

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Birch Creek Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 S Orchard Street Tacoma, WA 98409	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision and implement preventative measures to prevent unsafe feeding for one (Resident 1) of three residents reviewed for accidents. Failure to identify known risks, implement individualized, resident-centered interventions, including adequate supervision, communicating interventions to all relevant staff, provide training as needed to reduce those risks and ensure interventions were put into action, placed the resident at risk of being force fed, choked, developing aspiration pneumonia, and psychosocial harm. Findings included. Review of clinical census showed Resident 1 resided in the facility from [DATE] until 05/15/2025. Review of a facility incident investigation showed that on 05/11/2025, at approximately 1:30 PM, staff witnessed an apparent altercation involving Resident 1 and their son during a routine visit. Resident 1 was refusing to take their prescribed medications and had been resisting eating lunch when their son became increasingly frustrated. About 10 minutes of him attempting to encourage her to eat, he was observed yelling at the resident in Russian and then placed his hands on her throat in an apparent attempt to force her to swallow the medication and food. The facility implemented supervised visits and the care plan was revised, Resident's son not to be left alone in the room with her. Visits to occur in common areas. The resident was discharged to an Adult Family Home (AFH) as planned on 05/15/2025. Review of clinical census showed Resident 1 readmitted to the facility 06/25/2025. During an interview on 07/30/2025 at 1:46 PM, Staff H, Licensed Practical Nurse (LPN) stated prior to Resident 1's discharge to the AFH the restrictions were still in place. Resident 1's son wasn't supposed to be in the room with her alone, when he was there, they had staff with them at all times. During an interview on 07/30/2025 at 12:38 PM, Staff E, Social Services Director, during Resident 1's prior stay there was an incident where Resident 1's son was feeding Resident 1 and it appeared he was choking her. Staff E stated they discussed Resident 1's readmission, that Resident 1's son would have to be supervised with her during visits and Resident 1 would be up in the dining room for meals and during feedings. During an interview on 07/30/2025 at 11:46 AM, Staff C, LPN, Unit Manager, stated they were not aware of the incident that occurred previously as the resident was on the other side of the facility during that stay. Staff C stated at re-admission the son was allowed to visit and feed Resident 1 as they were not aware they were not allowed unsupervised visits. During an interview on 07/30/2025 at 1:09 PM, Staff F, Speech-language pathologist (SLP), Stated their student CC3 and themselves did an evaluation on 06/30/2025. An aide fed the resident who did fine on pureed diet and thin liquids. They tried different textures but Resident 1 wouldn't open their mouth, so they were done. Resident 1's son arrived at the end of the evaluation and they discussed that he only feeds her soft foods, soup, would give Resident 1 breaks and was aware they pocketed foods. Staff F confirmed there were no restrictions in place at that time regarding Resident 1's son feeding the resident. During an interview on 07/30/2025 at 12:30 PM, when asked why they did not implement the precautions previously in place, prior to readmission, Staff A, Administrator, stated before Resident 1 discharged to the AFH Staff G, SLP, did training with Resident 1's son and cleared him to feed Resident 1 independently. When asked if that was done prior to discharge, Staff A stated yes, that was their understanding. During an interview on 07/30/2025 at 1:29 PM, Staff G stated they had last treated Resident 1 on 04/02/2025. Staff G stated they tried to teach Resident 1's son how to encourage Resident 1 to eat, he understood but said he did not have five hours to get her to eat. Staff G stated they were making progress, then the insurance cut off and Resident 1 discharged. Staff G stated they were not aware of the 05/11/2025 incident and did not clear them prior to discharge. Review of a 06/25/2025 admission Note showed Resident 1 re-admitted to facility for Long Term Care (LTC) following prior discharge to AFH and subsequent prolonged hospitalization. Review of a facility reported incident showed on 07/25/2025 Resident 2 informed the Nursing Assistant instructor that they believed Resident 1's son was abusing Resident 1 and causing Resident 1 to yell out and make unusual sounds. Resident 2 could not see what occurred during the son's visits due to the curtain being drawn, but stated it sounded like the resident was gurgling and choking. Actions to prevent recurrence included notification to Resident 1's son that they were prohibited to be unsupervised with Resident 1, notified staff and placed a sign on room door stating to check with nurse before entering. Resident's son disallowed to visit unsupervised by staff. Son informed that he was no longer permitted to assist with feeding resident. During an interview on 07/30/2025 at 11:13 AM, Resident 2 stated that they and their son, Collateral Contact 1 (CC1) had heard Resident 1 choking, like they were gasping for</p>		