STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to implement their abuse prohibition policy for 1 of 3 residents (Resident 5) reviewed for abuse and/or neglect. The facility failed to completely and thoroughly investigate Resident 5's injury of unknown origin. The failure to initiate incident reports, conduct a thorough investigation to identify root cause(s) and all contributing factors placed the residents at risk for unidentified abuse or neglect, unidentified corrective actions, risk for injury, and unmet care needs. Findings included .Review of the facility Abuse policy dated 10/20/2022 showed the facility was committed to developing and operationalizing policies and procedures for the prevention, identification, investigation and reporting of abuse, neglect, and mistreatment.Review of the Washington State Department of Social and Health Services (DSHS) Nursing Home Guidelines 'The Purple Book', dated October 2015, showed Chapter 2, titled The Investigation Process, listed substantial injuries of unknown source as incidents that must be thoroughly investigated. Chapter 2 highlights that the key elements of any investigation were its prompt initiation and thoroughness. A comprehensive investigation aims to establish whether abuse or neglect occurred and how to prevent further occurrences.Further review of The Purple Book, Appendix K, titled Definitions, defined: Injuries of Unknown Source-any injury sustained by a resident where the source of the injury was not observed directly by a staff person and may be either superficial or substantial in nature. RESIDENT 5Review of the 11/03/2025 Minimum Data Set (MDS - an assessment tool) showed Resident 5 admitted to the facility 10/27/2025, with severe cognitive impairment, required substantial/maximal assistance with bed mobility, and had no falls since admission.Review of the admission Nursing Collection Tool dated 10/28/2025 showed a documented skin observation with bruising to the right lower extremity. There was no documented bruising or skin impairment observed on the resident's head or back.Review of the 10/28/2025 Rehabilitation CP showed Resident 5 was dependent for bed mobility, dependent for transfers requiring two people, and a sit to stand mechanical lift. The 10/28/2025 Anticoagulant CP showed Resident 5 was at risk for bleeding and bruising related to use of an anticoagulant. The 10/28/2025 Risk for Falls CP showed fall mats were added to the right and left side of the bed on 10/31/2025.Review of progress notes showed a 11/01/2025 2:27 AM Late Entry that Resident 5 was on alert charting related to new ordered medications, resident with no adverse reactions noted, resident also on neuro checks for three days, resident slept through the night, denied pain or discomfort during the shift. An 11/01/2025 3:26 PM Nursing Note showed Resident 5 continued with neuro checks post fall, vital signs stable. Similar documentation was noted in an 11/03/2025 2:24 PM note that Resident continued on alert charting after a fall. A 11/03/2025 9:23 PM alert note showed the resident continued on alert charting for bruise to forehead, on neuros since 10/31 which show no change and were at baseline. There was no documented assessment of the forehead bruise. Review of the October and November 2025 Incident Logs showed no reported incidents involving Resident 5. During an interview with Collateral Contact 1 (CC1) and Collateral Contact 2 (CC2) on 11/07/2025 at 3:06 PM, CC1 stated that on 10/31/2025 Resident 5 was observed with a goose egg (a visible bump) on their forehead. Resident 5 was also observed with bruising on their back. When asked, Resident 5 said they fell out of bed and a man picked them up. CC1 and CC2 said they reported it to the nurse at 9:00 AM, and management around 4:00 PM.On 11/07/2025 at 3:54 PM Resident 5 was observed with Staff C, Assistant Director of Nursing. Observed on Resident 5's right frontal forehead was a raised bump, green and yellow in color, which was the approximate size of a 50-cent piece. On Resident 5's back, on the right, was a red purple discoloration, which Staff C stated felt raised and looked like their skin was pinched. The bed had no side rails, instead there were soft side bolsters in place which Staff C stated they put on the bed a couple of days after Resident 5's admission.During an interview on 11/07/2025 at 4:08 PM, Staff D, Charge Nurse, stated that Resident 5 stated they fell but they were only oriented to self. Resident 5 stated a black man picked them up, but there were no men working. Staff D said they did a neurological assessment, placed fall mats down at the request of the family and updated the care plan. Staff D stated the forehead bruise was yellow and green in color, indicating it was an old bruise. When asked what the expectation was for an injury of unknown origin, Staff D replied, call the provider and file a report. When asked if they had filed an incident report, Staff D replied no and noted their mindset was to find out if the resident fell.During an interview on 11/07/2025 at 4:13 PM, Staff E, Unit Manager, stated they interviewed staff, but there were still people they needed to talk to. Staff E stated they determined the resident did not fall. Staff E stated they were not able to determine what occurred During an interview on 11/07/2025 at 4:21 PM, Staff B, Director of Nursing, stated

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 of 3 (Resident 1 & 2) residents who experienced dementia-related behaviors received care and services to mitigate adverse behaviors. The failure to assess residents individualized care needs through an interdisciplinary approach and implement a person-centered care plan prevented the facility from supporting residents to maintain their highest practicable physical, mental, and psychosocial wellbeing.Findings included . Dementia is a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons. However, dementia is not a specific disease. There are many types and causes of dementia with varying symptomology and rates of progression.Review of the facility Behavioral Assessment, Intervention and Monitoring Policy dated 10/01/2021, the interdisciplinary team would evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly.Review of the facility Elopement/Unsafe Wandering Risk Evaluations policy dated 04/18/2023 showed the facility was committed to ensuring that all reasonable measures were in place to ensure that each resident received adequate supervision and assistance devices to prevent accidents, including elopement and unsafe wandering.Review of the facility Abuse policy dated 10/20/2022 showed the facility would maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and/or misappropriation of resident property is more likely to occur. This included analysis of: The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as resident show have behaviors such as entering other residents' rooms.RESIDENT 1Review of the 10/18/2025 Minimum Data Set (MDS - an assessment tool) showed Resident 1 was assessed with encephalopathy (a medical condition characterized by a general dysfunction of the brain that affects cognitive function, consciousness, and behavior) and Non-Alzheimer's Dementia. Resident 1 was assessed with wandering behaviors, that occurred every 1 to 3 days, which placed the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility) but did not significantly intrude on the privacy or activities of others.Resident 1 was admitted to the facility on [DATE] following a hospital stay. Review of the 10/12/2025 hospital Discharge Summary showed the resident had diagnoses of Encephalopathy, delirium (a sudden onset and frequently reversible state of mental confusion), underlying cognitive deficit, and sundowning (a phenomenon where individuals with dementia experience increased confusion, agitation, and other behavioral changes in the late afternoon or evening hours).Review of an Elopement Risk Evaluation dated 10/13/2025 showed Resident 1 was assessed at risk of as they were alert with cognitive impairment, ambulatory, had verbally expressed a desire or plan to leave the facility unsupervised or stayed near an exit door, had a history of wandering and the family voiced concerns that would indicate the resident may try to leave. A wandergaurd was placed on the resident's left wrist and an at risk for elopement care plan implemented.Review of the 10/13/2025 Elopement Care Plan (CP) showed interventions including distraction, guide resident away from doors as tolerated, call family members to come in to take out for activities.Review of a 10/30/2025 note showed around 7:00 PM, Resident 1 pushed the front door open, and walked out the front door. The wandergaurd alarmed and staff responded. Resident 1 was placed on 15-minute checks.Review of the 15-minute check documentation showed the checks started at 7:00 PM. Resident 1 was wandering on 10/31/2025 from 8:00 PM until 3:30 AM on 11/01/2025. On 10/31/2025 at 9:15 PM Resident 1 was trying to elope. On 11/01/2025 Resident 1 was wandering from 2:15 PM until they went to sleep at 10:30 PM.Review of a 11/01/2025 6:18 PM Note showed Resident 1 spent most of the day wandering around and occasionally tried to open emergency exits. Review of the 15-minute check documentation showed Resident 1 was wandering at noon and eloped at 2:00 PM. On 11/02/2025 a 6:43 PM note showed Resident 1 eloped by following a visitor outside the front door.A 11/03/2025 3:20 PM note showed Resident 1 was found exit seeking in back hallway. Dietary staff intervened and redirected to the main hallway.A 11/09/2025 2:46 PM note showed Resident 1 became agitated, started to exit seek, and three staff members followed the resident outside the facility.Review of the resident's care plan did not specifically address exit seeking behaviors. The CP did not include additional interventions to address the resident's sundowning behavior, or specific times of increased behaviors.Review of progress notes showed a 10/13/2025 7:25 PM entry that Resident 1 was reported wandering and exit