STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505435	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eliseo	1301 N Highlands Parkway Tacoma, WA 98406

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644 Based on observation, interviews and record review, the facility failed to protect a resident's right to be free from mental and verbal abuse for 1 of 3 sample residents (Resident 2) reviewed for resident to resident altercation. This failure placed residents at risk of verbal and mental abuse, psychosocial harm, and diminished quality of life. Findings included . Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 10/22, showed the facility would implement policies and procedures to prevent and prohibit all types of abuse, that achieved the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict. The policy further showed the facility would make efforts to ensure all residents were protected from physical and psychosocial harm during and after the investigation. Examples included room changes, if necessary, to protect the resident from the alleged perpetrator. Review of Resident 1's Admission Minimum Data Set (MDS), an assessment tool, dated 08/16/2024, showed Resident 1 admitted to the Nursing Home on 08/09/2024 with a diagnosis of Dementia. Resident 1 was assessed with severely impaired cognitive skills, and exhibited behaviors of wandering which did not significantly intrude on the privacy or activities of others. Review of Resident 1's electronic medical record showed Resident 1 admitted to a shared room with Resident 2. Review of Resident 2's Quarterly MDS, dated [DATE], showed Resident 2 was a long term resident. According to the MDS, Resident 2 had a diagnosis of Dementia, and was assessed as cognitively intact. On 09/18/2024 at 11:47 AM, during an onsite visit, Resident 1 and Resident 2 were observed to share a room. Resident 1's bed was observed outside the bathroom, next to the shared sink, on the door side of the room. Resident 2's bed was observed by the window side of the room. On 09/18/2024 at 11:47 AM, during an interview, Resident 2 stated that Resident 1 tells me to get out and I say no. Resident 2 stated when (Resident 1) persists and yells to get out, I say now listen, there's two people who live here and we share one toilet, so let's not attack each other. If Resident 1's behavior continued, Resident 2 stated, I keep my distance and usually I leave. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 12:01 PM, when asked if they got along with their roommate, Resident 1 replied, No and proceeded to explain that Resident 2 steals their wife's things, their money, and everything. Resident 1 also voiced concern that Resident 2 used their towels. Review of Resident 1's progress notes showed a 09/10/2024 2:23 PM, note that Resident 1 was noted yelling and screaming to roommate (Resident 2), because roommate was just passing by and brushing teeth. Resident 1 thought Resident 2 was stealing and touching their belongings. Staff explained to Resident 1 the belongings were Resident 2's. Resident continues to get agitated at his roommate. Resident 2 was offered to go to the Bistro (a cafe on the facility campus). Separated both roommates. Staff documented that no physical altercation was noted. Review of a 09/10/2024 11:14 PM, Behavior note in Resident 1's record showed Resident 1 kept screaming at Resident 2 when Resident 2 was brushing their teeth, getting ready for bed, and going to the bathroom. Once Resident 2 was in bed, Resident 1 continued to walk over to Resident 2's side of the room and yell at Resident 2, accusing Resident 2 of stealing their wife's rings and being in their room. Review of the facility incident report and investigation dated 09/10/2024 at 10:00 PM, showed the immediate actions taken to protect the resident were documented as attempted to move Resident 1 to another unit but they refused. Resident 2 also refused to move. Residents on every 15 minute checks and staff outside door for closer observation during night. The intervention staff identified to prevent the incident from reoccurring was to separate the residents from the same room. Review of a 09/11/2024 06:32 AM, Alert note in Resident 1's chart showed staff were interviewed regarding resident yelling and screaming to clarify. Resident was not yelling or screaming but speaking in a loud voice telling roommate to leave the room. Interviewed both residents and explained that the sink was a shared space. Reassured Resident 1 that their roommate was not messing with their personal items but putting own personal items away. A 09/11/2024 09:15 AM, note in Resident 1's record showed Resident 1 was heard yelling at roommate in the morning. Staff went in to redirect resident and roommate was taken to dining room for meal. A 09/11/2024 9:18 AM note in Resident 2's record showed Resident 2 was easily redirected and wheeled self to dining room when roommate (Resident 1) was yelling at them. A 09/12/2024 4:58 AM, note in Resident 1's record showed Resident 1 only had a couple episodes of yelling at his roommate tonight. Staff redirected Resident 1 to leave the room and have a snack at the nurse's station. A 09/12/2024 5:00 AM Note in Resident 2's record showed Resident 2's roommate only yelled at them a few times through the night. The 15 minute monitoring continued. Review of Resident 1's record showed a 09/16/2024 01:07 AM note that there were no aggressive behaviors noted towards roommate although Resident 1 continued to wander over to roommate's side of the room. A 09/17/2024 10:21 AM Nurses Note showed every 15 minute checks were discontinued at that time. No further reports of negative interactions between roommates. On 09/18/2024 at 12:17 PM, Staff C, Registered Nurse (RN), stated after the 09/10/2024 incident there were a couple more episodes, but since then there with no more confrontations seen. Resident 1 was on 15 minute checks until the checks were discontinued on 09/17/2024. Staff C stated Resident 2 spends the majority of the days outside of the room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/2024 at 12:29 PM, Staff D, RN, Resident Care Manager (RCM), stated Resident 1 had difficulty understanding it's a shared room and the sink is a shared space. Staff D stated the behaviors got progressively worse, with Resident 1 yelling at Resident 2 to get out of the room. Resident 2 said they tried to hang out in the Bistro. Staff D said during the 15 minute checks there was no evidence that Resident 2 messed with Resident 1's belongings, rather Resident 1 was observed to go over to Resident 2's side of the room and look around. Staff D stated the residents were asked if one of them wanted to move and neither of them wanted to move. When asked if the facility was doing anything to protect Resident 2, Staff D said No, there's been no further interactions. On 09/18/2024 at 12:37 PM, Staff E, Nursing Assistant, stated when they hear Resident 1 yelling at Resident 2, they go into the room and try to talk to Resident 1. Staff E stated it was an everyday occurrence. Resident 1 did not like Resident 2. Staff E stated that Resident 2 tries to talk to Resident 1 and explain the situation to them. During an interview on 09/18/2024 at 12:42 PM, Staff F, Licensed Practical Nurse (LPN), stated Resident 1 gets upset with Resident 2, and thinks Resident 2 is taking their food, unplugging their clock, touching their stuff. Resident 1 yells and screams at Resident 2 really loud. When asked how frequently this behavior occurred, Staff F stated, That I've witnessed .at least every other day. Staff F stated they go into the room and try to get Resident 1 to stop, but it was hard to reorient Resident 1 when they were really upset. When asked what the facility was doing to protect Resident 2, Staff F stated keep the residents away from each other and noted that Resident 2 usually is out of the room at the Bistro. During an interview on 09/18/2024 at 2:00 PM, Staff A, Administrator, stated they were told there were no altercations between Resident 1 and Resident 2 for a week before the 15 minute checks were discontinued. Staff A stated resident protection was a priority and they planned to move Resident 1 to a private room when one became available. Reference WAC: 388-97-0640 (1)