STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505264	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview, and record review, the facility failed to consistently maintain the medication refrigerator temperature logs in 2 of 2 medication rooms (The 100/200 hall and 300/400 hall medication rooms) reviewed for medication storage. This failure placed the residents at risk for receiving compromised or ineffective medications. Findings included .Review of the facility's policy titled, Medication Storage, dated 2007, showed medications that required refrigeration, were to be kept in the refrigerator between 36 and 46 Fahrenheit (F, temperature scale) with a thermometer to allow temperature monitoring. It showed, A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily. <100/200 Hall Medication Room>Observation on 04/22/2026 at 8:04 AM with Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), of the medication room refrigerator located in the 100/200 hall medication room showed various liquid medications including vaccines that were stored in the refrigerator. The thermometer showed a temperature of 28F (outside of parameters). Review of the April 2026 refrigerator temperature logs from 04/01/2026 - 04/22/2026 showed missing documentation and that temperatures were not consistently being monitored and documented twice a day. During an interview on 04/22/2026 at 8:04 AM, Staff E, RCM/LPN, stated the refrigerator temperature was 28F which was out of parameters. Staff E stated the April 2026 refrigerator and freezer temperature logs were missing documentation and were not being documented on twice a day and should have been because there were vaccines stored in the refrigerator. <300/400 Hall Medication Room>Observation on 04/22/2026 at 11:24 AM with Staff K, Registered Nurse (RN), of the medication room refrigerator located in the 300/400 hall medication room showed various liquid medications including vaccines that were stored in the refrigerator. Review of the April 2026 refrigerator temperature logs from 04/01/2026 - 04/22/2026 showed missing documentation and that temperatures were not consistently being monitored and documented twice a day. During an interview on 04/22/2026 at 11:24 AM, Staff K, RN, stated the April 2026 refrigerator temperature logs were not consistently being documented twice a day and should have been because there were vaccines stored in the refrigerator. During an interview on 04/22/2026 at 11:54 AM Staff A, Administrator, stated that the 100/200 hall April 2026 refrigerator temperature logs had missing documentation and were not being documented twice a day. Staff A stated the 300/400 hall April 2026 refrigerator temperature logs were not consistently documented twice a day. Staff A stated this did not meet their expectations. Reference WAC 388-97-2340

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor potential adverse side effects (ASE) related to the use of psychoactive (affecting the mind) medications for 4 of 5 sampled residents (Residents 2, 11, 14, and 69) when reviewed for unnecessary medication use. Failure to have adequate indications or diagnosis for psychoactive medication use for Resident 2, consistent orthostatic blood pressure monitoring for Resident 11, and to conduct/obtain abnormal involuntary movement scale (AIMS) assessment for the use of an antipsychotic medication (a psychoactive medication that affects a person's mental status) for Residents 14 and 69, placed residents at risk of medical complications, unidentified presence and severity of AIM ASE, and a diminished quality of life. Findings included .Resident 2 Review of the electronic health record (EHR) showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (stroke caused by reduced blood flow in the brain), dementia (decline in cognitive function), and chronic obstructive pulmonary disease (restricted airflow that makes breathing difficult). Resident 2 was able to communicate needs. Review of the admission minimum data set (MDS, a required assessment) dated 02/19/2026 showed Resident 2 was receiving antipsychotic medication and did not have behaviors. Review of the provider order dated 02/13/2026 showed Resident 2 was ordered quetiapine 25 milligrams (mind altering medication) to be administered at bedtime without indication or diagnosis. During an interview on 04/22/2026 at 1:51 PM, Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 2 should have indication and diagnosis with an order of quetiapine. Resident 11 Review of the EHR showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include fracture of right arm, dementia, diabetes (high blood sugar) and heart failure. Resident 11 was not able to communicate needs. Review of the significant change MDS dated [DATE] showed Resident 11 was receiving antipsychotic medication. Review of a provider order dated 03/10/2026 showed Resident 11 was ordered Seroquel 25 mg (mind altering medication) twice a day for a diagnosis of vascular dementia without behaviors. Review of the EHR for the month of March 2026 showed Resident 11 did not have orthostatic (shows changes in blood pressure from laying sitting and standing, indicating side effects) blood pressure results. During an interview on 04/22/2026 at 1:56 PM, Staff E, RCM/LPN, stated Resident 11's diagnosis should have been updated and did not meet indication for use. Staff E stated the orthostatic blood (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure should have been completed. During an interview on 04/24/2026 at 11:36 AM, Staff C, Regional Director of Quality Assurance, stated lack of appropriate diagnosis for Resident 2 and 11's antipsychotic medications did not meet expectations. Resident 14 Review of the EHR showed that Resident 14 readmitted to the facility on [DATE] and had diagnoses to include schizoaffective disorder-depressive type (mental health condition combining primary schizophrenia symptoms such as hallucinations/false sensory perceptions or delusions/fixed false beliefs with major depressive episodes/persistent low mood), anxiety disorder, and post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or harmful event). Resident 14 was able to make needs known. Review of the quarterly MDS dated [DATE] and 03/03/2026 showed Resident 14 received an antipsychotic medications. Review of the EHR showed Resident 14's last AIMS assessment was conducted/obtained on 09/09/2026. Review of the medication administration records (MAR) from 10/01/2025 – 04/21/2026 showed Resident 14 had received an antipsychotic medication on a routine basis. During an interview on 04/22/2026 at 2:03 PM, Staff D, RCM/LPN, stated residents who received an antipsychotic medication were to have an AIMS conducted every six months. Staff D stated Resident 14 had an AIMS completed on 09/09/2025 and should have had another one performed in March 2026. During an interview on 04/22/2026 at 2:23 PM, Staff E, RCM/LPN, stated Resident 14's last AIMS was conducted on 09/09/2025 and was now late and needed to be conducted. Staff E stated AIMS were to be completed every six months for residents receiving antipsychotic medications. Resident 69 Review of the EHR showed that Resident 69 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (loss of cognitive function), congestive heart failure (when the heart is unable to pump blood efficiently) and depression. Resident 69 was unable to make needs known. Review of the providers' orders showed Resident 69 received antipsychotic medications used to treat/manage psychosis symptoms like hallucination, delusions, and severe agitation. Review of the EHR showed Resident 69 had an AIMS assessments conducted on 04/01/2025 and 01/06/2026. During an interview on 04/23/2026 at 1:08 PM, Staff D, RCM/LPN, stated residents who received an antipsychotic medication were to have an AIMS conducted every six months. Staff D stated Resident 69's 01/06/2026 AIMS was conducted late and did not meet expectations. Reference WAC-388-97- 0640(4)(9)

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	505264	A. Building B. Wing	04/24/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure sharps containers (containers to safely store used sharp, medical equipment, e.g. used needles) were regularly emptied and sharps were inaccessible to residents for 2 of 4 sampled sharps containers (200 and 300 hall) reviewed for accident hazards. This failure placed residents at risk of access to used medical equipment, transmission of dangerous infections, and a diminished quality of life. Findings included.Observation on 04/24/2026 at 10:18 AM showed the 200 hall medication cart had a sharps container affixed to the side. Observation showed the sharps container contained used needles which were visible/assessable and were stacked flush to the rim. Observation showed the spinning part which allowed the needles to fall to the bottom of the container and be inaccessible was not visible due to the amount of needles stacked atop it. Observation on 04/24/2026 at 10:20 AM showed the 300 hall medication cart had a sharps container affixed to the side and a few needles were visible. Observation showed the spinning part did not turn when needles were inserted and needles were starting to be stacked atop. During an interview on 04/24/2026 at 10:22 AM, Staff A, Administrator, stated the sharp containers having visible/accessible needles did not meet expectations. During an interview on 04/24/2026 at 11:32 AM, Staff C, Regional Director of Quality Assurance, stated the facility ensured used sharps, such as needles, were not an accident risk to residents be regularly emptying the sharps containers and sharps were fully enclosed at the bottom of the container. Staff C stated the sharps containers which had visible/accessible needles did not meet expectations. Reference WAC 388-97-1060(3)(g)

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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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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide non-pharmacological interventions (NPI, health interventions/approaches used instead of medication) for 2 of 5 sampled residents (Residents 11 and 14) when reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included.Resident 11 Review of the electronic health record (EHR) showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include fracture of right arm, dementia (decline in cognitive function), diabetes (high blood sugar) and heart failure. Resident 11 was not able to communicate needs. Review of April 2026 medication administration record (MAR) showed Resident 11 was administered acetaminophen (pain medicine) as needed seven times. Review of the acetaminophen order showed Resident 11 was to be offered nonpharmacological interventions prior to administering the pain medicine and was documented as not applicable. During an interview on 04/22/2026 at 1:57 PM, Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the nurses should have documented the interventions and not document not applicable. Resident 14 Review of the EHR showed that Resident 14 readmitted to the facility on [DATE] with diagnoses to include high blood pressure, anxiety disorder, and osteoporosis (a disease that weakens bones, making them fragile, thin, and brittle). Resident 14 was able to make needs known. Review of the April 2026 MAR from 04/01/2025 – 04/21/2025 showed Resident 14 had an order with a start date of 05/28/2024 for acetaminophen as needed for pain, document NPI attempted prior to providing the medication, and had listed NPI including a code for refusal. Documentation showed Resident 14 was provided acetaminophen on 04/07/2026 for pain; however, NA (not applicable) was documented for NPI interventions instead of a code from the listed NPIs. No NPIs were documented. Review of the April 2026 treatment administration records (TAR) from 04/01/2025 – 04/21/2025 showed Resident 14 had an order dated 04/21/2022, to document pain scale rating each shift and to record intervention and effectiveness every day and night shift. Documentation showed Resident 14 had a pain level of 0 each shift. During an interview on 04/22/2026 at 1:51 PM, Staff D, RCM/LPN, stated NPIs should be documented prior to giving an as needed pain medication. Staff D stated Resident 14 was provided as needed acetaminophen on 04/07/2026; however, NA was documented instead of NPIs and this did not meet expectations. During an interview on 04/22/2026 at 2:16 PM, Staff E, RCM/LPN, stated Resident 14 was given as needed acetaminophen on 04/07/2026 and the April 2026 MAR showed not applicable was documented and should have had an NPI and/or the code for refusal documented. Reference WAC-388-97- 1060(3)(k)(i)

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	505264	A. Building B. Wing	04/24/2026

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer and educate for influenza and pneumococcal vaccines for 2 of 5 sampled residents (Residents 21 and 10) reviewed for influenza and pneumococcal immunizations. These failures denied residents the opportunity to make an informed decision regarding receiving immunizations and/or placed the residents at risk for communicable diseases, complications of other medical conditions, hospitalization, and death. Findings included .Review of Resident 21's electronic health record (EHR) showed an admission date of 07/02/2022. There was no documentation that the facility provided education of the risks and benefits of the influenza vaccine for the 2025/2026 season. Review of Resident 10's EHR showed an admission date of 01/10/2026. There was no documentation that the facility provided education of the risks and benefits of the influenza vaccine or the pneumovax vaccine in 2026. During an interview on 04/24/2026 at 11:39 AM, Staff C, Regional Director of Quality Assurance, stated it was their expectation that all residents be offered the pneumococcal vaccines on admission and influenza vaccine annually with education provided on risks and benefits and a consent/declination form completed. Staff C stated that this was not done for Residents 21 and 10, and should have been. Reference WAC 388-97-1340(1)(2)(3)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review, the facility failed to ensure Covid-19 (a highly infectious respiratory illness caused by a virus) vaccinations had documented evidence in the medical record that education was provided regarding the benefits and potential side effects of the COVID-19 vaccine for 2 of 5 sampled residents (Residents 10 and 7) reviewed for Covid-19 vaccinations. There was no documented evidence that the resident/representative received education and accepted or refused the vaccine. These failures denied the resident/representative the right to make informed decisions and placed residents at risk for adverse health effects of a communicable disease. Findings included .Review of Resident 10's electronic health record (EHR) showed an admission date of 01/10/2026. There was no documentation that the facility provided education of the risks and benefits of the Covid-19 vaccine. Review of Resident 7's EHR showed an admission date of 02/11/2026. There was no documentation that the resident was provided education of the risks and benefits of the Covid-19 vaccine. During an interview on 04/24/2026 at 11:39 AM, Staff C, Regional Director of Quality Assurance, stated it was their expectation that all residents be offered the Covid-19 vaccines on admission with education provided on risks and benefits and a consent/declination form completed. Staff C stated that this was not done for Residents 7 and 10 and should have been. Reference WAC 388-97- 1620(2)(b)(i)(ii)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform residents of their right to formulate an advanced directive and failed to periodically review residents' decision to formulate an advanced directive for 2 of 3 sampled residents (Residents 57 and 63) reviewed for advanced directives. This failure placed residents at risk of lacking the ability to appoint someone to make decisions for them when incapacitated and a diminished quality of life. Findings included.Resident 57Review of the electronic health record (EHR) showed Resident 57 admitted to the facility on [DATE] with diagnoses to include pressure wound of the lower back, diabetes (too much sugar in the blood), and bipolar disorder (mental health condition characterized by manic highs and depressive lows). Resident 57 was able to make needs known. Review of the Profile page showed Resident 57 was their own responsible party and did not have a power of attorney (someone to make decisions for you when incapacitated) or guardian (someone appointed to make decisions for someone who is unable to make their own decisions). Review of a Care Conference Information evaluation, dated 04/14/2026, showed Resident 57 had an Advanced Directive (AD, a document stipulating who should make decisions for you if you are incapacitated, e.g. power of attorney or guardian). Resident 63Review of the EHR showed Resident 63 admitted to the facility on [DATE] with diagnoses to include chronic kidney disease, diabetes, and dementia (a group of symptoms that affects cognition). Resident 63 was able to make needs known. Review of the Profile page showed Resident 63 was their own responsible party and did not have a power of attorney or guardian. Review of a Care Conference Information evaluation, dated 01/25/2026, showed Resident 63 had an AD. During an interview on 04/22/2026 at 2:00 PM, Staff J, Social Services Director (SSD), stated the AD mentioned in the Care Conference Information evaluations referred to end-of-life care decisions. Staff J stated they were unsure how the facility was currently reviewing AD with residents and they would investigate. During an interview on 04/23/2026 at 10:31 AM, Staff J, SSD, stated AD should be reviewed with residents on admission, quarterly, and as needed. Staff J stated the facility was currently only reviewing end-of-life care decisions in the admission packet and Care Conference Information evaluation, and not resident AD. Staff J stated Residents 57 and 63 had not been informed of their right to formulate an AD and their AD decision was not reviewed, and this did not meet expectations. During an interview on 04/23/2026 at 10:47 AM, Staff A, Administrator, stated the facility reviewed AD through the admission packet and they should be reviewed at the quarterly care conference. Reference WAC 388-97-0280(3)(c)(i)(ii), -0300(1)(b)(3)(a)-(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, homelike environment for 2 of 17 sampled residents (Residents 10 and 48) reviewed for safe/homelike environment. The facility's failure to ensure Resident 10's damaged wall was repaired and Resident 48's room contained cleanable surfaces placed residents at risk of decreased mood, infection, and a diminished quality of life. Findings included.Resident 10 Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include Wernicke's encephalopathy (vitamin B deficiency that leads to confusion and unsteady walking), dementia (a group of symptoms that affects cognition), and delusional disorder (a mental health condition characterized by the presence non-bizarre fixed, false beliefs). Resident 10 was unable to make needs known. Observation on 04/20/2026 at 12:57 PM showed a large, damaged area to the wall above Resident 10's bed which revealed the brown cardboard color beneath. Observation showed the damage was circular and approximately one foot in diameter. Observation on 04/24/2026 at 11:55 AM showed the damaged area above Resident 10's bed had not been repaired. During an interview on 04/24/2026 at 12:14 PM, Staff L, Maintenance Director, stated wall damage should be reported by staff through the electronic maintenance system to ensure repairs were completed and resident rooms remained homelike. Staff L stated there was a large, damaged area approximately one foot in diameter above Resident 10's bed and it had not been reported to them. Staff L stated the damaged wall was not homelike. During an interview on 04/24/2026 at 12:36 PM, Staff A, Administrator, stated facility staff reported needed repairs through an electronic maintenance system and one-foot diameter wall damage was not homelike. Resident 48 Review of the EHR showed that Resident 48 readmitted to the facility on [DATE] with diagnoses to include heart failure, depression, and was able to make needs known. Observation and interview on 04/20/2026 at 10:43 AM showed Resident 48's bed's footboard had a foam noodle/pool noodle taped to the top. Resident 48 stated that their family member had placed it there. During an interview on 04/23/2026 at 12:38 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the pool noodle attached with tape to Resident 48's footboard did not create a homelike environment; however, it was placed there by a family member. Staff D stated it was not a cleanable surface and the issue needed to be followed up on to see if there was a solution to having a device that would be a cleanable surface. During an interview on 04/23/2026 at 12:45 PM, Staff A, Administrator, stated Resident 48's pool (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noodle placed on the footboard was not a cleanable surface. Staff A stated that they needed to see if it could be replaced with a medical grade device to create a homelike environment and have a cleanable surface. Reference WAC 388-97-0880

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 3 sampled residents (Resident 50) reviewed for personal property and grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed that Resident 50 readmitted to the facility on [DATE] with diagnoses to include high blood pressure, depression, anxiety disorder, and utilized a wheelchair for mobility. Resident 50 was able to make needs known. During an interview on 04/20/2026 at 12:37 PM, Resident 50 stated Resident 27 sped up and down the hallway in their wheelchair very fast all day. Resident 50 stated one time Resident 27's wheelchair wheel got caught in their wheelchair but was then able to go around. Resident 50 stated that staff were aware. Review of the facility's Grievance log from November 2025 - April 15, 2026, showed no grievance logged for Resident 50's safety concern regarding a resident that wheeled too fast up and down the hallway in their wheelchair. During an interview on 04/23/2026 at 2:54 PM, Staff A, Administrator, stated Resident 50 was evaluated on 04/16/2026 by physical therapy for wheelchair safety after Resident 50 had reported the concern to Staff B, Director of Nursing Services (DNS) on 04/15/2026; however, a grievance was not initiated and it should have been once Resident 50 reported the concern to the DNS. Staff A stated this did not meet their expectations. Reference WAC 388-97-0460

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure injuries of unknown sources were reported to the State Hotline for 1 of 2 sampled residents (Resident 42) when reviewed for abuse. This failure placed residents at risk for potential abuse/neglect and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 42 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (loss of cognitive function), congestive heart failure (when the heart is unable to pump blood efficiently) and anxiety. Resident 42 was able to make needs known. Review of the February 2026 accident and incident log showed an entry dated 02/28/2026 for Resident 42 related to skin. The incident was logged as Small bruises occurring in places generally vulnerable to trauma. The action taken was no further action and was not reported to the State Agency according to the incident log. Review of a 02/28/2026 progress note showed Large bruise to right breast noted.Purple/maroon in color with yellowing to outside edges note. [Resident 42] unable to recall or explain cause of bruising due to cognitive impairment and baseline confusion. During an interview on 04/23/2026 at 1:12 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the resident was unable to explain the injury due to cognitive impairment and because of the location of the bruise it should have been reported to the State Hotline. Reference WAC 388-97-0640(5)(a)

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 04/24/2026
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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate the potential for abuse and/or neglect for 1 of 2 sampled residents (Resident 42) reviewed for abuse and neglect. This failure placed Resident 9 at risk for psychosocial harm and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 42 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (loss of cognitive function), congestive heart failure (when the heart is unable to pump blood efficiently) and anxiety. Resident 42 was able to make needs known. Review of the February 2026 accident and incident log showed an entry dated 02/28/2026 for Resident 42 related to skin. The incident was logged as Small bruises occurring in places generally vulnerable to trauma. The action taken was no further action and was not reported to the State Agency according to the incident log. Review of a 02/28/2026 progress note showed Large bruise to right breast noted. Purple/maroon in color with yellowing to outside edges note. [Resident 42] unable to recall or explain cause of bruising due to cognitive impairment and baseline confusion. During an interview on 04/23/2026 at 1:12 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated an incident report should have been completed but they were unable to locate the investigation. During an interview on 04/23/2026 at 2:30 PM, Staff A, Administrator, stated they were unable to locate any documentation related to Resident 42's 02/28/2026 incident. Staff A stated an investigation should have been completed. Reference WAC 388-97-0640 (6)(a-c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505264	A. Building B. Wing	04/24/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received a transfer/discharge notice and/or offered a bed hold for 2 of 3 sampled residents (Residents 6 and 12) reviewed for discharge/hospitalization. This failure placed residents at risk of not understanding their reason for transfer, inability to return to their room, and a diminished quality of life. Findings included.Resident 6 Review of the electronic health record (EHR) showed Resident 6 was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. During an interview on 04/23/2026 at 1:01 PM, Staff M, admission Director, stated the admission department would follow-up with the resident and/or representative after discharge to the hospital and offer a bed hold and fill out a nursing home transfer or discharge notice and send it to the ombudsman. Review of the nursing home transfer or discharge notice for Resident 6 showed that this notice was not given to Resident 6 or their representative; the area was left blank. During an interview on 04/24/2026 at 11:49 AM, Staff C, Regional Director of Quality Assurance, stated Resident 6's transfer or discharge notice to the hospital did not meet expectations. Resident 12 Review of the EHR showed that Resident 12 readmitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), heart failure, and an anxiety disorder. Resident 12 was able to make needs known. During an interview on 04/20/2026, Resident 12 stated they had gone to the hospital; however, they did not recall if the facility offered/provided a bed hold. Review of the Nursing Home Transfer or Discharge Notice, showed Resident 14 was notified of transfer to the hospital on [DATE]; however, the form was signed by a staff member on 04/14/2026 and had not been signed by Resident 12 or their representative. Review of the EHR showed Resident 12 had transferred/discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. It showed no documentation that Resident 12 was offered/provided a bed hold. During an interview on 04/23/2026 at 4:14 PM, Staff A, Administrator, stated it was their expectation that nursing home transfer/discharge forms and bed holds be provided to the resident and/or their representative. Staff A stated they were not aware that Resident 12 was not offered/provided a bed hold or had a singed Nursing Home Transfer or Discharge Notice, for their transfer to the hospital on [DATE]. Staff A stated this did not meet their expectations. Reference WAC-388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080, -0140(1)(a)-(c)(i)-(iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive assessment was accurate for dental conditions or skin conditions for 2 of 17 sampled residents (Residents 35 and 3) reviewed for accuracy of the comprehensive assessment. These failures placed residents at risk of unidentified needs, risk of inadequate plan of care, and a diminished quality of life. Findings included.Resident 35 Review of the electronic health record (EHR) showed Resident 35 admitted to the facility on [DATE] with diagnoses to include spondylosis with myelopathy (compression of the bones in the spine), metabolic encephalopathy (brain dysfunction causing confusion and memory loss), and repeated falls. Resident 35 was able to make needs known. Observation on 04/20/2026 at 1:31 PM showed Resident 35 had damaged lower teeth and no upper teeth. Review of the 5-day minimum data set assessment (MDS), dated [DATE], showed Resident 35 was edentulous (lacked all teeth). During an interview on 04/23/2026 at 2:43 PM, Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 35 had lower teeth and the 02/18/2026 5-day MDS was inaccurate and needed correction. During an interview on 04/24/2026 at 11:28 AM, Staff C, Regional Director of Quality Assurance, stated Resident 35's 02/28/2026 5-day MDS was inaccurate for dental status, and this did not meet expectations. Resident 3 Review of the EHR showed Resident 3 readmitted to the facility on [DATE] with diagnoses to include heart failure, peripheral vascular disease (blood vessels usually in the legs and feet became narrowed, blocked, or damaged), non-pressure chronic ulcer (a long-lasting, slow-healing open sore caused by poor circulation) of the right calf, and inflammatory disorders of scrotum (swelling, pain, and redness in the testicles or surrounding structures). Resident 3 was able to make needs known. During an interview on 04/20/2026 at 10:25 AM, Resident 3 stated they had a wound along their right leg and that it was wrapped and treated by staff. Review of the care plan showed/included that Resident 3 had a non-pressure chronic ulcer of the right calf/ankle initiated on 04/16/2025 and lymphedema (swelling, thickened, bumpy, reddened skin) to the scrotum (the pouch of skin hanging behind the penis that holds and protects the testicles) initiated on 04/27/2023. Review of the treatment administration records (TAR), dated March and April 2026, showed Resident 3 received treatment for their wounds/impaired skin located on their right lower extremity and to the scrotum for wound healing/treatment. Review of Resident 3's quarterly MDS dated [DATE] showed no skin issues documented. (continued on next page)

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	505264	A. Building B. Wing	04/24/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2026 at 10:50 AM, Staff H, Minimum Data Set Coordinator/Registered Nurse (MDSC/RN), stated the March and April 2026 TARs showed Resident 3 had wound treatments conducted for the right lower extremity and scrotum. Staff H stated Resident 3's quarterly MDS dated [DATE] was not coded for their impaired skin integrity and should have been. During an interview on 04/24/2026 at 11:02 AM, after reviewing Resident 3's EHR, Staff C, Regional Director of Quality Assurance, stated the quarterly MDS dated [DATE] was not coded accurately and needed to be modified to reflect Resident 3's skin status. Reference WAC 388-97-1000(1)(a)(b)(4)(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were comprehensively completed to include resident participation for 2 of 17 sampled residents (Residents 12 and 50) when reviewed for care plans. This failure placed residents at risk of not having their input considered in their plan of care, lack of treatments, a decline in clinical condition, and a diminished quality of life. Findings included.Resident 12 Review of the electronic health record (EHR) showed Resident 12 was re-admitted to the facility on [DATE] with diagnoses of urinary tract infection (UTI) with extended-spectrum B-lactamases (ESBL, enzymes produced by bacteria that are resistant to widely used anti-infective medications), diabetes (high blood sugar), and foot infection. Review of a provider orders dated 04/19/2026 showed Resident 12 was ordered antibiotics (anti-infective) medications for their ESBL and foot infection. Review of the care plan on 04/23/2025 showed Resident 12 did not have focus, goal and interventions regarding their ESBL infection and precautions that should be used. During an interview on 04/24/2026 at 10:57 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, stated Resident 12 should have their ESBL/UTI infection and precautions on the care plan. During an interview on 04/24/2026 at 12:49 PM, Staff C, Regional Director of Quality Assurance, stated Resident 12 's care plan did not meet expectations about ESBL. Resident 50 Review of the EHR showed that Resident 50 readmitted to the facility on [DATE] with diagnoses to include high blood pressure, depression, and anxiety disorder. Resident 50 was able to make needs known. During an interview on 04/20/2026 at 12:16 PM, Resident 50 stated it had been a while since they participated in a care conference. Resident 50 stated they did not remember going to a care conference recently. Review of the EHR showed the last care conference Resident 50 participated in was held on 11/26/2025. During an interview on 04/23/2026 at 10:16 AM, Staff J, Social Services Director (SSD), stated care conferences were to be conducted initially within the first seven to ten days upon admit and then quarterly thereafter and/or as needed, and were to be documented in the resident's EHR. Staff J state Resident 50 had their quarterly care conference held on 11/26/2025 and should have had another one held in February 2026 and that did not happen. During an interview on 04/23/2026 at 11:02 AM, Staff A, Administrator, stated Resident 50 had a care conference on 11/26/2025 and should have had another care conference conducted in February 2026. Staff A stated they were unable to locate an invite for another care conference in Resident 50's EHR (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and there should have been. Reference WAC-388-97-1020(2)(c)(d), -1020(2)(e)(f)(4)(b)(d)-(f)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were assessed for hearing needs, obtained needed hearing devices, and hearing devices used were included in plans of care for 1 of 2 sampled residents (Resident 35) reviewed for communication/sensory. This failure placed the residents at risk of inability to hear, reduced ability to participate in activities, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 35 admitted to the facility on [DATE] with diagnoses to include spondylosis with myelopathy (compression of the bones in the spine), metabolic encephalopathy (brain dysfunction causing confusion and memory loss), and repeated falls. Resident 35 was able to make needs known. During an interview and observation on 04/20/2026 at 1:31 PM, Resident 35 stated they used hearing aids at home, and they had left them there before coming to the facility. Observation showed Resident 35 was able to hear questions if the speaker raised their voice to a soft yell. Review of the plan of care, initiated on 02/12/2026, showed no focus area related to hearing or the use of hearing aids for Resident 35. Review of a provider's encounter note, dated 02/20/2026 showed, Behavior: Cooperative throughout the interview, though noted significant hearing impairment requiring repeated questions and clarification and Speech: Normal volume and rhythm, though patient frequently requested repetition due to hearing difficulties. During an interview on 04/23/2026 at 12:07 PM, Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the facility ensured residents with hearing difficulties were provided with assistive devices by reaching out to the admitting hospital to see if their hearing devices were left there and then asking the provider to make a referral to a hearing specialist. Staff E stated Resident 35 was hard of hearing and required a raised voice to communicate. Staff E stated Resident 35 would benefit from a device to increase their hearing, they were unaware Resident 35 had hearing aids at their home, and the facility should have reached out to obtain Resident 35's hearing aids. During a follow-up interview on 04/23/2026 at 2:46 PM, Staff E, RCM/LPN, stated Resident 35's hearing difficulties and hearing aid use should have been included in the plan of care. During an interview on 04/24/2026 at 11:28 AM, Staff C, Regional Director of Quality Assurance, stated the facility should have attempted to obtain Resident 35's hearing aids, and, if unsuccessful, should have referred Resident 35 to a hearing specialist to obtain new hearing aids. Staff C stated hearing difficulties and hearing aid use should be included in the plan of care. Staff C stated Resident 35's lack of care for their hearing difficulties did not meet expectations. Reference WAC 388-97-1060(2)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide complete nail care to 1 of 3 sampled residents (Resident 1) reviewed for activities of daily living (ADL). This failure placed dependent residents at risk for unmet care needs, poor hygiene and diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses of diabetes (too much sugar in the blood), polyneuropathy (nerve damage to multiple nerves) and vascular dementia (reduced or blocked blood flow to the brain, leading to cognitive decline and impaired daily functioning). Resident 1 required extensive staff assistance for ADLs. Observation on 04/20/2026 at 11:59 AM showed Resident 1 laid in bed with their feet in pressure relieving boots. Resident 1's toenails on both feet were long, curved and discolored. Review of the provider's orders showed an order for diabetic nail care (nail care performed by a medical professional) weekly on Wednesdays. Observation on 04/22/2026 at 3:00 PM and 04/23/2026 at 10:00 AM showed Resident 1's toenails remained long, curved and discolored. Review of the April MAR showed Staff F, Licensed Practical Nurse (LPN), signed off on diabetic nail care on 04/22/2026. During an interview on 04/23/2026 at 11:07 AM, Staff F, LPN, stated diabetic nail care included both toenails and fingernails. Staff F stated if residents had thick toenails they were referred to podiatry (foot doctor). Staff F stated the nail care completed for Resident 1 was filing of their fingernails, but their toenails were not included. Staff F did not provide an explanation why Resident 1's toenails were not completed but said they would complete them when they had time. During an interview on 04/23/2026 at 11:30 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the expectation was for nursing staff to complete resident's fingernails and toenails with weekly diabetic nail care. Staff D stated a referral should only be completed if there was an order from the provider or if resident's had thick toenails. Reference WAC 388-97-1060 (2)(c)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement an individualized activity plan for 1 of 3 sampled residents (Residents 61) reviewed for activities. The failure to develop and implement an activity plan of care, that incorporated residents stated interests, hobbies and preferences, placed the residents at risk for boredom, isolation, and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 61 admitted to the facility on [DATE] with diagnoses of stroke, vascular dementia (group of symptoms that affect cognition) and kidney failure. Resident 61 was non-verbal and unable to make needs known. Observations on 04/20/2026 at 9:45 AM, 04/21/2026 at 11:41 AM and 04/22/2026 at 1:46 PM showed Resident 61 laid in bed awake looking at the ceiling or the wall. There was a television in the room, but it was not observed on during any of the observations. Review of Resident 61's care plan (CP) showed the activity focus, goals and invention areas were incomplete. Review of the March and April 2026 activity flow sheet showed Resident 61 was not offered and did not participate in any individual or group activities. During an interview on 04/22/2026 at 2:02 PM, Staff G, Activity Director, reviewed the EHR and stated they should have contacted Resident 61's resident representative to assist with the activity care plan. Staff G stated based on the activity flow sheet Resident 61 had not been offered any independent or group activities and that did not meet expectations. Reference WAC 388-97-0940 (1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents on a fluid restriction were not provided too much fluid for 1 of 4 sampled residents (Resident 78) reviewed for nutrition. This failure placed residents at risk of fluid overload, a decreased clinical status, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 78 admitted to the facility on [DATE] with diagnoses to include acute hypoxemic respiratory failure (the lungs cannot adequately transfer oxygen to the blood), chronic systolic congestive heart failure (reduced ability for the heart to contract and pump blood effectively), and end-stage renal disease (kidney function has dropped to less than 10-15% of normal). Resident 78 was able to make needs known. Review of the care plan, initiated 01/12/2026, showed Resident 78 had a fluid restriction of 1800 milliliters (ml, unit of volume), with nursing providing 480 ml twice a day for 965 ml total and dietary providing 835 ml total per tray card. Review of a provider's order, dated 04/18/2026, showed Resident 78 had a fluid restriction of 1800 ml, with nursing providing 540 ml twice a day for 1080 ml total and dietary providing 240 ml per meal tray for 720 ml total. Review of the January, February, March, and April 2026 medication administration record (MAR) showed how much fluid nursing provided Resident 78 but did not include fluids provided by dietary and did not include the total amounts of fluids consumed. Review of the March 2026 MAR showed nursing provided Resident 78 the following fluids: 04/19/2026 1080 ml, 04/20/2026 1080 ml, and 04/21/2026 1080 ml. Review of a tray card, dated, 04/23/2026, showed Resident 78 was provided the following liquids by dietary: Breakfast: 8 ounces (oz) milk and 8 oz coffee, for a total of 16 oz (473 ml), Lunch: 6 oz lemonade (177 ml), Dinner: 6 oz lemonade (177 ml), and Daily total: 827 ml (107 ml more than provider's order). Review of a fluid tracking form, printed 04/23/2026, showed nursing aids provided Resident 78 the following fluids: 04/19/2026 958 ml, 04/20/2026 840 ml, and 04/21/2026 640 ml. Review of the March 2026 MAR, tray card, and fluid tracking form from 04/19/2026 through 04/21/2026 showed Resident 78 consumed the following total fluids: 04/19/2026 2,865 ml, 04/20/2026 2,747 ml, and 04/21/2026 2,547 ml (respectively, 1,065 ml, 947 ml, and 747 ml over fluid restriction). During an interview on 04/23/2026 at 11:54 AM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the facility would ensure a resident on a fluid restriction would not overconsume liquids by nurses recording provided fluid in the MAR, nursing aids recording fluids provided in the fluid tracking form, and dietary providing the amount of fluid on the tray card. Staff D stated staff should total the fluid recorded to ensure the residents on a fluid restriction were not provided too much fluid. During an interview on 04/23/2026 at 3:00 PM, Staff C, Regional Director of Quality Assurance, stated residents on a fluid restriction were only provided fluids by nursing and dietary and should not receive fluids from nursing aids. Staff C stated nursing provided the fluids specified in the MAR and dietary provided fluids specified by the tray card. Staff C stated Resident 78 was provided fluids over their fluid restriction on some days and this did not meet expectations. Reference WAC 388-97-1060(3)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure recommendations from mental health consultations were followed up on for 1 of 5 sampled residents (Resident 11) reviewed for unnecessary antipsychotic (mind altering) medications. This failure placed the residents at risk for increased side effects, increased behaviors and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include fracture of right arm, dementia (decline in cognitive function), diabetes (high blood sugar) and heart failure. Resident 11 was not able to communicate needs. Review of the significant change minimum data set assessment (MDS) dated [DATE] showed Resident 11 was receiving antipsychotic medication and had experienced a fall with injury. Review of a provider order dated 03/10/2026 showed Resident 11 was ordered Seroquel 25 mg (mind altering medication) twice a day for a diagnosis of vascular dementia without behaviors. Review of EHR showed Resident 11 was seen by psychiatry (branch of medicine focused on diagnosis, treatment and prevention of mental, emotional and behavioral disorders) on 03/06/2026 and showed Resident 11 had recommendations to perform Keppra (medication for seizures) levels and to consider a neurology consultation. Review of the EHR showed Resident 11 was seen by psychiatry on 03/11/2026 with recommendations to discontinue Celexa (a medication for depression) for potential side effects of mania. Review of the EHR showed Resident 11 did not have blood levels for Keppra, and recommendations to discontinue Celexa were not followed. Review of the EHR showed Resident 11 had a fall with injury on the 19th of March and was sent to the hospital. During an interview on 04/22/2026 at 2:03 PM, Staff E, Resident Crae Manager/Licensed Practical Nurse (RCM/LPN), stated typically the process was to read the recommendations from specialist such as psychiatry and follow up on them. Staff E stated Resident 11's psychiatric recommendations should have been completed. Reference WAC 388-97-1000(2)(f)(g)

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 04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were completed to address all aspects of care for 1 of 5 sampled residents (Resident 9) reviewed for dementia care. Failure to develop and implement care plans to address residents' dementia diagnoses and behaviors, placed the residents at risk for unmet care needs, avoidable decline, and diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses of Alzheimer's Dementia (effects memory), chronic pain, and diabetes (too much sugar in the blood). Resident 9 was rarely/never understood, had a short-term memory problem, made poor decisions and required extensive assistance with activities of daily living. Review of the EHR showed Resident 9 had no Care Plan (CP) specifically for Focus, Goals or Interventions related to Alzheimer's Dementia. Review of the April 2026 MAR showed no behavior monitoring in place related to Alzheimer's Dementia. During an interview on 04/22/2026 at 2:57 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated they were unable to locate a CP for Resident 9 related to Dementia care. Staff D stated the expectation was that residents were to have an individualized CP that addressed all areas of care. Reference WAC 388-97-1040 (1)(a-c)

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 04/24/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had dental devices to improve resident ability to eat for 1 of 2 sampled residents (Resident 35) reviewed for dental. This failure placed the residents at risk of discomfort, reduced nutritional intake, unintended weight loss, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 35 admitted to the facility on [DATE] with diagnoses to include spondylosis with myelopathy (compression of the bones in the spine), metabolic encephalopathy (brain dysfunction causing confusion and memory loss), and repeated falls. Resident 35 was able to make needs known. Observation and interview on 04/20/2026 at 1:31 PM showed Resident 35 had damaged lower teeth and no upper teeth. Resident 35 stated they used an upper denture, but it was at their home. Review of the 5-day minimum data set assessment (MDS), dated [DATE], showed Resident 35 was edentulous (lacked all teeth). Review of the care plan, initiated 02/12/2026, did not show a focus area or interventions for dental or denture use. Review of a nutritional assessment, dated 02/16/2026, showed Resident 35 was missing teeth, had dentures but did not have them, and was at risk for further altered nutrition/hydration status related to missing teeth. During an interview on 04/23/2026 at 12:11 PM, Staff E, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the facility ensured residents' dental issues were resolved by having an outside dental provider visit the facility and, if there was a more immediate need, would refer residents to outside dental providers. Staff E stated Resident 35 used upper dentures, but it was not included in their plan of care. Staff E stated the facility should of reached out to obtain Resident 35's denture, and, if unable to obtain, should have referred Resident 35 to get a new denture. During an interview on 04/24/2026 at 11:28 AM, Staff C, Regional Director of Quality Assurance, stated the facility assessed residents for dental needs on admission, quarterly, and as needed and residents with dental needs would have a dental plan of care. Staff C stated Resident 35's dental needs should have been included in their plan of care, and the facility should have referred Resident 35 for new dentures. Staff C stated Resident 35's dental care did not meet expectations. Reference WAC 388-97-1060(3)(j)(vii), -1060(1)(3)(j)(vii)