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	06/26/2025

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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to notify residents of what the charge would be for services not covered under their Medicare Managed Care and/or private pay agreements for 1 of 1 resident (Resident 3) reviewed for billing practices. This failure put residents at risk of unknown service costs, frustration and lack of services. Findings included . Resident 3 was admitted to the facility on [DATE]. Resident 3's Health Center admission Packet, undated, showed the private pay charges for the daily room rates and showed that unless covered by a private insurance provider the resident would be charged for a list of services if they were prescribed or requested. The list of services did not include the charges for the services. On 06/18/2025 at 12:13 PM, Staff A, admission Assistant, said they reviewed the Health Center admission Packet with Resident 3. Staff A said the only charges they reviewed with residents admitting to the facility are the daily room and board charges for private pay residents and they gave residents a list of charges for the beauty salon. Staff A said they do not have the costs for medical supplies and/or therapy. Resident 3's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (ABN), dated 12/13/2025, showed Resident 3's insurance would no longer pay for the resident's stay as of 12/15/2024 and the resident would have to pay out of pocket beginning on 12/16/2024 for the care they had been receiving. The ABN showed the care they had received was physical therapy, occupational therapy, daily skilled nursing care and room and board. The ABN showed they estimated the costs at $687.00 per day and the resident was requesting the services continue. The ABN had no other charges listed. Resident 3's progress notes, dated 12/16/2024, showed the resident expressed they needed therapy since they were paying privately. Resident 3's therapy minutes report, dated 12/01/2024 through 12/31/2024, showed Resident 3 had no therapy minutes documented from 12/20/2024 through 12/27/2024. (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 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/2025 at 1:33 PM, Staff H, Rehab Director, said they stopped Resident 3's therapy on 12/20/2025 because the resident's stay was no longer authorized by their insurance. On 06/18/2025 at 3:23 PM, Staff B, Social Service Director (SSD), said the facility utilized the ABN to notify residents of the charges they will incur when their insurance will no longer be paying for their stay. Staff B said the only charge listed on Resident 3's ABN was $687 per day. Staff B said that charge is the daily room and board charge. Staff B said they do not provide any information on the other charges residents may incur for the remainder of the stay. On 06/23/2025 at 11:35 AM, Collateral Contact (CC1), said they handled Resident 3's finances. CC1 said when Resident 3's insurance stopped paying for Resident 3's stay, the facility had Resident 3 sign an Advance Beneficiary Notice of Non-coverage (ABN) document that showed the resident would pay privately for the services they had been receiving. CC1 said Resident 3 and CC1 believed they would continue to receive all the services they had been receiving in the facility when the insurance was paying, to include room and board, physical therapy and occupational therapy. CC1 said the facility did not notify them of separate charges and/or provide them with the charges for services outside of the private pay daily rate that was listed on the ABN. On 06/26/2025 at 11:43 AM, Staff C, [NAME] Coordinator, said the facility did not provide a list of charges on admission except for the private daily room and board rates. Staff C said the charges for services and/or items were provided on the billing statement after the residents had incurred the cost. On 06/26/2025 at 12:19 PM, in a joint interview with Staff D, Administrator and Staff B, SSD, Staff B said they saw how the ABN could be confusing to residents and/or families regarding what services are covered for the estimated daily rate. Staff B said going forward they would be changing the form so there would be no confusion about what the estimated cost encompasses. Staff D said they had not been providing residents and/or families with charges for services except for the daily room and board rate prior to incurring the cost. WAC Reference 399-97-0300 (1)(e) .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to ensure medical records were complete and accurate for 3 of 3 residents (Resident 1, 2 and 3). This failure placed residents at risk for incomplete and inaccurate medical records and unmet care needs. Findings included . <RESIDENT 1> Resident 1 was admitted on [DATE] with a diagnosis of a stroke. Resident 1's mental health provider notes, dated 06/17/2025, showed the resident was crying throughout the session, had thoughts of despair and was at moderate to high risk for suicide or self-injurious behaviors. Resident 1's progress notes, dated 06/18/2025 at 2:42 AM, showed the resident was on alert for suicidal ideation and was observed during Q [every] 15 minutes checks. Resident 1's physician orders, dated 06/17/2025 and discontinued on 06/19/2025, showed an order to ensure a 15-minute check form was completed. On 06/18/2025 at 12:54 PM Resident 1 was observed sitting in her wheelchair next to her bed. Observation from the hallway showed the resident's legs were visible and the resident's body and head were not visible due to the wall inside the room. Resident 1's room was observed during a continuous observation from 12:59 PM until 1:25 PM. During that time no staff members looked in the room and/or entered the resident's room. At 1:25 PM, Staff E, Certified Nursing Assistant (CNA), was observed entering the room. On 06/18/2025 at 1:27 PM, Staff E, CNA, said Resident 1 was on 15-minute checks and they were documenting they had checked on the resident on the 15-minute monitoring log that was hanging on a clipboard outside of the resident's room. The monitoring log was observed and there was no documentation for 12:45 PM, 1:00 PM, or 1:15 PM. When asked why there were no entries on the log for those times, Staff E said they had been on break, and that was the last time they had checked on the resident and they were just returning. On 06/26/2025, Resident 1's Q 15 Min Monitor [every 15-minute monitor] log, dated 06/18/2025, was reviewed. The log showed documentation every 15 minutes on 06/18/2025, including the times of 12:45 PM, 1:00 PM and 1:15 PM. On 06/26/2025 at 2:20 PM, Staff G, Resident Care Manager (RCM), said the expectation was for staff to only document the tasks they personally complete and Staff E should not have documented they completed observations on 06/18/2025 when they were not present. <RESIDENT 2> (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 was admitted [DATE] with diagnoses of medically complex conditions. Review of the facility's fall investigation report, dated 06/04/2025, showed Resident 2 sustained a fall. The report showed the nursing post fall response was to begin monitoring every 15 minutes and a monitoring log was initiated. Resident 2's physician's orders, dated 06/05/2025 and ended 06/08/2025, showed an order for the nurse to ensure q [every] 15 minutes checks were completed. Resident 2's Q 15 Min Monitor log, dated 06/05/2025, showed documentation of every 15-minute checks from 12:00 AM through 6:00 AM. There was no documentation for the remainder of the day on the form. Resident 2's Medication Administration Record (MAR), dated 06/01/2025 through 06/30/2025, showed documentation the 15-minute checks were completed on 06/05/2025. On 06/26/2025 at 2:20 PM, Staff G, RCM, reviewed Resident 2's medical record and acknowledged the resident's log, dated 06/05/2025, was blank after 6:00 AM. Staff G said the checks should have been completed for the remainder of the day and the licensed nurse should not have documented on the MAR the 15-minute checks were completed. <RESIDENT 3> Resident 3 was admitted to the facility on [DATE]. Review of the facility fall investigation report, dated 12/27/2024, showed Resident 3 sustained a fall. The investigation report showed the nursing post fall response was to begin monitoring every 15 minutes and a monitoring log was initiated. Review of Resident 3's Q 15 Min Monitor log showed documentation of 15 min checks after initiation on 12/27/2024 and on 12/28/2024. On 12/29/2024, the log showed monitoring every 15 minutes from 12:00 AM until 6:00 AM and again at 6:00 PM until the log was completed on 12/30/2024 at 10:00 AM. There was no documentation between 6:00 AM and 6:00 PM on 12/29/2024. On 06/26/2025 at 2:20 PM, Staff G, Resident Care Manager, said the facility used 15-minute checks for a variety of concerns including falls, suicidal thoughts and resident to resident altercations. Staff G said when a resident was placed on 15-minute checks a clipboard is placed outside of their room with a log to document the checks occurred. Staff G said everyone that completed the check documents on the log. Staff G said the licensed nurse documents on the MAR that the checks were completed for their shift. Staff G said the expectation is staff documented tasks they completed, and the licensed nurses reviewed the 15-minute documentation and signed off the MAR if the 15-minute checks were completed. Staff G said it was not acceptable to document the 15-minute checks were completed if they were not and/or to not complete the checks. Reference WAC 388-97-1720 (1)(a)(i-iv)(b) .