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	01/28/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their bowel protocol by not administering necessary bowel medications per policy and provider orders for 1 of 4 residents (Resident 1) reviewed for constipation. This failure placed residents at risk of constipation, rehospitalization, and a diminished quality of life.Findings included.Review of a facility policy titled Management of Constipation, undated, showed bowel patterns would be documented daily. Review of the document showed if a resident did not have a bowel movement (BM) in 48 hours, the facility bowel protocol would have been initiated. Review showed the protocol as follows:-if no BM in two days, give Milk of Magnesia (MOM, a medication to relieve constipation) on the morning of the third day on day shift-if no BM in 8-10 hours after MOM, perform digital rectal exam-If soft stool present give Bisacodyl (a medication to relieve constipation) rectal suppository on evening shift-if no results from rectal suppository within 4 hours, call provider for resident specific orders for an enema (injection of fluid into the rectum to remove stool)RESIDENT 1Resident 1 admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, heart failure, and dementia. The 5-day Medicare minimum data set (MDS), an assessment tool, dated 01/02/2026, showed Resident 1 was severely cognitively impaired.During an interview on 01/15/2026 at 1040 AM, Collateral Contact A, (CC A), daughter, said Resident 1 discharged home on [DATE]. CC A said Resident 1 returned to the hospital on [DATE] in the early morning hours at around 1:00 AM. CC A said Resident 1 was in pain and needed to have a bowel movement. CC A said Resident 1 did not have a BM for the duration of their stay at the facility. CC A said when Resident 1 returned to the hospital, they had an impaction (a large, hard mass of stool that gets stuck so badly in your colon that you cannot push it out.) CC A said Resident 1 had to have the stool removed by hospital staff, causing further health complications.Review of an admission document titled Nurse to Nurse Handoff Form, (a form used to receive a report from the hospital staff to the facility staff), showed Resident 1 had their last BM on 12/28/2025.Review of the Electronic Heath Record (EHR) showed Resident 1 did not have a BM documented for the duration of their stay at the facility. Review of the provider orders, dated 12/29/2025, showed orders for the bowel management protocol included MOM on the third day if no BM, a digital exam if no BM in the next 8-10 hours, a rectal suppository on night shift if no results, and if no results within 4 hours of suppository, to contact the provider for orders for an enema.Review of the Medication Administration Record (eMAR) showed Resident 1 was administered MOM on 12/31/2025. Review of the eMAR showed no documentation of a digital rectal exam, a rectal suppository, or an enema. Review of the eMAR showed the provider was not notified.During an interview on 01/28/2026 at 11:50 AM, Staff B, Certified Nursing Assistant (CNA), said the CNA would document if a resident would or would not have a BM in the EHR under Point of Care (POC) documentation. Staff B said, if a resident had not had a BM in three days, they would let the nurse know.During an interview on 01/28/2026 at 11:53 AM, Staff C, CNA, said the CNA would document if a resident had a (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BM in the computer. Staff C said if a resident did not have a BM in three days, they would notify the nurse.During an interview on 01/28/2026 at 11:59 AM, Staff D, Licensed Practical Nurse (LPN), said the CNA would record the BM in the computer. Staff D said if the resident did not have a BM in three days, they would give an as needed medication per the provider orders for constipation. During an interview on 01/28/2026 at 12:09 PM, Staff E, LPN, said if a resident did not have a BM, they would give MOM on day 3. Staff E said if the resident did not have a BM after receiving MOM, then they would give a suppository. Staff E said if neither were effective, they would contact the doctor to get an order for an enema. During an interview on 01/28/2026 at 01:24 PM, Staff F, Resident Care Manager/LPN, said Resident 1 did not have a BM during their stay at the facility. Staff F said MOM was given on 12/31/2026 at 10:00 AM and again on 1/2/2026 at 06:21 AM. Staff F said there was no digital exam done and no further interventions for constipation were found on the MAR. Staff F said the facility bowel protocol was not followed and it should have been. During an interview on 01/28/2026 at 2:00 PM, Staff A, Director of Nursing/Registered Nurse (DNS/RN), said Resident 1 was administered 12/31/2026 on day three of no BM. Staff A said the bowel protocol was not followed when no additional interventions for constipation per provider orders and the policy. Staff A said the expectation is to follow the bowel protocol and provider orders for constipation.Reference WAC 388-97-1060(1)-(3)