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	04/22/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate resident's and resident representative's preferences for medical oversight into the plan of care for 1 of 3 residents (Resident 2) reviewed for resident rights. This failure placed residents at risk of suboptimal clinical outcomes, medical complications and frustration.Findings included .Resident 2 was admitted on [DATE] with diagnoses including peripheral arterial disease (circulatory condition where narrowed blood vessels reduce blood flow to the limbs, most commonly the legs) and diabetes. The admission Minimum Data Set Assessment (MDS), an assessment tool, dated 10/13/2025, showed Resident 2 had moderate cognitive impairment, required substantial assistance from staff for dressing, bed mobility and transfers. The MDS showed it was very important for Resident 2's family to be involved in discussions about their care.Resident 2's hospital Podiatry Consult, dated 10/03/2025, showed Resident 2 had a history of diabetic ulcerations (wounds) on the right foot that continued to be stable with no open ulcerations. The consult showed the plan was for betadine (wound treatment) to be applied to all digits (toes), toenails and stable eschars (thick black layer of dead tissue that forms over wounds) on 1-5 toes with gauze in webspace (between toes) of toes 1-4 and sponge (type of dressing) over the toes and Kerlix (gauze) wrap of the foot for protection against any potential trauma from bumping the bed/sheet pressure. The consult showed upon Resident 2's discharge from the hospital they would continue outpatient care at the podiatrist's office.On 02/04/2026 at 3:13 PM, Collateral Contact 1 (CC1), said Resident 2 had been admitted to the facility with strict instructions from the podiatrist. CC1 said Resident 2's toe wounds had been treated by their podiatrist for a long time, and it was very important to follow their instructions to save Resident 2's toes. CC1 said the facility would not allow Resident 2's podiatrist to treat Resident 2 and/or they would not follow the recommendations until it was too late. CC1 said it was very frustrating, the nursing staff would not listen to them, and it caused the toe wounds to deteriorate.On 03/03/2026 at 10:00 AM, Collateral Contact 3 (CC3), said they had cared for Resident 2's toe wounds at home prior to hospitalization. CC3 said Resident 2's podiatrist had kept the wounds stable. CC3 said when they went to visit Resident 2 at the facility they observed there was no wrapping on the foot. CC3 was very concerned because the podiatrist had told them not to allow sheets to touch the wounds because it could cause issues. CC3 said they talked to the nurse and told them they wanted Resident 2's podiatrist involved and to follow their treatment orders, but they would not listen to them until it was too late and Resident 2's toe wounds became infected. Resident 2's physician orders, dated 10/06/2025, on admission, showed an order for nursing staff to put betadine on the toes, a dressing between toes 4 and 5 and cover with a light gauze dressing. The order was discontinued on 10/07/2025.Resident 2's Wound Consultant note, dated 10/07/2025, showed the treatment plan for the right toes was to paint the toes with betadine and leave them open to air.Resident 2's communication to the medical provider, dated 10/08/2025, showed CC1 was in the resident's room and was insisting the toes on the right foot need to be wrapped with gauze after they were painted with betadine.Resident 2's progress notes, dated 10/14/2025, showed CC3 was at the facility and discussed the treatment Resident 2 had (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with their podiatrist prior to admission and they were concerned about Resident 2's wound on their toes. The note showed CC3 felt the podiatrist knew Resident 2's right foot better and felt there was an infection in Resident 2's toes. The progress note showed facility staff informed CC3 that the resident's treatment plan may not have aligned with Resident 2's podiatrist but those recommendations were considered and the treatment plan was addressing the resident's needs at that time. Resident 2's wound consultant provider notes, dated 10/14/2025, showed the right toes were assessed and they were without signs of infection.Resident 2's progress notes, dated 10/14/2025, showed Resident 2 had an appointment with their podiatrist on 10/17/2025.Resident 2's physician orders, dated 10/15/2025, showed an order to paint the right toes with betadine apply gauze between the toes and wrap with gauze.Resident 2's podiatrist consult dated 10/17/2025, showed Resident 2 had an infected ulcer on their distal 1st right (toe) and an abscess with ulcer on distal 3rd right (toe). The consult showed an order for antibiotics.On 04/21/2026 at 12:18 PM, Staff F, Physician Assistant and Wound Consultant, said they did not remember if they were aware Resident 2 had long standing relationship with their podiatrist. Staff F said they changed Resident 2's wound care orders for the toes after admission because with eschar on wounds they typically leave them open to air. Staff F said they did not have in their notes that Resident 2's family wanted the toes wrapped in gauze per Resident 2's podiatrist on 10/08/2025, but that would have been fine. Staff F said they said it was fine if Resident 2 saw their podiatrist and they managed the chronic toe wounds.On 04/22/2026 at 2:03 PM, Staff G, Adult Gerontology Nurse Practitioner, said they cared for Resident 2 during their stay at the facility. Staff G said they did not manage wounds and deferred to the facility's Wound Consultant. Staff G said they had no issue if Resident 2's podiatrist was involved with their care.On 04/22/2026 at 12:46 PM, Staff C, Director of Nursing, said Resident 2's treatment recommendations from the podiatrist consult at the hospital should have been considered on admission and when the family raised concerns. Staff C said there was no documentation that Resident 2 and/or their representatives were consulted or notified of the wound care orders, dated 10/06/2025, on admission, were discontinued on 10/07/2025 and a new order that did not include wrapping the toes was initiated. Staff C said they should have been notified, and the new order should have been discussed with them.Reference WAC 388-97-0200(2) 0900(1)1000(1)(a)1020(2)(f)1880(2)(f)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on interview and record review, the facility failed to provide complete medical records upon request for 2 of 3 residents (Resident 1 and 2) reviewed for medical records. This failure placed residents at risk of lack of knowledge of their medical condition, continuity of care and frustration.Findings included.On 02/04/2026 at 3:13 PM, Collateral Contact 1 (CC1) said their family had requested the complete medical records of Resident 1 and 2 and had received the records however they had missing documents and were not complete. CC1 said the records did not show the identity of some of the care staff.Resident 1's Authorization to Disclose Health Information, dated 10/21/2025, showed Resident 1's legal representative had requested Resident 1's entire record from the facility.Resident 2's Authorization to Disclose Health Information, dated 10/21/2025, showed Resident 2's legal representative had requested Resident 1's entire record from the facility. On 02/06/2026 at 12:42 PM, Staff A, Medical Records Assistant, said when a resident and/or resident representative requested their medical record they sent the entire record per their request. Staff A said Resident 1's and Resident 2's records were downloaded into a computer file and downloaded onto a flash drive. Staff A said the electronic software the facility used, Point Click Care, had a feature that allowed the records to be downloaded into a file.Review of the contents of the files sent to Resident 1's and Resident 2's representatives on 04/21/2026, showed incomplete medical records. Review of the Documentation Survey Report sent in the files showed no authentication of the Nursing Assistant documentation.On 04/21/2026 at 2:27 PM, Staff B, Director of Health Information, said they reviewed the medical records that were sent to Resident 1's and Resident 2's representatives and they were not the complete medical records. Staff B said they were missing some orders, progress notes, medical provider notes, assessments and other records. Staff B said they had contacted Point Click Care, their electronic medical record software provider, and discovered when the facility had configured their software, they did not configure it to download the complete medical record. Staff B said this had been configured years ago and no one had brought it to their attention until now.On 04/21/2026 at 2:43 PM, Staff C, Director of Nursing, said they reviewed the medical records and acknowledged Resident 1's and Resident 2's entire medical records were not sent to them. Staff C reviewed the Documentation Survey Report and acknowledged the report did not contain the identification of who completed the documentation of care and services. Staff C said the entire record should have been sent upon request and the documentation should be authenticated by the staff that provided the care and services.Reference WAC 388-97-0300(2)(a)(b)

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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 recognize potential diabetic complications for 1 of 3 residents (Resident 1) and failed to determine and document cause and treatment for a skin tear for 1 of 3 residents (Resident 2) reviewed for quality of care. This failure placed residents at risk of medical complications, infection and a decreased quality of life.Findings included.RESIDENT 1Resident 1 was admitted on [DATE] with diagnoses including Diabetes (condition that affects blood sugar levels in the blood). The admission Minimum Data Set (MDS), an assessment tool, dated 09/03/2025, showed Resident 1 was severely cognitively impaired.On 02/26/2026 at 10:18 AM, Collateral Contact 4 (CC4), said they visited Resident 1 daily at the facility. CC4 said Resident 1 had not been eating at the facility and was not doing well. CC4 said they had asked the nursing staff why they were not checking Resident 1's blood sugar because they were a diabetic and took medication for it. CC4 said the staff told them they had checked it for a few days when Resident 1 was admitted and it was okay, so they did not check it again. CC4 said one day Resident 1 did not look well and a family member insisted on seeing the doctor, CC4 said the staff said everything was fine and did not think it was necessary to check Resident 1's blood sugar.Resident 1's physician orders, dated 08/27/2025, showed glipizide (medication to lower blood sugar for diabetics) daily.Resident 1's physician orders, dated 08/27/2025, showed blood sugar checks daily for seven days.Resident 1's medical provider notes dated 09/23/2025, showed Resident 1 had persistent nausea and vomiting with poor po [oral] intake.Resident 1's medical provider note dated 09/24/2025, showed ongoing nausea throughout the day with poor po intake.Resident 1's progress note dated 09/25/2025, showed Resident 1 had refused both lunch and dinner and drank 120 milliliters of boost (nutritional supplement).Resident 1's medical provider notes, dated 09/26/2025, showed continued poor po intake, nausea and vomiting. Provider note showed plan for further workup to rule out cause but Resident 1's family declined further in house workup and requested hospital transfer.Resident 1's hospital emergency room note, dated 09/26/2025, showed Resident 1 glucose level (blood sugar level) was 47 (low glucose levels are typically defined as below 70) and was given D50 (sugar solution administered through the veins used to treat severe low blood sugar).Resident 1's hospital history and physical, dated 09/26/2025, showed Resident 1 had hypoglycemia (low blood sugar) due to glipizide and nil (zero) PO intake.On 04/22/2026 at 12:46 PM, Staff C, Director of Nursing (DNS), said they had reviewed Resident 1's medical record and it showed Resident was on glipizide daily from 08/27/2025 until they were hospitalized on [DATE]. Staff C said they had not checked Resident 1's blood sugar after the first week after admission. Staff C said Resident 1 had not been eating well and had nausea and vomiting leading to their hospitalization on 09/26/2025 and the nursing staff should have advocated to have Resident 1's blood sugar checked.On 04/22/2026 at 2:03 PM Staff G, Adult Gerontology Nurse Practitioner, said they did not have a good answer why Resident 1's blood sugar was not checked when they were on glipizide and not eating well. Staff G said they should have ordered blood sugar checks. RESIDENT 2Resident 2 was admitted on [DATE] with diagnoses including peripheral arterial disease (circulatory condition where narrowed blood vessels reduce blood flow to the limbs, most commonly the legs) and diabetes. The admission MDS, dated [DATE], showed Resident 2 had moderate cognitive impairment, required substantial assistance from staff for dressing, bed mobility and transfers. The MDS showed it was very important for Resident 2's family to be involved in discussions about their care.On 02/04/2026 at 3:13 PM CC1 said Resident 2 was sent to the hospital from the facility and when they arrived, they were notified of a large skin tear on Resident 2's arm. CC1 said they were unaware of the injury, did not know how Resident 1 sustained the injury and were very concerned.Resident 2's Wound Summary, dated 10/23/2025, showed a facility acquired skin tear that had light, bloody exudate (drainage) and was 6.00 centimeters (cm) by 4.00 cm.On 04/22/2025 at 12:46 PM, Staff C, DNS, said they had no idea how the skin tear occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff C said they reviewed Resident 2's medical record and found no documentation of the skin tear except for the initial Wound Summary. Staff C said there was no treatment ordered, no investigation of how the skin tear occurred, discussion with the resident and/or representative. Staff C said the nursing staff did not follow the facility procedure when they discovered the skin tear.Reference WAC 388-97-1060(3)(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to accurately document the amount of food eaten for 2 of 3 residents (Resident 3 and 4) reviewed for documentation. This failure placed residents at risk for inaccurate medical records, clinical assessments and lack of clinical interventions.Findings included.On 03/03/2026 at 10:00 AM, Collateral Contact 2 (CC2), said they had assisted their family members to eat at the facility and sat with them numerous times during meals. CC2 said when they asked the facility staff what was recorded in the medical record for food consumed during meals it did not match with what they had witnessed, they lied.On 04/21/2026 at 12:03 PM, Resident 3 was observed eating their lunch in the dining room. Staff D, Certified Nursing Assistant (CNA), was assisting Resident 3 to eat. Observation of Resident 3's lunch tray showed a few bites taken out of the main dish and the remainder of the meal untouched. Resident 3 indicated they were finished eating and wanted to return to their room. Staff D assisted Resident 3 out of the dining room. Staff D said Resident 3 had only taken two bites of their meal and a few sips of their supplement.Resident 3's Meal Monitor, dated 04/21/2026 at 12:51 PM, showed Resident 3 had consumed 51-75% of their meal at lunch. Resident 3's Meal Monitor showed the documentation was completed by Staff E, CNA.On 04/21/2026 at 2:00 PM, Staff E, CNA, said they had documented the amount of food eaten at lunch for Resident 3. Staff E said they determined how much food the resident had consumed by observing their tray after they finished the meal. When asked why they documented Resident 3 had consumed 51-75% of their lunch meal when it was observed they had only taken a few bites and the meal was observed largely untouched, Staff E said they must have looked at the wrong tray and/or the documentation was a mistake and they would correct it.On 04/21/2026 at 2:15 PM, Resident 4 was observed eating their lunch. Resident 4 said they enjoyed the lunch and it took them a while to eat their meals. Resident 4 had eaten all their potatoes, 75% of the chicken and 50% of the green beans and were actively eating.Resident 4's Meal Monitor, dated 04/21/2026 at 12:52 PM, showed Resident 4 had consumed 25-50% of their meal.On 04/21/2026 at 2:21 PM, Staff D, CNA, was observed entering Resident 4's room and asked Resident 4 if they were done eating. Resident 4 said they were still eating and wanted to finish their lunch.On 04/21/2026 at 2:22 PM, Staff D, CNA, reviewed Resident 4's Meal Monitor that showed Resident 4 had consumed 25-50% of their lunch and was documented at 12:52 PM. Staff D said they did not know why the documentation had been completed while Resident 4 was still eating their lunch. Staff D said the documentation for the amount residents consume at meals should not be charted until the resident is finished with their meal. Staff D said Resident 4 had already eaten greater than 50% of their lunch.On 04/21/2026 at 2:43 PM, Staff C, Director of Nursing, said staff should document the amount of food consumed at the end of the meal. Staff C said staff should document accurately and not document until the resident was finished with their meal.Reference WAC 388-97-1720(1)(a)(i)-(iv)(b).