025 at 9:23 AM, Staff D, Registered Nurse/Resident Care Manager, reviewed the EHR for Resident 66 and was not able to find a consent for Divalproex. Staff D stated Resident 66 should have informed consent prior to the administration of the medication.</p> <p>During an interview on 03/27/2025 at 9:28 AM, Staff C, Corporate Registered Nurse, stated Resident 66's lack of consent for mood stabilizing medication did not meet expectations.</p> <p>Reference WAC 388-97-0300(3)(a)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to obtain an advanced directive (AD, a legal document that establishes a representative to make medical decisions when you and unable to) and/or perform periodic reviews of AD for 1 of 3 sampled residents (Resident 24) when reviewed for AD. This failure placed the resident at risk of not having an established decisionmaker, lack of ability to direct care, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 24 initially admitted to the facility on [DATE] with diagnoses that included depression and anxiety disorder. Resident 32 was able to make needs known.</p> <p>Review of the Comprehensive Plan of Care Review form, with an effective date of 05/02/2024, showed Resident 24 had no AD in place, did not wish to formulate an AD, and declined assistance with executing an AD.</p> <p>Review of Resident 24's Care Conference Information forms, dated 10/17/2024 and 12/19/2024, showed both forms were marked Yes, for having an AD; however, there was no documented discussion related to AD.</p> <p>Review of the current focused Advanced Directive care plan, initiated on 08/04/2020 revised on 04/25/2023, showed Resident 24 did not wish to establish an advanced directive at that time. A care plan intervention, dated 08/23/2022, showed to review AD with Resident 24 quarterly and as needed with any change in condition. This care plan did not show that Resident 24 had an AD in place.</p> <p>During an interview on 03/27/2025 at 1:36 PM, Staff G, Social Services Director (SSD), stated Resident 24 did not have an AD in place and documentation during care conferences on 10/17/2024 and 12/19/2024 did not show that AD was discussed. Staff G stated periodic review of Resident 24's AD was not documented, and this did not meet expectations.</p> <p>During an interview on 03/27/2025 at 2:03 PM, Staff A, Administrator, stated new residents and/or the responsible party were asked to provide a copy of AD upon admission to the facility and/or were asked if they would like to establish an AD, provided AD information, and assist to formulate an AD as needed. Staff A stated AD was to be reviewed upon admission, during quarterly care conferences, and as needed. Staff A stated they were not aware that Resident 24 did not have an AD and/or did not have documented quarterly review of AD during care conferences, and this did not meet expectations.</p> <p>Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(a-c)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on observation, interview, and record review, the facility failed to make needed repairs to maintain a homelike environment on 2 of 4 halls (Halls 100 and 400) and failed to use reusable utensils to maintain a homelike dining experience on 1 of 4 halls (Hall 300) when reviewed for environment. These failures place residents at risk for diminished mood, feelings of worthlessness, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observations of the shared bathroom for rooms [ROOM NUMBERS] on 03/24/2025 at 9:50 AM, 03/25/2025 at 9:03 AM, and 03/27/2025 at 10:03 AM showed the lower part of both sides of the doorway frame and walls had gouges and peeled off paint.</p> <p>During an interview on 03/27/2025 at 10:03 AM, Staff J, Maintenance Director, stated the shared bathroom for rooms [ROOM NUMBERS] showed both sides of the corner wall doorway frame with gouges that needed to be repaired. Staff J stated staff were to put in a report into TELS (electronic system to put in a work order for items/issues to be fixed, repaired, or replaced) and then they would be able to work on it. Staff J stated the shared bathroom issues were not reported in TELS and should have been. Staff J stated these findings did not meet expectations.</p> <p>During an interview on 03/27/2025 at 11:46 AM, Staff A, Administrator, stated they were not aware the shared bathroom for rooms [ROOM NUMBERS] doorframe and wall issues was not reported in TELS and this did not meet expectations.</p> <p>49926</p> <p>Observation on 03/25/2025 at 10:33 AM showed room [ROOM NUMBER] with wall gouges at the headboard wall, paint peeling off the wall, the over the bed night light had a plastic bag instead of cord to turn on and off, and the corner wall between bathroom door and main wall had multiple gouges and paint had been scraped off.</p> <p>During an interview on 03/27/2025 at 1:26 PM, Staff EE, Licensed Practical Nurse, stated staff communicated via Point Click Care (PCC) communication into TELS system.</p> <p>During an interview on 03/27/2025 at 1:33 PM, Staff A, Administrator, stated the facility had a new maintenance director and was working on maintenance issues, but the environment for room [ROOM NUMBER] did not meet expectation.</p> <p>40817</p> <p>Observation on 03/25/2025 at 9:01 AM showed the bathroom attached to room [ROOM NUMBER] had pink tape on the enabler bars near the toilet.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/24/2025 at 12:43 PM showed in room [ROOM NUMBER] the floorboard molding near bathroom was coming away from the wall and gouges to the bathroom door. Observation showed a plastic bag was tied to the pull cord to the overbed light on bed A and the front of one nightstand table was missing for bed B.</p> <p><PLASTIC UTENSILS></p> <p>During an interview on 03/24/2025 at 12:04 PM, Resident 46 stated the facility used plastic silverware on occasion.</p> <p>Observation and interview on 03/26/2025 at 11:52 AM, showed staff stopped using metal silverware and began placing black plastic silverware on the trays for the 300 hall. Staff W, Dietary Aide, stated there were not enough metal silverware for the entire facility and black plastic silverware would be used when the metal silverware was out.</p> <p>During an interview on 03/26/2025 at 1:30 PM, Staff X, Dietary Services Manager, stated the facility was not able to provide each resident metal silverware during meal services. Staff X stated the facility would wait until the metal silverware was low then order more. Staff X stated using plastic silverware may not be considered homelike for some residents.</p> <p>During an interview on 03/27/2025 at 8:48 AM, Staff A, Administrator, stated the facility should maintain enough metal silverware for each resident during meal services. Staff A stated using plastic silverware could cause concerns with maintaining a homelike environment and did not meet expectation.</p> <p>Reference WAC 388-97-0880</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on observation, interview, and record review, the facility failed to conduct an assessment and signed consent for the use of low bed, bed next to the wall and tilt in space wheelchair for 1 of 2 sampled residents (Resident 38) when reviewed for use of physical restraints. This failure placed the resident at risk for injury, unmet needs, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia (brain function impairment with memory and judgment loss), dislocation of internal left hip prosthesis (an artificial body part), and depression.</p> <p>Review of the admission minimum data set (MDS, an assessment tool), dated 12/24/2024, showed Resident 38 was a high fall risk and required assistance of staff for mobility. Resident 38 was not able to communicate their needs.</p> <p>Observation on 03/25/2025 at 1:40 PM, showed Resident 38 in their room sitting in tilt in space wheelchair with their upper body reclined back.</p> <p>Observation on 03/25/2025 at 2:29 PM, showed Resident 38 in a low bed and the bed was next to the wall blocking access and movement to the right side of their body.</p> <p>Observation on 03/26/2025 at 9:04 AM, showed Resident 38 laying on the low bed next to the wall.</p> <p>Review of Resident 38's care plan showed focus area for high risk for falls, date initiated 12/17/2024 and revised on 03/25/2025, which showed interventions for bed against the wall and keep the bed in lowest position.</p> <p>Review of Resident 38's EHR showed no assessment and consent for the low bed, bed by the wall and tilt in space wheelchair.</p> <p>During an interview on 03/26/2025 at 9:24 AM, Staff EE, Licensed Practical Nurse, stated low bed, bed by the wall, and tilt in space wheelchair could be used as a restraint and should have an assessment and consent prior to use.</p> <p>During an interview on 03/27/2025 at 9:10 AM, Staff C, Corporate Registered Nurse, stated the expectations for low bed, bed by the wall, and tilt in space wheelchair were to be assessed and consented prior to their use. Staff C stated Resident 38's lack of consent and assessment for use of low bed, bed by the wall, and tilt in space wheelchair did not meet expectation.</p> <p>Reference WAC 388-97-0620(1)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on interview and record review, the facility failed to transmit resident minimum data set (MDS, an assessment tool) to the Centers for Medicare & Medicaid Service (CMS) within the required timeframe for 1 of 19 sampled residents (Resident 53) when reviewed for MDS timeliness in transmission/submission. This failure to ensure MDS assessment and tracking records were completed and transmitted timely as required placed the resident at risk for unmet care needs and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 53 was admitted to the facility on [DATE] and discharged from the facility on 12/19/2024.</p> <p>Review of the MDS section in the EHR showed Resident 53 had Medicare-5 Day MDS dated [DATE] completed but not submitted to CMS, and a discharge MDS dated [DATE] was completed but not submitted to CMS.</p> <p>During an interview on 03/27/2025 at 3:13 PM, Staff JJ, Registered Nurse/MDS Nurse, stated the facility transmitted MDS once a week to CMS, and was not sure why Resident 53's MDS were not submitted.</p> <p>During an interview on 03/27/2025 at 3:23 PM, Staff K, Registered Nurse/Regional Reimbursement Analyst, stated some residents were missed and the facility was doing an audit.</p> <p>During an interview on 03/27/2025 at 3:25 PM, Staff C, Corporate Registered Nurse, stated Resident 53's MDS data not being transmitted to CMS did not meet expectation.</p> <p>Reference WAC 388-97-1000(4)(b), (5)(b)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to ensure the minimum data set (MDS, a required assessment tool) accurately reflected a weight loss of 10 percent or more in six months for 1 of 3 sampled residents (Resident 24) when reviewed for nutrition. This failure placed the resident at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 24 readmitted to the facility on [DATE] with diagnoses that included malnutrition (the body does not get the right amount or type of nutrients it needs to function properly), anxiety disorder, and depression. Resident 24 was able to make needs known.</p> <p>During an interview on 03/25/2025 at 9:17 AM, Resident 24 stated the food did not taste good and they thought they were losing weight because they did not eat enough.</p> <p>Review of Resident 24's EHR showed on 08/07/2024 the resident weighed 124.6 pounds (lbs.) and on 02/11/2025 the resident weighed 110.0 lbs., which was a 11.72 % weight loss in six months.</p> <p>Review of the quarterly MDS, dated [DATE], showed Resident 24's weight was 110.0 lbs. and documented there was no or unknown weight loss of 10% or more in the last six months.</p> <p>During an interview on 03/27/2025 at 10:44 AM, Staff K, Registered Nurse/Regional Reimbursement Analyst, stated Resident 24's quarterly MDS dated [DATE] was inaccurately coded for weight loss. Staff K stated Resident 24 had a significant weight loss.</p> <p>During an interview on 03/27/2025 at 11:06 AM, Staff C, Corporate Registered Nurse, stated Resident 24's significant weight loss should have been captured in the quarterly MDS dated [DATE]; however, that did not happen.</p> <p>Reference WAC 388-97-1000(1)(b)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567</p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool) assessments were accurately completed for 4 of 5 sampled residents (Residents 5, 28, 66 and 38) when reviewed for PASARRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs.</p> <p>Findings included .</p> <p>Review of a document titled, PASARR Policy, dated 07/2024, showed any potential admissions identified to have a positive Level I PASARR screen must be evaluated by the designated state authority, through the Level II PASARR process, and approved for admission prior to admitting to the nursing facility unless that individual meets criteria for an exempted hospital discharge. The Level II PASARR evaluations were required for all nursing facility residents identified to have indicators of serious mental illness/intellectual disability (SMI/ID) during the Level I screening or at any time during residency in the nursing facility and for any resident with confirmed SMI or ID who presents with significant changes in their cognitive or physical conditions.</p> <p>Resident 5</p> <p>Review of Resident 5's quarterly minimum data set (MDS, a required assessment tool), dated 03/11/2025, showed the resident readmitted on [DATE] with multiple health conditions including Alzheimer's (a progressive disorder that primarily affects memory, thinking, and reasoning skills, leading to a decline in cognitive function and eventually impacting daily activities), depression, and a psychotic disorder (a mental health condition characterized by a loss of touch with reality, leading to distorted perceptions and beliefs). The electronic health record (EHR) showed the resident was able to make their needs known.</p> <p>Review of Resident 5's EHR showed a Level I PASARR, dated 04/19/2023, was completed by the facility's social work staff. The PASARR form had documentation that was marked No Level II evaluation indicated.</p> <p>During an interview on 03/26/2025 at 12:29 PM, Staff G, Social Service Director (SSD), stated they were unaware of the need to forward the Level I PASARR to the Level II evaluator and further stated they would now need to forward the document to ensure if any behavioral health care services were needed.</p> <p>During an interview on 03/26/2025 at 1:16 PM, Staff C, Corporate Registered Nurse, stated it was their expectation if Resident 5's Level I PASARR had SMI/ID conditions then it was to be forwarded to the Level II evaluator for any potential behavior health care services that was needed.</p> <p>38344</p> <p>Resident 28</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the EHR showed Resident 28 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, and psychotic disorder. Resident 28 was able to make needs known.</p> <p>Review of the Level I PASARR, dated 05/02/2023, showed Resident 28 had mood disorders, psychotic disorder, and anxiety disorder; however, it showed No Level II evaluation indicated.</p> <p>During an interview on 03/26/2025 at 12:06 PM, Staff G, SSD, stated Resident 28's Level I PASARR, dated 05/02/2023, showed the resident had serious mental illness indicators marked and should have had a referral for a Level II PASARR evaluation. Staff G stated they were unable to locate a Level II evaluation for Resident 28.</p> <p>During an interview on 03/26/2025 at 12:55 PM, Staff A, Administrator, stated Resident 28 should have been referred for a Level II evaluation and this did not meet expectations.</p> <p>49926</p> <p>Resident 38</p> <p>Review of the EHR showed Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia (brain function impairment with memory and judgment loss), major depression, and bipolar disorder (disorder with mood swings ranging from depressive lows to manic highs).</p> <p>Review of the admission MDS, dated [DATE], showed Resident 38 used antipsychotics (mind altering medications) and antidepressants. Resident 38 was not able to communicate their needs.</p> <p>Review of the EHR showed Resident 38's Level I PASARR form completed on 12/17/2024. The Level I PASARR form did not identify Resident 38 as needing Level II PASARR referral.</p> <p>Resident 66</p> <p>Review of the EHR showed Resident 66 was admitted to the facility on [DATE] with diagnoses to include major depression, altered mental status, and dementia. Resident 66 was not able to communicate needs.</p> <p>Review of the admission MDS, dated [DATE], showed Resident 66 had received antipsychotics and antidepressants.</p> <p>Review of the EHR showed Resident 66 had no Level I PASARR form in the record.</p> <p>During an interview on 03/25/2025 at 12:51 PM, Staff G, SSD, stated the process for PASARR was to be done prior admission and the facility would review them for accuracy and update as needed.</p> <p>During an interview on 03/27/2025 at 9:57 AM, Staff A, Administrator, stated Residents 38 and 66 not having accurate PASARR forms did not meet expectation.</p> <p>Reference WAC 388-97-1915(1)(2)(a-c)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</p> <p>Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for 2 of 19 sampled residents (Residents 10 and 7) when reviewed for comprehensive care plans. Failure to care plan Resident 10's fall preventions and Resident 7's range of motion services placed residents at risk of avoidable injury, loss of movement, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 10</p> <p>Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses of hemiplegia (loss of movement on one side), diabetes (too much sugar in the blood), and deafness. Resident 10 was able to make needs known.</p> <p>Review of the facility's incident log from October 2024 to March 2025 showed Resident 10 had fallen on 10/08/2024, 12/01/2024, and 12/15/2024.</p> <p>Review of the incident reports for the falls on 10/08/2024, 12/01/2024, and 12/15/2024 showed new fall interventions to reduce reoccurrence of falls had been developed after each.</p> <p>Review of Resident 10's 02/04/2022 initiated care plan showed no focus area related to falls and did not include the fall interventions developed after the 10/08/2024, 12/01/2024, and 12/15/2024 falls.</p> <p>During an interview on 03/27/2025 at 2:13 PM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated facility staff were aware of what fall interventions to use by checking the care plan. Staff H stated Resident 10 had recently had a series of falls and the fall interventions drafted after those falls should be documented in the resident's care plan. Staff H stated Resident 10 did not have a care plan for falls and this did not meet expectation.</p> <p>During an interview on 03/27/2025 at 2:46 PM, Staff C, Corporate Registered Nurse, stated all fall interventions should be included on the care plan, so staff were aware of them. Staff B stated Resident 10 did not have a care plan for fall prevention and this did not meet expectation.</p> <p>49926</p> <p>Resident 7</p> <p>Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital disorder of movement, muscle tone and posture), anxiety, depression, and contracture of muscles (permanent tightening of muscles). Resident 7 was able to communicate needs.</p> <p>(continued on next page)</p>		

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

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 03/24/2025 at 3:08 PM showed Resident 7 lying in bed in their room with fingers on both hands appeared rigid, curled inward towards palms, with some fingers overlapping on top of other fingers. Resident 7 stated staff did not do anything for their hands.</p> <p>Review of Resident 7's care plan initiated on 10/06/2022 showed multiple focus areas for contractures without any interventions for managing the contractures or range of motion plan to assist in preventing deterioration.</p> <p>During an interview on 03/27/2025 at 1:15 PM, Staff BB, Director of Rehabilitation, stated Resident 7 had worked with occupational therapy and had hand splints but Resident 7 declined to use them, and this should have been added to the care plan.</p> <p>During an interview on 03/27/2025 at 1:45 PM, Staff C, Corporate Registered Nurse, stated residents admitted to the facility with contractures should have services set up to maintain functions and should be addressed in the care plan. Staff C stated Resident 7's care plan did not meet expectation.</p> <p>Reference WAC 388-97-1020(1),(2)(a)(b)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to ensure a resident's care plan was revised and accurately reflected the resident's care needs for 1 out of 19 sampled residents (Resident 24) when reviewed for care planning and revision of care plans. This failure placed the resident at risk for unmet care needs, medical complications, inaccurate care plan documentation, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health records (EHR) showed Resident 24 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, psychotic disorder (mental health condition that causes abnormal thinking and perceptions) and malnutrition (the body does not get the right amount or type of nutrients it needs to function properly). Resident 24 was able to make needs known.</p> <p>Review of the focused care plan initiated on 09/26/2024 showed Resident 24 was on an antipsychotic medication related to dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychosis [psychotic disorder].</p> <p>Review of the focused care plan, initiated on 01/21/2021, showed Resident 24 had a nutritional problem that included it was related to dementia. It showed an intervention initiated on 02/17/2025 for an oral nutritional supplement of house med-pass (a fortified nutritional shake that provides extra calories and proteins) twice a day and to monitor and record amount consumed.</p> <p>Review of the form titled Psychotropic Drug and Behavior Review, with an effective date of 02/19/2025, showed the interdisciplinary team (IDT, a group of professionals from different disciplines who work together to achieve a common goal) recommendations included that Resident 24's diagnosis of dementia was removed, per mental health professional.</p> <p>During an interview on 03/26/2025 at 2:31 PM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated Resident 24's care plan did not meet expectation because the diagnosis of dementia should have been removed from the focused care plans for antipsychotic medication and nutritional problem. Staff H stated Resident 24's care plan needed to be revised.</p> <p>During an interview on 03/26/2025 at 2:39 PM, Staff C, Corporate Registered Nurse, stated Resident 24's care plans for antipsychotic medication and nutritional problem should not have included the diagnosis of dementia. Staff C stated Resident 24's care plans needed to be revised.</p> <p>Review of the medication administration record (MAR) dated February 2025 showed Resident 24 had an order with a start date of 02/17/2025 for house med-pass two times a day and to document milliliters (ml.) consumed. Documentation showed Resident 24 refused to take the house med-pass and the order was discontinued on 02/24/2025.</p> <p>Review of Resident 24's provider orders on 03/25/2025 showed no order for house med pass.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/27/2025 at 9:33 AM, Staff H, LPN/RCM, stated care plans were to be revised with a change in condition and/or as needed. Staff H stated Resident 24 did not have an order for house med-pass and the care plan needed to be revised and that intervention removed.</p> <p>During an interview on 03/27/2025 at 10:15 AM, Staff C, Corporate Registered Nurse, stated care plans were to be revised on a quarterly basis, with a change of condition, and as needed. Staff C stated Resident 24 did not have a provider order for house med-pass and if the order had been discontinued then it should have been removed from the care plan when order was discontinued, and this did not meet expectations.</p> <p>Review of the MAR dated March 2025 from 03/01/2025 - 03/26/2025 showed Resident 24 was prescribed an anticoagulant (AC, prevent blood from clotting) medication with a start date of 02/11/2025 every evening related to atrial fibrillation (an irregular heart rate). Documentation showed Resident 24 was administered the AC per provider's order.</p> <p>Review of Resident 24's current care plan on 03/27/2025 showed no documentation of anticoagulant medication use or interventions to monitor for side effects.</p> <p>During an interview on 03/27/2025 at 9:29 AM, Staff H, LPN/RCM, stated Resident 24's care plan should have been revised when the order for AC medication was obtained. Staff H stated Resident 24's care plan needed to be revised to include the use of AC medication and to monitor for side effects.</p> <p>During an interview on 03/27/2025 at 10:26 AM, Staff C, Corporate Registered Nurse, stated residents with orders for AC medications should be care planned and be monitored for side effects. Staff H stated Resident 24's care plan was missing AC medication use and monitoring of side effects and this did not meet expectations.</p> <p>Reference WAC 388-97-1020 2(c)(d), 5(b)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for 5 of 19 residents (Residents 5, 10, 24, 59, and 19) when reviewed for care and services. The facility failed to notify a provider (Resident 5), to follow provider parameters (Residents 10 and 19), to provide nonpharmacological interventions (Residents 10 and 24), to document alert charting (Resident 59), and to monitor for side effects (Resident 24). These failures placed residents at risk for unmet care needs, avoidable side effects, and a diminished quality of life.</p> <p>Findings included .</p> <p>According to the Lippincott Manual of Nursing Practice, Tenth Edition ([NAME], [NAME] & [NAME], 2014, page 16), The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable.</p> <p>According to [NAME], Duell & [NAME], Clinical Nursing Skills, 6th Edition, page 4, Nurse Practice Act identified skills and functions that professional nurses perform in daily practice included, in part, to administer treatments per physician's orders.</p> <p>The Washington State Nurse Practice Act, WAC 246-840-710(2)(d), states nurses violate standards of practice by, Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards.</p> <p>Resident 5</p> <p>Review of Resident 5's quarterly minimum data set (MDS, a required assessment tool), dated 03/11/2025, showed Resident 5 readmitted on [DATE] with multiple health conditions including Alzheimer's (a progressive disorder that primarily affects memory, thinking, and reasoning skills, leading to a decline in cognitive function and eventually impacting daily activities), dementia, depression, and diabetes. The electronic health record (EHR) showed the resident was able to make their needs known.</p> <p>Review of Resident 5's current focus care plan, dated 03/03/2023, showed the resident had diabetes mellitus. Interventions included for licensed staff to administer diabetic medication as ordered by the provider and to monitor and document for side effects and effectiveness. In addition, LNs were to report to the provider, when necessary, signs and symptoms of hypoglycemia (low blood sugar).</p> <p>Review of Resident 5's current providers orders showed licensed staff were to administer Lantus (an insulin) subcutaneous (under the skin) 20 units one time a day for diabetes. The February 2025 and March 2025 medication administration record (MAR) showed multiple dates that the LNs had held the Lantus medication when the resident's blood glucose test was recorded as being below 100, on the following dates: 02/27/2025- 77, 03/11/2025- 81, 03/13/2025- 84, 03/20/2025- 79, 03/22/2025- 84, and 03/23/2025- 92. The LNs had documented they had held the medication; however, the EHR showed no documentation the provider was notified.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/2025 at 1:01 PM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated it was their expectation if the LNs were holding the Lantus insulin medication for a low blood glucose then the provider should be contacted and it was documented in the EHR.</p> <p>During an interview on 03/2/2025 at 1:16 PM, Staff C Registered Nurse/ Corporate stated it was their expectation the provider would be notified, and a progress note was documented by the LN in the residents EHR, if the resident had a low blood glucose reading.</p> <p>40817</p> <p>Resident 10</p> <p>Review of the EHR showed Resident 10 admitted to the facility on [DATE] with diagnoses of hemiplegia (loss of movement on one side), diabetes (too much sugar in the blood), and deafness. Resident 10 was able to make needs known.</p> <p>Review of provider's orders showed Resident 10 was prescribed oxycodone (a narcotic pain medication) as needed (PRN) for pain 7-10, dated 10/15/2024, and acetaminophen (an over-the-counter pain medication), dated 10/17/2024, PRN. Review showed there was no parameters for when to administer the acetaminophen and there were no orders to provide nonpharmacological interventions (NPI) prior to providing either pain medication.</p> <p>Review of the November 2024 MAR showed Resident 10 received oxycodone with less than 7-10 pain on 7 of 12 occasions, was not offered NPI, and acetaminophen was not provided.</p> <p>Review of the December 2024 MAR showed Resident 10 received oxycodone with less than 7-10 pain on 1 of 4 occasions, was not offered NPI, and acetaminophen was not provided.</p> <p>Review of the February 2024 MAR showed Resident 10 received oxycodone with less than 7-10 pain on 1 of 1 occasion, was not offered NPI, and acetaminophen was not provided.</p> <p>During an interview on 03/27/2025 at 10:29 AM, Staff H, LPN/RCM, stated PRN pain medications should be provided after offering NPI and within the parameters associated with the order. Staff H stated Resident 10 was prescribed two PRN pain medications but did not have an order for NPI. Staff H stated Resident 10 was provided PRN pain medications outside of parameters and without offering NPI, and this did not meet expectation.</p> <p>During an interview on 03/27/2025 at 10:48 AM, Staff C, Corporate Registered Nurse, stated NPI should be offered prior to residents receiving PRN pain medications and these medications should be given within the provided parameters. Staff B stated Resident 10 receiving PRN pain medications without NPI and outside of provider's parameters did not meet expectation.</p> <p>38344</p> <p>Resident 24</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EHR showed Resident 24 readmitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis (a chronic/long lasting disease-causing pain, swelling, and stiffness of the joints), anxiety disorder, and atrial fibrillation (an irregular heart rate). Resident 24 was able to make needs known.</p> <p>Review of the provider order, dated 02/11/2025, showed Resident 24 was prescribed oxycodone immediate release (used to treat severe, acute/sudden pain) every eight hours as needed for pain management related to chronic pain. It showed to hold the medication for sedation (a state of reduced consciousness/awareness), and a respiratory rate of less than 12.</p> <p>Review of the provider order, dated 02/11/2025, showed Resident 24 was prescribed the medication rivaroxaban (an anticoagulant/blood thinner) in the evening related to atrial fibrillation.</p> <p>Review of the March 2025 MAR from 03/01/2025 - 03/24/2025 showed Resident 24 received the as needed oxycodone one to three times a day for a total of 50 times and there were no documented respiratory rates or NPI documented prior to providing the medications. Review showed Resident 24 received anticoagulant medication per provider orders; however, there was no documentation to show side effects for this medication was being monitored.</p> <p>Review of Resident 24's March 2025 treatment administration record (TAR) from 03/01/2025 - 03/24/2025 showed no documentation to monitor for side effects related to anticoagulant medication use.</p> <p>During an interview on 03/26/2025 at 9:49 AM, Staff H, LPN/RCM, stated Resident 24's March 2025 MAR showed the resident received as needed oxycodone; however, NPI were not documented as offered and respiratory rates were not monitored and documented prior to giving the PRN pain medication. Staff H stated this did not meet expectations.</p> <p>During an interview on 03/27/2025 at 10:26 AM, Staff C, Corporate Registered Nurse, stated Resident 24's March 2025 MAR and/or TAR should have had NPI and monitoring for sedation and respiratory rate documented prior to providing as needed pain medication and this did not meet expectations.</p> <p>During an interview on 03/26/2025 at 10:21 AM, Staff H, LPN/RCM, stated residents receiving anticoagulant medications were to have side effects monitored and documented in the TAR. Staff H stated Resident 24 received anticoagulant medications; however, the monitoring must have got missed because side effects were not being monitored on the March 2025 TAR and should have been.</p> <p>During an interview on 03/27/2025 at 10:26 AM, Staff C, Corporate Registered Nurse, stated Resident 24's side effect for anticoagulant medication use was not being monitored on the March 2025 MAR or TAR, and they should have been.</p> <p>51907</p> <p>Resident 59</p> <p>Resident 59 admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms affecting memory and thinking), cerebral infarct (stroke), encephalopathy (a change in how the brain functions), and altered mental status. The admission MDS, dated [DATE], showed Resident 59 had confusion and poor memory recall, but could usually understand others.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/24/2025 at 2:43 PM showed Resident 59 was being monitored one-on-one (1:1) by staff.</p> <p>Review of the EHR showed on 03/23/2025 Resident 59 was placed on 1:1 for new behaviors and suicidal statements.</p> <p>Review of the provider note, dated 03/23/2025, showed Resident 59 was distraught, at times wanting to die. Ativan (an anti-anxiety medication) was ordered every six hours as needed and a provider would see Resident 59 in the morning.</p> <p>Review of the progress note, dated 03/23/2025 at 6:02 PM, showed Resident 59's family member was notified of new behaviors and suicidal statement. There was no note by a nurse showing the resident's behavior, statements, a 1:1 being started, or initiation of alert charting.</p> <p>Review of the provider note, dated 03/24/2025, showed Resident 59 was seen by the provider and the order for Ativan was continued.</p> <p>Review of the progress note, dated 03/24/2025 at 7:42 PM, showed an alert charting note for the 1:1 status. The progress note was completed over 24 hours after the first nurse's note about the resident's behaviors or suicidal statement.</p> <p>Review of the progress note, dated 03/25/2025 at 7:24 PM, showed Resident 59 continued on a 1:1 and no behaviors were noted. This was over 23 hours since the last alert note in the chart.</p> <p>Review of the care plan on 03/25/2025 showed the care plan had not been updated since his new suicidal statements and being placed on a 1:1.</p> <p>During an interview on 03/26/2025 at 10:10 AM, Staff Z, Certified Nursing Assistant (CNA), stated they were told Resident 59 was on a 1:1 because the resident was showing signs of depression. Staff Z stated the staff was supporting the resident's emotional needs by continuing the 1:1.</p> <p>During an interview on 03/26/2025 at 2:45 PM, Staff D, RN/RCM, stated alert charting should be completed every shift. Staff D stated the care plan should have been updated.</p> <p>During an interview on 03/27/2025 at 10:08 AM, Staff C, Corporate Registered Nurse, stated their expectation was for staff to complete alert charting on an every shift basis and update the care plan when a change occurred with a resident.</p> <p>46067</p> <p>Resident 19</p> <p>Review of the electronic health record showed Resident 19 admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (complete paralysis or weakness) of left side, dementia, and atrial fibrillation. Resident 19 was able to make needs known.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EHR showed a provider's order dated 04/02/2024 for Metoprolol 25 mg to give 0.5 tablet by mouth once daily. The order specified to hold the medication for SBP less than 100 or pulse less than 60 and notify provider.</p> <p>Review of the EHR showed a provider's order, dated 05/22/2024, for the blood pressure medication Lisinopril 40 milligram (mg) give one tablet by mouth once daily. The order specified to hold the medication for systolic blood Pressure (SBP, the top number) less than 100 or if pulse less than 60 and notify provider.</p> <p>Review of the March 2025 MAR showed on 03/03/2025, 03/10/2025 and 03/18/2025 Resident 19's pulse was assessed below 60 and the Lisinopril 40 mg was not held as directed and the provider was not notified. On 03/04/2025 and 03/18/2025 Resident 19's pulse was assessed below 60 and the Metoprolol 25 mg was not held as directed and the provider was not notified.</p> <p>During an interview on 03/27/2025 at 10:38 AM, Staff H, LPN/RCM, stated the expectation was LN staff should have followed the provider's order as directed.</p> <p>During an interview on 03/27/2025 at 11:58 AM, Staff C, Corporate Registered Nurse, stated the expectation was staff should have held the medication and contacted the provider.</p> <p>Reference WAC 388-97 -1620(2)(b)(i)(ii),(6)(b)(i)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</p> <p>Based on observation, interview, and record review, the facility failed to assist residents with activities of daily living (ADL) for 3 of 5 sampled residents (Residents 10, 421, and 425) when reviewed for ADL. The facility's failure to assist Resident 10 with nail care and assist Residents 421 and 425 with grooming placed residents at risk for decreased mood, feelings of worthlessness, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 10</p> <p>Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses of hemiplegia (loss of movement on one side), diabetes (too much sugar in the blood), and deafness. Resident 10 was able to make needs known.</p> <p>Observation and interview on 03/24/2025 at 3:36 PM showed Resident 10 had yellowed nails approximately a half inch in length on the right hand. When asked if facility staff assisted Resident 10 with cutting their nails, Resident 10 indicated they did not.</p> <p>Review of the care plan, initiated 02/04/2022, showed Resident 10 had an ADL performance deficit and should be provided diabetic nail care by nursing once a week.</p> <p>Review of a provider's order, dated 07/11/2023, showed Resident 10 was to receive diabetic nail care once a week and to notify the provider of any problems.</p> <p>Observation on 03/27/2025 at 1:03 PM showed Resident 10 continued with long, yellowed nails on the left hand.</p> <p>During an interview on 03/27/2025 at 2:18 PM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated residents with diabetes typically had orders for nursing to provide diabetic nail care and refusals would be documented. Staff H stated Resident 10's nails were long and required trimming. Staff H stated Resident 10's ADL services did not meet expectation.</p> <p>During an interview on 03/27/2025 at 2:21 PM, Staff C, Corporate Registered Nurse, stated typically a resident with diabetes would have a provider's order to receive nail care. Staff B stated Resident 10's long nails did not meet expectation.</p> <p>51907</p> <p>Resident 421</p> <p>Resident 421 admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline in physical and functional abilities) and need for assistance with personal care. The admission minimum data set (MDS, an assessment tool), dated 03/25/2025, showed Resident 421 was usually able to make their needs known and understand others.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/24/2025 showed Resident 421 laid in bed with their coat on with a strong smell of urine noted.</p> <p>Observation on 03/25/2025 at 2:29 PM showed Resident 421 stood in the doorway to their room with disheveled hair. The heels of their feet were not in their sneakers and the sneakers were not tied. Two different staff walked by Resident 421 without stopping to assist the resident.</p> <p>Observation on 3/27/2025 at 8:40 AM showed Resident 421 sat on the side of their bed eating breakfast. There was dark sediment noted under their fingernails.</p> <p>Review of the care plan dated 03/21/2025 showed Resident 421 required partial physical assist with bathing, bed mobility, dressing, personal hygiene, and toilet use.</p> <p>During an interview on 03/27/2025 at 9:34 AM, Staff Z, Certified Nursing Assistant (CNA), stated Resident 421 went to the bathroom independently. Staff Z stated Resident 421 did not ask for help but would accept help when offered.</p> <p>Resident 425</p> <p>Resident 425 admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis affecting right dominant side, and vascular dementia (a group of symptoms affecting memory and thinking). The end of Medicare Part A stay MDS, dated [DATE], showed Resident 425 was dependent on staff for all care.</p> <p>Observation on 03/24/2025 at 2:39 PM showed Resident 425 was in bed with their gown on. Their hair was disheveled.</p> <p>Observation on 03/25/2025 at 12:41PM showed Resident 425 slept in bed. Their hair was disheveled, and they were wearing a hospital gown. The call light was hanging off side of bed and not in reach. There was dark sediment under fingernails on both hands</p> <p>Observation on 03/25/2025 at 1:40 PM showed Resident 425 laid in bed with a hospital gown. Their hair was disheveled.</p> <p>Observation on 03/26/2025 at 8:55 AM showed Resident 425 laid on their back in bed with hospital gown on. Their hair was disheveled. Their fingernails had dark sediment under them on both hands. The call light was laying on the floor and not within reach</p> <p>Observation on 03/26/2025 at 10:58 AM showed Resident 425 laid on their back in bed with hospital gown on. Their hair was disheveled. There was dark sediment under their fingernails. The call light was laying on the floor and not within reach.</p> <p>Observation on 03/26/2025 at 11:30 AM showed Resident 425 laid on their back in bed with a hospital gown on. Their hair was disheveled. There was dark sediment under their fingernails. The call light was laying on the floor and not within reach.</p> <p>(continued on next page)</p>		

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

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/26/2025 at 12:21 PM showed Resident 425 laid on their back in bed with hospital gown on. Their hair was disheveled. There was dark sediment under their fingernails. The call light was on the floor and not within reach.</p> <p>Observation on 03/26/2025 at 2:27 PM showed Resident 425 laid on their back in bed with a hospital gown on. Their hair was disheveled. There was dark sediment under their fingernails. The call light was on the floor and not within reach.</p> <p>Review of the care plan dated 02/20/2025 showed Resident 425 was dependent on staff for care. Review showed Resident 425 required one- or two-person physical assist for all ADLs.</p> <p>During an interview on 03/26/2025 at 1:30 PM, Staff AA, CNA, stated Resident 425 was dependent on staff for their care. Staff AA stated Resident 425 was not able to use their call light as it was outside of the resident's reach and staff checked on them one to two hours. Staff AA stated Resident 425 did not refuse care.</p> <p>During an interview on 03/27/2025 at 9:55 AM, Staff C, Corporate Registered Nurse, stated it was their expectation that ADL care would be provided timely and as care planned.</p> <p>Reference WAC 388-97- 1060 (2)(c)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</p> <p>Based on observation, interview, and record review, the facility failed to provide an activity program to engage residents for 2 of 2 sampled residents (Residents 3 and 425) when reviewed for activities. This failure placed residents at risk of boredom, decreased mood, feelings of worthlessness, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 3</p> <p>Review of the electronic health record (EHR) showed Resident 3 admitted to the facility on [DATE] with diagnoses to included schizophrenia (a serious mental illness that affects a person's ability to think clearly, manage emotions, and interact with others), diabetes (too much sugar in the blood), and epilepsy (a brain condition that causes someone to have repeated seizures). Resident 3 was not able to make needs known.</p> <p>Review of the activity profile, dated 01/14/2025, showed Resident 3 was most happy when able to watch their television (TV) and enjoyed listening to spiritual, country, and oldies music. Review showed Resident 3 enjoyed bingo and musical performance group events.</p> <p>Review of the care plan, initiated 05/31/2021, showed Resident 3 had an ongoing desire to participate in activities and enjoyed bingo, parties, and board/card game group activities. Review showed Resident 3 enjoyed watching TV and listening to music as individual activities. Review showed Resident 3 required one-on-one activity visits which included listening to music, manicures, aroma therapy, and crochet.</p> <p>Review of the 30-day lookback of activities on 03/25/2025 showed Resident 3 had one group activity and one one-on-one activity, both dated 03/15/2025.</p> <p>Review of an activity progress note, dated 03/24/2025, showed activity staff found Resident 3 staring at a blank TV and put on a DVD for them. Review showed Resident 3 had no other DVDs, so activity staff brought more movies and the resident's mood was increased.</p> <p>Observation on 03/24/2025 at 1:21 PM showed Resident 3 in their room with eyes open. Observation showed no TV or music on, and Resident 10 sat in bed looking around their room.</p> <p>Observation on 03/25/2025 at 8:59 AM showed Resident 3 in their room looking at a DVD case. No TV or music was on.</p> <p>Observation on 03/25/2025 at 1:11 PM showed Resident 3 laid in bed eyes open with the lights turned off. No TV or music was on and Resident 3 gazed at the ceiling.</p> <p>Observation on 03/25/2025 at 3:25 PM showed Resident 3 in bed with eyes closed and lights on. No TV of music was on.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/26/2025 at 8:13 AM showed Resident 3 in bed eyes open looking around the room with no TV or music on.</p> <p>Observation on 03/27/2025 at 9:59 AM showed Resident 3 in bed eyes open with no TV or music playing. Resident 3 drank a soda and looked around the room.</p> <p>During an interview on 03/27/2025 at 11:03 AM, Staff FF, Activity Director, stated the facility ensured residents who did not leave their room had activities by following a one-on-one activity schedule and this would be documented in a progress note. Staff FF stated Resident 3 most enjoyed watching TV or DVDs. Staff FF stated both activity staff and nursing staff were responsible for ensuring that Resident 3 had their TV on.</p> <p>During an interview on 03/27/2025 at 11:32 AM, Staff A, Administrator, stated residents who did not leave their room were provided activities through activity staff following a one-on-one schedule and would be recorded in a progress note. Staff A stated Resident 3's lack of activities did not meet their expectation.</p> <p>51907</p> <p>Resident 425</p> <p>Resident 425 admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis affecting right dominant side (weakness and paralysis of the right side of the body), and vascular dementia (a group of symptoms affecting memory and thinking). The end of Medicare Part A stay minimum data set (MDS, an assessment tool), dated 03/07/2025, showed Resident 425 was dependent on staff for all care.</p> <p>Review of the care plan dated 02/20/2025 showed Resident 425 was dependent on staff for activities, cognitive stimulation, and social interaction. Interventions included: Staff would provide social and one-on-one visits and activities to help meet Resident 425's activity goals. The care plan stated Resident 425's preferred activities were: Visits in room, music, television, movies, reading to them, and family visits.</p> <p>Observation on 03/25/2025 at 12:41 PM showed Resident 425 in bed. There was no radio or TV on.</p> <p>Observations were made at the following dates and times when no television or music was playing and Resident 425 remained in bed with no activity staff present: 03/25/2025 12:41 PM, 03/25/2025 1:40 PM, 03/25/2025 2:35 PM, 03/26/2025 8:55 AM, 03/26/2025 10:58 AM, 03/26/2025 11:30 AM, 03/26/2025 12:21 PM, 03/26/2025 1:01 PM, 03/26/2025 1:30 PM, 03/26/2025 2:27 PM, and 03/27/2025 8:40 AM.</p> <p>During an interview on 03/27/2025 at 11:50 AM, Staff FF, Activity Director, stated activity staff checked on Resident 425 daily and would turn on the television or music. Staff FF stated activity staff would complete one-on-one activity with Resident 425. Staff FF stated if there was any participation or attempts at activities, they would be charted in the progress notes.</p> <p>Review of the progress notes for March 2025 and February 2025 show no progress notes from activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reference WAC 388-97- 0940 (1)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and/or residents' person-centered care plans for 3 of 5 sampled residents (Residents 37, 425, and 38) when reviewed for position/mobility and for 1 of 5 sampled residents (Resident 66) when reviewed for unnecessary medications. The facility failed to ensure orders were in place prior to applying a brace/splint (a device used to immobilize and support a body part) (Resident 37), apply an immobilizer device per provider's order (Resident 38), implement turning and repositioning (Resident 425), and follow bowel protocols (Resident 66). These failures placed residents at risk for medical complications, unmet needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 37</p> <p>Review of the electronic health record (EHR) showed Resident 37 admitted to the facility on [DATE] with diagnoses to include stroke, hemiplegia/hemiparesis (complete and partial paralysis, muscle weakness and loss of movement, of one side of the body), and aphasia (a language disorder that affects a person's ability to communicate). Resident 37 was sometimes able to make needs known.</p> <p>Observations on 03/24/2025 at 10:32 AM, 03/25/2025 at 1:08 PM, 03/25/2025 at 3:08 PM, and 03/26/2025 at 9:11 AM showed Resident 37 with a brace/splint placed on their right lower leg/foot.</p> <p>Review of Resident 37's provider orders on 03/25/2025 showed no provider order for a brace/splint for the right lower leg/foot.</p> <p>Review of the current care plan on 03/25/2025 showed no documentation for Resident 37 to have a brace/splint applied to the right lower leg/foot.</p> <p>During an interview on 03/26/2025 at 1:49 PM Staff L, Certified Nursing Assistant (CNA), stated Resident 37 wore a brace on their right lower leg/foot. Staff L stated they applied the brace when Resident 37 got up in their wheelchair and it would be removed when in bed. Staff L stated they were unable to locate the brace in Resident 37's care plan and thought it used to be there.</p> <p>During an interview on 03/26/2025 at 1:55 PM, Staff M, Licensed Practical Nurse (LPN), stated they had seen Resident 37 with a brace on their right lower leg/foot. Staff M stated they were unable to locate a provider order for the brace and thought it used to be ordered and maybe it dropped off. Staff M stated the brace was not documented in Resident 37's care plan.</p> <p>During an interview on 03/26/2025 at 2:01 PM, Staff C, Corporate Registered Nurse, stated they were unable to locate a provider order for the use of a brace/splint and there should have been one in place if Resident 37 had it on. Staff C stated they did not see a care plan for the use of a brace/splint in Resident 37's care plan and this did not met expectations.</p> <p>51907</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 425</p> <p>Resident 425 admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis affecting right dominant side, and vascular dementia (a group of symptoms affecting memory and thinking). The end of Medicare Part A stay minimum data set (MDS, an assessment tool), dated 03/07/2025, showed Resident 425 was dependent on staff for all care.</p> <p>Observation on 03/24/2025 showed Resident 425 was lying in bed on their back. Resident 425 was laying diagonally in their bed with head on the right side of the bed and feet at the left side of their bed.</p> <p>Review of EHR on 03/25/2025 showed Resident 425 required two staff physical assistance to turn and reposition in bed.</p> <p>Review of the care plan, dated 02/19/2025, showed Resident 425 had potential for impairment to skin integrity due to poor skin turgor (elasticity of the skin). Review showed Resident 425 had severe cognitive (mental processes involved in gaining knowledge and comprehension) impairment.</p> <p>Observation on 03/25/2025 at 12:44 PM and 1:42 PM showed Resident 425 laid in bed on their back. Their head was at the left side of the head of the bed, and their feet were in the center of the foot of the bed.</p> <p>Observation on 03/25/2025 at 3:05 PM and 03/26/2025 at 8:55 AM and 10:58 AM showed Resident 425 laid in bed on their back with pillows under both of their arms.</p> <p>Observation on 03/26/2025 at 11:30 AM showed Resident 425 laid in bed on their back.</p> <p>Observation on 03/26/2025 at 12:21 PM, 1:01 PM, 1:30 PM, and 2:27 PM showed Resident 425 laid in bed on their back with their right arm on a pillow.</p> <p>During an interview on 03/26/2025 at 1:30 PM, Staff Z, CNA, stated dependent residents were turned and repositioned every two hours. Staff Z stated Resident 425 would slide down in bed and needed repositioning more often at times.</p> <p>During an interview on 03/26/2025 at 2:45 PM, Staff D, Registered Nurse/Resident Care Manager (RN/RCM), stated dependent residents should be turned and repositioned every two hours.</p> <p>During an interview on 03/27/2025 at 9:54 AM, Staff C, Corporate Registered Nurse, stated dependent residents should be turned every two to three hours which was their expectation.</p> <p>49926</p> <p>Resident 38</p> <p>Review of EHR showed Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia (brain function impairment with memory loss and judgment loss), dislocation of internal left hip prosthesis (an artificial body part), and depression.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS, dated [DATE], showed Resident 38 was high fall risk and required assistance of staff for mobility. Resident 38 was not able to communicate their needs.</p> <p>Review of the provider's orders, dated 03/13/2025, showed right knee immobilizer, check every shift. The order was signed twice a day by licensed nurses from 03/13/2025 to 03/25/2025.</p> <p>Review of the discharge instructions from orthopedic specialist, dated 12/17/2024, showed Resident 38 to maintain knee immobilizer at all times to minimize movement in the knee.</p> <p>Observation on 03/24/2025 at 9:40 AM and 1:40 PM showed Resident 38 sat in their wheelchair without right knee immobilizer on.</p> <p>Observation on 03/25/2025 at 2:29 PM showed Resident 38 in low bed without knee immobilizer on.</p> <p>During an interview on 03/26/2025 at 9:24 AM, Staff EE, LPN, stated Resident 38's right knee immobilizer should be placed by therapy in the morning. Staff EE pulled the knee immobilizer from the nightstand.</p> <p>During an interview on 03/27/2025 at 9:10 AM, Staff C, Corporate Registered Nurse, stated Resident 38 not having the right knee immobilizer placed per the order did not meet expectation.</p> <p>Resident 66</p> <p>Review of the EHR showed Resident 66 was admitted to the facility on [DATE] with diagnoses to include major depression, altered mental status, and dementia (brain function impairment with memory and judgment loss). Resident 66 was not able to communicate needs and needed staff assistance for activities of daily living.</p> <p>Review of the EHR showed Resident 66 did not have documented bowel movements (BM) from 02/28/2025 through 03/05/2025 (six days).</p> <p>Review of the medication administration record for March 2025 showed Resident 66 had multiple orders for different medications for constipation: Dulcolax suppository for constipation, Fleet enema as needed for constipation, and milk of magnesium as needed for constipation. The as needed orders for constipation were not administered in March 2025.</p> <p>During an interview on 03/26/2025 at 11:40 AM, Staff GG, CNA, stated when the residents were independent, they asked the residents if they had a BM and documented in the EHR, and when the resident was dependent on staff for incontinent care, the staff documented what was the size and consistency of the BM.</p> <p>During an interview on 03/26/2025 at 12:10 PM, Staff HH, LPN, stated the residents bowel records were flagged in the EHR when they had not had a BM for three days and the nurses should follow the medication orders.</p> <p>During an interview on 03/27/2025 at 9:14 AM, Staff C, Corporate Registered Nurse, stated Resident 66's bowel management services did not meet expectation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reference WAC 388-97-1060(1)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on observation, interview, and record review, the facility failed to provide services to increase range of motion or to prevent further decrease in range of motion for 1 of 3 sampled residents (Resident 7) when reviewed for contractures (a shortening of tissue which leads to rigidity of the joints) and mobility. This failure placed the resident at risk for worsening contractures, inability to complete activities of daily living, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 7 admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital disorder of movement, muscle tone and posture), anxiety, depression, and contracture of muscles. Resident 7 was able to communicate needs.</p> <p>Observation and interview on 03/24/2025 at 3:08 PM showed Resident 7 laid in bed in their room with fingers to both hands with rigidity, curled inward towards palms with some fingers overlapping on top of other fingers. Resident 7 stated staff did not do anything for their hands.</p> <p>Review of Resident 7's care plan, initiated 10/06/2022, showed no instructions or directions for performing range of motion to hands.</p> <p>During an interview on 03/27/2025 at 1:15 PM, Staff BB, Director of Rehabilitation, stated Resident 7 had worked with occupational therapy, had declined using hand splints, and their contractures were not measurable.</p> <p>During an interview on 03/27/2025 at 1:45 PM, Staff C, Corporate Registered Nurse, stated when the facility admitted residents with contractures, they would have services set up to maintain their functions. Staff C stated Resident 7' s contracture management did not meet expectation.</p> <p>Reference WAC 388-97- 1060(3)(d),(j)(ix)</p>		

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Avamere at Pacific Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 38344</p> <p>Based on observation, interview, and record review, the facility failed to ensure a bathroom emergency call light (a system used to call for help) cord length was no higher than six inches from the floor in 1 of 4 hallways (400 hallway) when reviewed for accident hazards. This failure placed residents at risk for inability to reach the call light cord if they fell on the floor, delayed response in an emergency, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observations on 03/24/2025 at 9:50 AM, 03/25/2025 at 9:03 AM, 03/25/2025 at 12:49 PM, and 03/27/2025 at 10:03 AM showed the shared bathroom for rooms [ROOM NUMBERS] had an emergency call cord that ended at the location of the handlebar attached to the wall to the left of the toilet (greater than six inches from the floor).</p> <p>During an interview on 03/25/2025 at 12:59 PM, Resident 28 in room [ROOM NUMBER] stated they did not use the bathroom at that time.</p> <p>During an interview and observation on 03/27/2025 at 9:51 AM, Resident 17 in room [ROOM NUMBER] stated they did use the bathroom and did not notice the emergency call cord was short and did not know how long it had been that way.</p> <p>Review of Resident 28's electronic health record (EHR) showed Resident 28 readmitted to the facility on [DATE] with diagnoses to include high blood pressure, chronic kidney disease (damaged kidneys that can't filter blood properly leading to a buildup of waste and other health problems over time), dementia (a group of thinking and social symptoms that interferes with daily functioning), osteoarthritis (joints wear down over time, causing pain, stiffness and potentially reduced movement), and was able to make needs known.</p> <p>Review of the quarterly minimum data set (MDS, a required assessment tool) dated 01/09/2025 showed Resident 17 was independent with transfers, walking, and toileting.</p> <p>During an interview on 03/27/2025 at 10:03 AM, Staff J, Maintenance Director, stated bathroom emergency call light cords should hang approximately two inches from the floor so if a resident was to fall on the floor they could reach the call cord. Staff J stated the shared bathroom for rooms [ROOM NUMBERS] emergency call light cord was too short and needed to be brought to the required length. Staff J stated that staff were to put in a report into TELS (electronic system to put in a work order for items/issues to be fixed, repaired, or replaced) and then they would be able to work on it. Staff J stated the short emergency call cord was not reported in TELS and should have been. Staff J stated these findings did not meet expectations.</p> <p>During an interview on 03/27/2025 at 11:46 AM, Staff A, Administrator, stated emergency call light cords in a bathroom should be two inches from the floor. Staff A stated they were not aware the shared bathroom for rooms [ROOM NUMBERS] call light cord was too short and not reported in TELS and should have been. Staff A stated this did not meet expectations.</p> <p>(continued on next page)</p>

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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reference WAC 388-97-1060 (3)(g)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to monitor and consistently document weights per provider orders for 1 of 3 sampled residents (Resident 24) when reviewed for nutrition. This failure placed resident at risk for medical complications, unmet needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 24 readmitted to the facility on [DATE] with diagnoses that included malnutrition (the body does not get the right amount or type of nutrients it needs to function properly), anxiety disorder, and depression. Resident 32 was able to make needs known.</p> <p>During an interview on 03/25/2025 at 9:17 AM, Resident 24 stated the food did not taste good and they thought they were losing weight because they did not eat enough.</p> <p>Review of the provider order dated 12/02/2024 showed Resident 24 was ordered to have bi-weekly weights related to weight loss on day shift every two weeks on Monday.</p> <p>Review of Resident 24's EHR showed the following weight documentation for the provider ordered bi-weekly weights in their treatment administration records (TAR) and the EHR weights tab:</p> <p>-January 2025 TAR showed it was initialed on 01/13/2025 and on 01/27/2025 as completed; however, no weights were documented in the weights tab for this month.</p> <p>-February 2025 TAR showed a blank/no initial on 02/10/2025; however, 110.0 lbs. was documented on 02/11/2025 in the weights tab.</p> <p>-March 2025 TAR from 03/01/2025 - 03/25/2025 showed it was initialed on 03/10/2025 and on 03/24/2025 as completed; however, no weights were documented in the weights tab for this month.</p> <p>During an interview on 03/27/2025 at 9:33 AM Staff H, Licensed Practical Nurse/Resident Care Manager, stated Resident 24 did not have weights documented bi-weekly per provider's order for the months of January through March 2025 and Resident 24's TARs had blanks and/or were initialed as completed even though weights were not obtained and documented in the weights tab. Staff H stated this did not meet expectations.</p> <p>During an interview on 03/27/2025 at 10:15 AM, Staff C, Corporate Registered Nurse, stated the expectation was that nurses followed provider's orders. Staff C stated Resident 24's bi-weekly weights were not monitored and documented per provider's order, and this did not meet expectations.</p> <p>Reference WAC 388-97-1060 (3)(h)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on interview and record review, the facility failed to act on the consultant pharmacist's medication regimen review (MRR) recommendations and/or to have clearly documented rationale for not following the recommendation for 2 of 5 sampled residents (Residents 24 and 4) when reviewed for unnecessary medication use. This failure placed the residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life.</p> <p>Findings included .</p> <p>Resident 24</p> <p>Review of the electronic health record (EHR) showed Resident 24 readmitted to the facility on [DATE] with diagnoses that included high blood pressure and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Resident 24 was able to make needs known.</p> <p>Review of Resident 24's consultant pharmacist MRR form titled, Note To Attending Physician/Prescriber, dated 03/03/2025 showed a recommendation to clarify the directions for ordered topical diclofenac 1% gel (used to treat aches and pains) to include specific administration parameters and to show, Do not exceed 32 grams per day. The portion of the form for Physician/Prescriber Response was blank and not filled out.</p> <p>Review of the provider order dated 02/11/2025 showed Resident 24 was prescribed diclofenac sodium external gel 1% (used to treat aches and pains) topically to right shoulder/arm two times a day related to arthritis (joint swelling and tenderness). It showed to discontinue for refusals and notify provider. The pharmacist's 03/03/2025 recommendation for this medication was not implemented.</p> <p>Review of Resident 24's consultant pharmacist MRR form titled, Note To Attending Physician/Prescriber, dated 03/03/2025 showed a recommendation to discontinue ordered medication rivaroxaban (an anticoagulant/blood thinner) due to the drug had a higher risk of side effects for Resident 24's specific type of atrial fibrillation. It showed at the next scheduled dose to initiate the medication apixaban (an anticoagulant/blood thinner) and included the recommended dose, route, and frequency.</p> <p>Review of the provider's orders on 03/25/2024 at 1:53 PM showed Resident 24 continued to have an active order dated 02/11/2025 for rivaroxaban in the evening related to atrial fibrillation. The pharmacist's 03/03/2025 recommendation for this medication was not implemented.</p> <p>During an interview on 03/27/2025 at 8:51 AM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated they had just received March 2025's pharmacy recommendations yesterday (03/26/2025) and would be reviewing/following up on the recommendations today. Staff H stated Resident 24's consultant pharmacist MRR forms dated 03/03/2025 related to the medications diclofenac sodium external gel 1% and rivaroxaban were not addressed and should have been followed up on sooner.</p> <p>(continued on next page)</p>

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

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/27/2025 at 10:31 AM, Staff C, Corporate Registered Nurse, stated Resident 24's pharmacy recommendations for March 2025 did not meet expectations and should have been addressed.</p> <p>40817</p> <p>Resident 4</p> <p>Review of the EHR showed Resident 4 admitted to the facility on [DATE] with diagnoses to include dementia (a loss of memory, language, problem-solving and other thinking abilities), depression, and psychosis (trouble telling what's real from what is not). Resident 4 was able to make needs known.</p> <p>Review of the EHR showed an MRR, dated 12/02/2024, with a recommendation to decrease some medications. Review showed the provider declined the recommendation on 01/17/2025.</p> <p>Review of the pharmacist medication review report for January 2025 showed Resident 4 had a recommendation for January.</p> <p>During an interview on 03/27/2025 at 10:29 AM, Staff H, LPN/RCM, stated the pharmacist would conduct a MRR monthly. Staff H stated these should be reviewed by the provider within 72 hours, but the facility had been struggling to do this. Staff H stated Resident 4 had a recommendation from 12/02/2024 which was not reviewed until 01/17/2025, and this did not meet expectation.</p> <p>During an interview on 03/27/2025 at 10:42 AM, Staff C, Corporate Registered Nurse, stated MRR were conducted on admission and monthly and should be responded to timely. Staff B stated Resident 4's delay in MRR response until 01/17/2025 and missing recommendation from January 2025 did not meet expectation.</p> <p>Reference WAC 388-97-1300 (1)(c)(iii), (4)(c)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 2 of 4 medication carts (100 and 300 medication carts) and 1 of 2 medication rooms (100/200 medication room) when reviewed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective treatment, and diminished quality of life.</p> <p>Findings included .</p> <p>Observation of medication room on 03/26/2025 at 1:58 PM with Staff E, Licensed Practical Nurse (LPN), showed the temperature log for March 2025 of the medication refrigerator to have missing documentation for 22 out of 26 opportunities. Review of the refrigerator showed storage of vaccinations, medication and emergency medication supply.</p> <p>During an interview on 03/26/2025 at 2:05 PM, Staff E, LPN, stated licensed nurses were to check the temperature of the refrigerator in the medication room and document twice a day.</p> <p>Observation of the 100 hall medication cart on 03/26/2025 at 1:50 PM with Staff E, LPN, showed the following medications that were not dated when opened: Lanta [NAME] (eye drops), artificial tears, Fluconazole (nasal spray), and expired Fluconazole second container dated 11/30/2024 and Fluconazole third container dated 12/24/2024.</p> <p>During an interview on 03/26/2025 at 1:52 PM, Staff E, LPN, stated the multi-use medications should be dated when opened and discarded after 30 days of use.</p> <p>Observation of the 300 hall medication cart on 03/26/2025 at 2:10 PM with Staff KK, LPN, showed Basaglar Insulin pen dated 02/21/2025 (insulin expires 28 days after it's open).</p> <p>During an interview on 03/26/2025 at 2:12 PM, Staff KK, LPN, stated they were not sure when the insulin expired.</p> <p>During an interview on 03/27/2025 at 1:39 PM, Staff C, Corporate Registered Nurse, stated the multi-use medications were to have dates when they were opened, insulin pens were to be discarded when expired and the medication storage refrigerator was to have temperature checked and documented twice a day. The expired, undated medications and medication refrigerated storage in the medication room did not meet expectation.</p> <p>Reference WAC 388-97-1300(2)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</p> <p>Based on observation, interview, and record review, the facility failed to provide prompt dental services for 2 of 3 sampled residents (Residents 28 and 10) when reviewed for dental. This failure placed the residents at risk for continued dental problems and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 28</p> <p>Review of the electronic health record (EHR) showed Resident 28 readmitted to the facility on [DATE] with diagnoses that included malnutrition (the body does not get the right amount or type of nutrients it needs to function properly) and diabetes (high blood sugar levels). Resident 28 was usually able to make needs known.</p> <p>During an interview and observation on 03/24/2025 at 10:00 AM, Resident 28 stated they could not wear dentures because they did not fit right, and staff were aware. Resident 28 had no teeth and was not wearing dentures.</p> <p>Review of Resident 28's care plan, initiated on 01/15/2020, showed the resident had oral/dental health problems related to edentulous (no natural teeth), had functional impairment, and received new top/bottom dentures on 04/01/2024. It had an intervention that showed, Coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>Review of Resident 28's dental/dentures exam form dated 01/23/2025 showed a referral to adjust upper and lower dentures. It included handwritten note on the form that showed patient said they did not wear dentures due to discomfort. It showed, Future Appointments, and had a checkmark for Recall Exam.</p> <p>During an interview on 03/26/2025 at 12:19 PM, Staff L, Certified Nursing Assistant (CNA), stated Resident 28 had dentures but chose not to wear them because they did not like the way they fit. Staff L stated they told a nurse about a month and a half ago but did not recall who they told. Staff L stated Resident 28's dentures were in a denture cup in their room.</p> <p>During an interview on 03/26/2025 at 12:29 PM, Staff H, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated the dentist/denturist came to the facility almost quarterly and they were here yesterday (03/25/2025). Staff H stated Resident 28's dental/dentures exam form dated 01/23/2025 showed a referral to adjust upper and lower dentures and should be seen on next visit which was yesterday. Staff H stated Resident 28 was not seen by the dentist and should have been seen.</p> <p>During an interview on 03/26/2025 at 12:40 PM, Staff G, Social Services Director (SSD), stated Resident 28 was not on the list to be seen by the dentist on 03/25/2025 and was not sure why.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/2025 at 12:59 PM, Staff A, Administrator, stated they were not aware Resident 28 should have been by the dentist yesterday (03/25/2025) and was not on the list and was not seen. Staff A stated Resident 28's dental care and services were not handled appropriately and timely.</p> <p>40817</p> <p>Resident 10</p> <p>Review of the EHR showed Resident 10 admitted to the facility on [DATE] with diagnoses of hemiplegia (loss of movement on one side), diabetes (too much sugar in the blood), and deafness. Resident 10 was able to make needs known.</p> <p>During an interview and observation on 03/24/2025 at 3:31 PM, when asked about their teeth and pain, Resident 10 pointed in their mouth and nodded.</p> <p>Review of a dental examination report, dated 05/22/2024, showed a referral for x-ray, evaluation, and extraction of teeth. A handwritten note on the report showed, Talk to family and a second handwritten note, 06/10/24 will talk to.</p> <p>Review of Resident 10's care plan, initiated 02/04/2022, showed, Last Cleaning: 7/31/24- Missing teeth, broken teeth. visible decay. Review did not show the recommendations from the 05/22/2024 examination.</p> <p>During an interview on 03/27/2025 at 2:04 PM, Staff H, LPN/RCM, stated after a dental examination with recommendations the facility would schedule a follow-up appointment. Staff H stated after the 05/22/2024 dental examination, Resident 10's family member should have been contacted to follow-up on the dentist's recommendations. Staff H stated there was no documentation showing this had occurred.</p> <p>During an interview on 03/27/2025 at 2:58 PM, Staff C, Corporate Registered Nurse, stated facility staff should follow-up on dental recommendations and Resident 10's lack of follow-up did not meet expectations.</p> <p>Reference WAC 388-97-1060 (1), (3)(j)(vii)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</p> <p>Based on observation, interview, and record review, the facility failed to provide food in an individualized manner when the therapeutic diet was not followed for 1 of 3 sampled residents (Resident 23) when reviewed for nutrition. This failure placed residents at risk of choking and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 23 admitted to the facility on [DATE] with diagnoses to include schizophrenia (a serious mental illness that affects a person's ability to think clearly, manage emotions, and interact with others), epilepsy (a brain condition that causes someone to have repeated seizures), and psychosis (trouble telling what's real from what is not). Resident 23 was able to make needs known.</p> <p>Observation of Resident 23's lunch meal ticket on 03/24/2025 at 12:48 PM showed to provide easy to chew foods and the plate had one large piece of unaltered fried chicken. The fried chicken did not appear to be easy to chew.</p> <p>Review of an aspiration precautions sign hanging on Resident 23's wall on 03/24/2025 at 12:48 PM showed to provide the resident easy to chew foods.</p> <p>Review of a provider's order, dated 12/27/2019, showed Resident 23 had a diet of regular easy to chew texture.</p> <p>Review of the care plan, initiated 06/20/2017, showed Resident 23 had a risk for aspiration (breathing in food) with an intervention to provide diet as ordered.</p> <p>Observation on 03/27/2025 at 12:42 PM showed Resident 23 had received country fried steak for lunch. The country fried steak did not appear easy to chew and there was no gravy on top. Resident 23's meal tray card showed to provide easy to chew foods.</p> <p>During an interview on 03/27/2025 at 1:16 PM, Staff Y, Registered Dietician, stated staff were aware of what diet to provide residents through their provider's diet order which was transferred to their meal ticket. Staff Y stated the fried chicken served for lunch on 03/24/2025 was regular texture and would need to be taken off the bone and tested for softness before being served to be easy chew and residents on easy to chew diets should have received baked chicken for lunch. Staff Y stated the country fried steak served for lunch on 03/27/2025 was regular texture and residents on easy to chew diets should have received a hamburger patty with gravy for lunch. Staff Y stated Resident 23 should not have received the fried chicken on 03/24/2025 or the country fried steak on 03/27/2025, and this did not meet the expectation.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 03/27/2025 at 1:45 PM, Staff A, Administrator, stated diet orders were entered by the provider which was then transferred to the meal ticket and followed by the kitchen. Staff A stated the expectation was for residents to receive ordered diets and Resident 23 receiving food outside their diet did not meet expectation.</p> <p>Reference WAC 388-97-1100 (1), -1220</p>

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40817</p> <p>Based on observation and interview, the facility failed to maintain sanitary food storage and preparation areas when reviewed for kitchen. This failure placed residents at risk of foodborne illness, avoidable discomfort, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observation on 03/24/2025 at 9:23 AM showed the kitchen walk-in refrigerator contained a plastic bag with three energy water drinks and a coffee canned drink. Observation showed an extra-large fountain drink with straw in a different area of the refrigerator.</p> <p>During an interview on 03/24/2025 at 12:02 PM, Staff Y, Registered Dietician, stated the energy waters, coffee canned drink, and fountain drink were likely staff items and should not be stored in the facility walk-in refrigerator.</p> <p>Observation on 03/26/2025 at 11:30 AM showed Staff X, Dietary Services Manager, performed hand hygiene and turned off the water with bare hands.</p> <p>Observation on 03/26/2025 at 11:40 AM showed Staff V, Cook, performed hand hygiene and turned off the water with bare hands.</p> <p>Observation on 03/26/2025 at 12:05 PM showed a preparation table behind the tray line contained a disposable coffee cup and underneath the tray line on a shelf was a disposable cup with a lid and a fork.</p> <p>During an interview on 03/26/2025 at 12:39 PM, Staff X, Dietary Services Manager, stated the coffee cup contained staff water and the disposable cup contained peach cobbler (the dessert of the day) and a disposable fork. Staff X stated neither item should be stored near the tray line.</p> <p>Observation on 03/26/2025 at 12:19 showed a milk glass dropped on the ground. Staff W, Dietary Aide, retrieved the glass, put it in the dishwashing area, and returned to work without performing hand hygiene.</p> <p>Observation on 03/26/2025 at 12:29 PM showed a bottle of energy water under the steamtable on a shelf.</p> <p>During an interview on 03/26/2025 at 1:30 PM, Staff X, Dietary Services Manager, stated staff items should not be stored with kitchen food items to avoid cross contamination and should be stored outside the kitchen. Staff X stated staff performing hand hygiene should use a paper towel to turn off the water and not use bare hands. Staff X stated staff should perform hand hygiene after retrieving items from the floor.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 03/27/2025 at 8:48 AM, Staff A, Administrator, stated staff and facility food should not be stored together and the observations of staff food in the facility kitchen walk-in refrigerator and near the tray line did not meet expectation. Staff A stated staff should not turn off the water with bare hand after performing hand hygiene and should perform hand hygiene after retrieving items from the floor. Staff A stated the hand hygiene observations did not meet expectation.</p> <p>Reference WAC 388-97-1100 (3), -2980</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper fit and use of personal protective equipment (PPE, equipment worn to minimize exposure to infectious diseases/illnesses) as required for transmission-based precautions (TBP, precautions/PPE used with known or suspected infectious diseases/illnesses) for 3 nursing staff (Staff N, O, and P) in 3 of 4 halls (100, 200, and 300 halls) when reviewed for infection control. Also, the facility failed to complete the ongoing collection and analyzation of infection control data, which included the identification of organisms present in the facility for 3 of 3 months (December 2024, January 2025, and February 2025) when reviewed for infection control. These failures placed residents, visitors, and staff at risk for communicable diseases, infections and related complications.</p> <p>Findings included .</p> <p><TBP></p> <p>Review of the facility policy titled Categories of Transmission-Based Precautions revised 03/21/2024 showed Transmission-Based Precautions in addition to Standard Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others and require additional precautions in addition to those of Standard Precautions.</p> <p>100 Hall</p> <p>Observation on 03/24/2025 at 10:32 AM showed a contact precautions sign posted outside of room [ROOM NUMBER] which instructed staff to put on PPE (gloves and gown) prior to entering the resident's room.</p> <p>Observation on 03/24/2025 at 12:58 PM, showed Staff N, Certified Nursing Assistant (CNA), entered room [ROOM NUMBER] without putting on the required PPE.</p> <p>200 Hall</p> <p>Observation on 03/24/2025 at 12:08 PM showed a droplet/contact precautions sign posted outside of room [ROOM NUMBER] which instructed staff to put on PPE (gloves, gown, mask and eye protection) prior to entering the resident's room.</p> <p>Observation on 03/24/2025 at 12:49 PM, showed Staff N, CNA, and Staff P, CNA, entered room [ROOM NUMBER] without putting on the required PPE.</p> <p>300 Hall</p> <p>Observation on 03/24/2025 at 10:22 AM showed a contact precautions sign posted outside of room [ROOM NUMBER] which instructed staff to put on PPE (gloves and gown) prior to entering the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/24/2025 at 10:46 AM, showed Staff O, Licensed Practical Nurse (LPN), entered room [ROOM NUMBER] without putting on PPE.</p> <p>During an interview on 03/26/2025 at 10:11 AM, Staff Q, Registered Nurse/Infection Preventionist (RN/IP), stated it was their expectation that staff follow the posted precautions signs when entering the rooms and providing care.</p> <p>Observation on 03/24/2025 at 10:18 AM showed an aerosol precautions sign posted outside of room [ROOM NUMBER]. The door was open, and the sign included a section to mark the time precautions ended. It noted If the air changes per hour are unknown, the door to the room should stay closed and anyone entering the room must wear a NIOSH [National Institute for Occupational Safety and Health] approved fit-tested N95 or equivalent or higher-level respirator for a minimum of 3 hours following the procedure.</p> <p>Review of the facility's respiratory protection program dated 07/16/2021 showed All employees designated to use the FFR's [full face respirators/N95] will be fit-tested by a trained 'Fit Tester' using either a NIOSH approved qualitative or quantitative process before using a respirator.</p> <p>Review of employee files on 03/27/2025 showed Staff R, S, T, and U had no documentation they had been fit tested for the use of and proper fit of N95 respirators.</p> <p>During an interview on 03/26/2025 at 12:17 PM, Staff C, Corporate Registered Nurse, stated they were unable to locate documentation of N95 fit testing for the sampled staff. Staff C stated staff should have fit testing done on hire and annually and records of it kept in the employee files.</p> <p><Surveillance Tracking></p> <p>Review of the facility policy titled Infection Prevention and Control revised 08/2019 showed section 3.b, Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices and detecting unusual pathogens with infection control implications.</p> <p>Review of the facility provided documents titled January 2025 ABO [antibiotic] Stewardship and February 2025 ABO Stewardship showed a list of residents receiving antibiotics. The list did not include the cite/location/type of infection, the symptom onset dates or the identified organisms. No documentation of surveillance tracking of infections for the month of December 2024 was provided.</p> <p>During an interview on 03/26/2025 at 10:11 AM, Staff Q, RN/IP, stated they had just started in the position a few weeks ago and had to create the line listings and maps for January and February 2025 yesterday (03/25/2025) but did not create one for December 2024. Staff Q stated the line listing and maps should be updated daily and include the type/site of infection and identified organisms if available.</p> <p>During an interview on 03/26/2025 at 11:04 AM, Staff C, Corporate Registered Nurse, stated it was their expectation the IP track the cite/location/type of infections, the symptom onset dates, and the identified organisms on the infection control line listing daily.</p> <p>Reference WAC 388-97 -1320 (2)(a) (b) (c)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</p> <p>Based on interview and record review, the facility failed to offer and provide influenza and/or pneumococcal vaccines for 3 of 5 sampled residents (Residents 56, 37, and 48) when reviewed for vaccinations. This failure placed the residents at a higher risk for contracting influenza and pneumococcal infections, related complications, and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled Vaccination of Residents revised October 2019 showed, All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated, Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations, If vaccines are refused, the refusal shall be documented in the resident's medical record., and If the resident receives a vaccine, at least the following information shall be documented in the resident's</p> <p>medical record: a. Site of administration; b. Date of administration; c. Lot number of the vaccine (located on the vial); d. Expiration date (located on the vial); and e. Name of person administering the vaccine.</p> <p>Resident 56</p> <p>Review of the electronic health record (EHR) showed Resident 56 admitted to the facility on [DATE] with diagnoses of infection of the skin and asthma (a chronic lung disease). The resident was able to make needs known.</p> <p>Review of the EHR on 03/24/2025 showed Resident 56 was offered the influenza vaccine and it accepted on 01/30/2025. No documentation was found that the resident was provided the influenza vaccine.</p> <p>Resident 37</p> <p>Review of the EHR showed Resident 37 admitted to the facility on [DATE] with diagnoses including hemiplegia (unable to move half of the body) and a brain bleed. The resident was able to make needs known.</p> <p>Review of the EHR on 03/24/2025 showed no documentation that Resident 37 was offered, educated, provided or declined the pneumococcal vaccine.</p> <p>Resident 48</p> <p>Review of the EHR showed Resident 48 admitted to the facility on [DATE] with diagnoses including respiratory failure and diabetes (too much sugar in the blood). The resident was able to make needs known.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EHR on 03/24/2025 showed Resident 48 was offered and consented to receive the pneumococcal vaccine on 06/03/2024. No documentation was found in the resident's EHR that the resident was administered the vaccine.</p> <p>During an interview on 03/24/2025 at 12:03 PM, Staff Q, Registered Nurse/Infection Preventionist, stated residents should be offered on admission the influenza and pneumococcal vaccines and if they consent, they should get an order and administer the vaccines, but this did not happen for Residents 56, 37, and 48.</p> <p>During an interview on 03/24/2025 at 3:10 PM, Staff C, Corporate Registered Nurse, stated it was their expectation that staff educate, offer and administer the influenza and pneumococcal vaccines on admission and annually.</p> <p>Reference WAC 388-97-1340 (1), (2), (3)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</p> <p>Based on interview and record review, the facility failed to offer and provide Covid-19 vaccines for 2 of 5 sampled residents (Residents 28 and 37) when reviewed for vaccinations. This failure placed the residents at a higher risk for contracting Covid-19 infections, related complications, and a decreased quality of life.</p> <p>Findings included .</p> <p>Resident 28</p> <p>Review of the electronic health record (EHR) showed Resident 28 admitted to the facility on [DATE] with a diagnosis of diabetes (too much sugar in the blood). The resident was able to make needs known.</p> <p>Review of the EHR showed the resident had consented to receive the Covid-19 vaccine on 10/31/2024. No documentation was found in the resident's EHR that Resident 28 was administered the Covid-19 vaccine.</p> <p>Resident 37</p> <p>Review of the EHR showed Resident 37 admitted to the facility on [DATE] with diagnoses including hemiplegia (unable to move half of the body) and a brain bleed. The resident was able to make needs known.</p> <p>Review of the EHR on 03/24/2025 showed no documentation that Resident 37 was offered, provided or declined the Covid-19 vaccine.</p> <p>During an interview on 03/24/2025 at 12:03 PM, Staff Q, Registered Nurse/Infection Preventionist stated residents should be offered on admission the Covid-19 vaccine and if the consented they should get an order and administer it, but this did not happen for Residents 28 and 37.</p> <p>During an interview on 03/24/2025 at 3:10 PM, Staff C, Corporate Registered Nurse, stated it was their expectation that staff educate and offer the Covid-19 vaccine on admission and annually, obtain an order and administer it if due and requested.</p> <p>No associated WAC</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>34567</p> <p>Based on interview and record review, the facility failed to ensure oversight of certified nurse assistants (CNA) received 12 hours of in-service training per year as required and were provided mandatory dementia management training when reviewed for nurse competencies or their performance evaluations reviews. Failure to ensure CNAs completed required hours of training and competencies and conduct annual performance evaluation reviews placed residents at risk for potential negative outcomes and unmet care needs.</p> <p>Findings included .</p> <p>During an interview on 03/27/2025 at 11:49 AM, Staff CC, CNA, stated they had worked at the facility for the last three years and would be contacted on occasion via email as to what training they needed; however, they did not remember as to what training was still needed and further stated they did not remember getting any performance evaluations the last few years.</p> <p>During an interview and record review on 03/27/2025 at 11:53 AM, Staff Q, Registered Nurse/Infection Preventionist/Staff Development Coordinator, stated they or the facility's human resources did not have access to the computer training records for the facility's CNA, or their performance review records, so they could not produce the staffs' computer training records and did not know whether the required 12 hour of continued education was being met.</p> <p>During an interview on 03/27/2025 at 12:36 PM Staff C, Corporate Registered Nurse, stated it was their expectation the staff competencies and performance reviews were readily available to ensure staff possess the necessary competencies and skill sets and the necessary training was completed to meet resident needs.</p> <p>During an interview on 03/27/2025 at 12:39 PM, Staff DD, Pay Benefit Coordinator, stated they had just started working at the facility a couple weeks ago and did not have access to the computer training record. The facility was unable to provide documentation.</p> <p>During an interview on 03/27/2025 at 12:41 PM, Staff A, Administrator, stated the records for the CNA should be readily available and the necessary trainings were completed to ensure the staff were competent in dealing with the residents' care.</p> <p>Reference WAC 388-97-1680 (2) (a-c)</p>		