

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567</b></p> <p>Based on interview and record review the facility failed to have psychotropic (medications that affect a person's mental state) medication consents signed and in place prior to resident receiving medications for 3 of 5 sampled residents (Residents 40, 78 &amp; 119) reviewed for psychotropic medication use. This failure placed the residents at risk for adverse side effects and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's document titled, The Process of Informed Consent, dated December 1998, showed to be fully informed, a nursing facility resident must receive appropriate and meaningful information relative to their health care decision-making. The procedure included language that residents could reasonably be expected to understand; Current medical condition or prognosis, Expected medical condition or prognosis, Suggested treatment or services, Anticipated results of proposed treatment, Recognized serious possible risks, complications and anticipated benefits involved in treatment and in the recognized possible alternative forms of treatment, including non-treatment.</p> <p>Resident 40</p> <p>Resident 40 readmitted to the facility on [DATE] with multiple diagnoses to include heart disease, dementia (a condition that impairs memory), anxiety and had a psychotic disorder. Review of Resident 40's quarterly Minimum Data Set (MDS), a required assessment tool, dated 03/01/2024, showed Resident 40 was able to make their needs known.</p> <p>Review of Resident 40's electronic health record (EHR) showed a current provider's order for risperidone (antipsychotic medication), dated 10/23/2023, to be administered by licensed nurses (LNs) three times a day to Resident 40. The provider had increased the risperidone medication from twice a day to three times a day; however, Resident 40's clinical documentation showed no consent was obtained from the resident's guardian for the increase.</p> <p>Resident 78</p> <p>Resident 78 admitted to the facility on [DATE] with multiple diagnoses to include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, and difficulty with balance and coordination), dementia, and depression. Review of quarterly MDS, dated [DATE], showed Resident 78 was able to make their needs known.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 78's EHR showed a provider's order for citalopram (used in the treatment of depression), dated 03/20/2023, to be administered by LNs one time a day to Resident 78 for major depressive disorder.</p> <p>Review of Resident 78's EHR showed no consents were provided to the resident and/or residents representative upon admission for the medication citalopram.</p> <p>During an interview on 06/04/2024 at 12:20 PM, Staff C, Registered Nurse/Unit Manager, stated their expectations would be for the LNs to obtain the consents from either the resident or the resident's representative prior to administration of the psychotropic medication and document in the record.</p> <p>During an interview on 06/04/2024 at 1:30 PM, Staff B, Director of Nursing Services (DNS), stated the expectation for obtaining consents would be for the LNs to obtain the consents for the psychotropic medication first from either the resident's representative or the resident and document in the resident's medical records.</p> <p>46148</p> <p>Resident 119</p> <p>Resident 119 admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>Review of the EHR showed Resident 119 was receiving donepezil (used to treat Alzheimer's disease) daily for dementia, olanzapine (used to treat psychotic disorders) daily for dementia, with start dates of 02/25/2024; mirtazapine (used to treat depression) daily for sleep disturbance and risperidone daily for dementia with start dates of 2/24/2024.</p> <p>Review of Resident 119's EHR showed no documentation that the resident or their representative was provided education on the risks and benefits of the medications in writing or that consent was obtained prior to the use of the medications.</p> <p>During an interview on 06/05/2024 at 3:10 PM, Staff B stated it was their expectation that residents who received psychotropic medications or their representative received education on the risks and benefits of such medications and consent be obtained prior to administration.</p> <p>Reference WAC [PHONE NUMBER]300(3)(a), -0260, -1020(4) (a-b)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49926</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from physical restraints with the use of a mobility device for 1 of 3 sampled residents (Resident 78) when reviewed for physical restraints. This failure placed residents at risk for avoidable injury, psychological harm, and decreased quality of life.</p> <p>Findings included .</p> <p>Resident 78 was admitted to the facility on [DATE] with multiple diagnoses to include Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements and difficulty with coordination), asthma, and depression. Resident 78 was able to make needs known.</p> <p>Observation on 06/02/2024 at 11:15 AM showed Resident 78 using a tilt in space wheelchair (w/c) with a pressure alarm attached to it. Resident 78 was leaning to the front right. A staff member repositioned the resident and tilted the w/c back.</p> <p>Review of Resident 78's electronic health record showed no documentation of a restraint assessment or provider order for a restraint/tilt in space w/c.</p> <p>Review of initiated care plan, dated 03/03/2023, showed no care plan instructions about the tilt in space w/c or how to position Resident 78.</p> <p>On 06/05/2024 Staff C, Registered Nurse/Unit Manager, produced a care plan, provider order and restraint assessment related to the use of the tilt in space w/c. The provider order and care plan included specific angles to tilt Resident 78's w/c.</p> <p>On 06/05/2024 at 2:22 PM, during an interview and observation of Resident 78, Staff C stated Resident 78 was not positioned appropriately and appeared uncomfortable. Staff C confirmed there were no markings on the w/c to identify the angle of tilt to meet the provider order and care plan.</p> <p>Reference WAC 388-97-0620(1)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49926</p> <p>Based on interview and record review, the facility failed to accurately assess a pressure ulcer/skin condition for 1 of 3 sampled residents (Resident 7) reviewed for pressure injury. This failure placed the resident at risk for health complications and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 7 was admitted to the facility on [DATE] with multiple diagnoses to include Alzheimer's disease (a brain disorder that destroys memory and thinking skills), adult failure to thrive, and abnormal weight loss. Resident 7 was not able to make needs known.</p> <p>Review of a quarterly Minimum Data Set (MDS), an assessment tool, dated 05/20/2024, showed Resident 7 had two unstageable pressure ulcers (injury to skin due to pressure) which were present on admission.</p> <p>During an interview on 06/05/2024 at 10:06 AM, Staff K, MDS Nurse, stated it was coded inaccurately as Resident 7's pressure ulcers developed after admission into the facility.</p> <p>During an interview on 06/05/2024 at 11:22 AM, Staff B, Director of Nursing Services, stated the expectation was to make sure the MDS assessment matched the resident's condition.</p> <p>Reference WAC 388-97-1000(1)(b)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46148</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 3 of 4 sampled residents (Residents 2, 88 &amp; 28) reviewed for anticoagulant (blood thinner medication) use and/or indwelling urinary catheter (IUC, a tube inserted in the body to empty the bladder of urine) care. The facility failed to ensure Resident 28 and 88's provider's orders for IUC were in place and/or accurate, and Resident 2's anticoagulant monitoring for side effects were documented. These failures placed residents at risk of medical complications, unmet needs, and a poor quality of life.</p> <p>Findings included .</p> <p>Review of Lippincott's Manual of Nursing Practice, dated 2024, showed that for patients receiving anticoagulation therapy observe carefully for any possible signs of bleeding and report immediately so that anticoagulant dosage may be reviewed and altered, if necessary.</p> <p>Resident 2</p> <p>Resident 2 admitted to the facility on [DATE] with a diagnosis of atrial fibrillation (a chronic heart condition with abnormal heartbeat).</p> <p>Review of the electronic health record (EHR) showed Resident 2 was receiving Eliquis (a medication that thins the blood) to prevent blood clots twice a day with a start date of 09/01/2020.</p> <p>Observation and interview on 06/02/2024 at 2:16 PM showed Resident 2 had some bruising on both their arms and stated they had some bruising on their legs.</p> <p>Review of Resident 2's care plan, dated 03/26/2020, showed an entry for alteration in cardiac status related to atrial fibrillation with an intervention to assess the resident for abnormal bleeding.</p> <p>Review of Resident 2's EHR showed no documentation related to monitoring for abnormal bleeding or bruising.</p> <p>During an interview on 06/04/2024 at 11:17 AM, Staff C, Registered Nurse/Unit Manager, stated Resident 2 should have had an order on the medication administration record (MAR) to monitor for adverse side effects of the anticoagulant medication but did not.</p> <p>During an interview on 06/04/2024 at 11:44 AM, Staff B, Director of Nursing Services, stated it was their expectation that Resident 2 had an order in the MAR for staff to monitor for adverse side effects of anticoagulant medications.</p> <p>Resident 88</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 88 admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements and difficulty with coordination), neuromuscular disfunction of the bladder (inability to control the bladder) and benign prostate hypertrophy (BPH, an enlarged prostate).</p> <p>During an interview and observation on 06/02/2024 at 10:58 AM, Resident 88 stated they had severe lower abdominal pain because of the catheter. The resident was grimacing and holding their groin.</p> <p>Review of the EHR showed an order dated 11/27/2023 for an IUC (Specify Size) for Retention -change monthly on 27th of Month, and an order dated 06/02/2024 for IUC Changed as Needed for BPH with urinary retention AND change on night shift on the 2nd of every month.</p> <p>Review of the care plan showed an entry dated 11/27/2023 for the IUC but did not specify the type or size to be used.</p> <p>During an interview on 06/04/2024 at 11:30 AM, Staff C, RN/UM, stated that Resident 88 should have had the size and type of IUC included in the orders and the care plan. Staff C stated the orders should have been clear on what day the IUC was to be changed.</p> <p>During an interview on 06/04/2024 at 11:41 AM, Staff B, DNS, stated Resident 88 should have had clear orders and a care plan which contained the type and size of IUC to be used.</p> <p>38344</p> <p>Resident 28</p> <p>Resident 28 readmitted to the facility on [DATE] with a diagnosis of neurogenic bladder (lack of control to urinate), used an IUC, and was able to make needs known.</p> <p>Review of the June 2024 treatment administration record (TAR) showed Resident 28 had an order, dated 04/25/2024, for monthly IUC changes and as needed, 20 French (size of the IUC) on the 19th of every month. Documentation showed it was scheduled to be changed on 04/19/2024. An order dated 05/30/2024 showed to change the resident's IUC 22 French/30 cubic centimeters balloon (inflatable balloon at the end of the catheter to keep it in place) coude (a curved/bent tip at the end of the catheter) as needed for improper function.</p> <p>During an interview on 06/05/2024 at 12:09 PM Staff C stated that Resident 28 had two conflicting provider orders related to their IUC size and type and needed to be clarified by the provider.</p> <p>During an interview on 06/05/2024 at 12:25 PM, Staff B stated that Resident 28's provider orders related to their IUC did not meet expectations due to conflicting orders. Staff B stated that the expectation was that resident's with IUCs should have a clear and accurate provider order to include the type, size, and indication for use.</p> <p>Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34567</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 5 of 25 sampled residents (Residents 107, 30, 42, 78, and 2) reviewed for quality of care. Failure to consistently monitor and document edema (swelling caused by too much fluid trapped in the body's tissues) for Resident 107 and 30, provide management of a surgical wound for Resident 42, ensure adequate positioning was provided for Resident 78, and notify the provider of an acute change in respiratory status for Resident 2 placed the residents at risk for worsening conditions, discomfort, and a decreased quality of life.</p> <p>Findings included .</p> <p>Resident 42</p> <p>Resident 42 admitted to the facility on [DATE] with a diagnosis of fracture of left femur with subsequent placement of an intramedullary rod (a medal rod used to stabilize long bone fractures within the cavity of the bone).</p> <p>During an interview on 06/03/2024 at 10:08 AM, Resident 42's family member stated they believed the resident's surgical wound was not being properly managed at the facility and that Resident 42 had to be readmitted to the hospital for an infection to the surgical wound site.</p> <p>Review of Resident 42's electronic health record (EHR) showed that a surgical wound culture was obtained on 03/25/2024.</p> <p>Review of Resident 42's EHR showed that a call was placed to the lab by a licensed nurse (LN) on 03/29/2024 (four days after the culture was obtained) to check on the surgical wound culture; however, per the lab it was still being processed.</p> <p>Review of Resident 42's progress notes, dated 04/01/2024, showed the following:</p> <p>6:46 AM - Resident 42's upper right hip incision showed inflamed, purulent (consisting of, containing, or discharging pus), and painful wound next to surgical site. Palpation (touching) by the LN revealed a possible cyst/abscess. The provider was contacted, assessed the resident, and informed the LN that antibiotics would be ordered.</p> <p>5:24 PM - The on-call provider was notified of Resident 42's surgical wound cultures and an order for an antibiotic was obtained; however, the facility would need to contact the orthopedic surgeon prior to initiating the antibiotic orders. The antibiotic order for the right hip infection was placed on hold until the orthopedic doctor is called in the a.m.</p> <p>Review of Resident 42's progress notes, dated 04/02/2024, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8:05 AM - A LN had called the orthopedic office and left a message with a scheduler regarding the resident's hip incision that had dehiscence (splitting or bursting open either partial or total separation of the wounds edges due to failure of proper wound healing), the wound culture results, and that the antibiotics had not yet been administered.</p> <p>2:07 PM - LN was awaiting a call back from the orthopedics office.</p> <p>5:17 PM - LN had documented the facility's provider ordered antibiotic that was on-hold to be administered.</p> <p>Review of Resident 42's progress notes, date 04/03/2024, showed that the resident was seen at the orthopedic office and new antibiotic orders were ordered along with a PICO drain (a wound care system that provides suction that draws out excess fluid from the wound to promote healing).</p> <p>During an interview on 06/04/2024 at 1:15 PM, Staff E, Registered Nurse/Unit manager, stated the culture results of Resident 42's surgical wound site should have been obtained within a timely manner and that there was a delay in getting the antibiotics started [greater than 9 days] while they waited on the orthopedics office to respond back to the facility. Staff E stated Resident 42 could have been sent to the emergency room to be seen quicker and treatment started sooner rather than waiting for the orthopedic providers office to respond.</p> <p>During an interview on 06/04/2024 at 1:35 PM, Staff B, Director of Nursing Services, stated that their expectation would be for the LNs to call the lab sooner to obtain the cultures results and if the orthopedic providers office was not responsive to the LNs calls then an option should have been to send the resident to the emergency room to be seen.</p> <p>Resident 107</p> <p>Resident 107 readmitted to the facility on [DATE] with a diagnosis to include congestive heart failure (CHF, a condition in which the hearts capacity to pump blood cannot keep up with the body's needs, that may result in buildup of fluid in the ankles, feet arms and other organs).</p> <p>Review of Resident 107's focus care plan, dated 05/19/2024, showed the resident had CHF. Multiple interventions directed the facility staff to assess daily for edema, to notify the provider for increased in edema, and weights to be monitored daily.</p> <p>During an interview on 06/03/2024 at 9:03 AM, Resident 107's family member stated that another family member had concerns that facility staff had not provided the necessary care and services for Resident 107's CHF, such as elevating Resident 107's legs and monitoring excess fluid accumulation.</p> <p>Review of Resident 107's incident investigation report dated 05/23/2024 showed documentation that Resident 107's family member had filed a complaint with the facility of neglect and the facility staff were not caring for the resident's needs related to CHF. Documentation within the incident report showed Resident 107 felt that their legs were swollen.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/05/2024 at 9:26 AM, Staff D, Registered Nurse/Minimum Data Set Nurse, stated they were the investigating staff who had reviewed the incident investigation and assessed Resident 107. Staff D stated they had noted the resident with +1 pitting edema (a measurement severity scale of fluid accumulation that showed an immediate rebound with a two millimeter (mm) pit or indentation in the resident's skin) to their lower extremities and that the resident's weight was up slightly. Staff D stated they had concluded the licensed nurse (LN) staff did not follow the focus care plan for the CHF and Resident 107's EHR clinical progress notes did not reflect any assessment of the resident's edema being documented.</p> <p>During an interview on 06/05/2024 at 11:20 AM, Staff B stated their expectation would be for LNs to ensure the focus care plan was followed and the LNs monitored and documented the resident's edema daily as part of their assessments.</p> <p>46148</p> <p>Resident 2</p> <p>Resident 2 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a chronic lung disease) and CHF.</p> <p>During an interview on 06/02/2024 at 2:16 PM, Resident 2 stated that they had chest congestion and chest pain when they coughed. Observation showed the resident coughing up yellow mucus and was grimacing. The resident stated that the cough started on 06/01/2024.</p> <p>Observation and interview on 06/03/2024 at 11:51 AM showed Resident 2 coughing and grimacing and stated the staff had given them some cough medicine, but it did not help much.</p> <p>Review of the Resident 2's EHR showed an order for Mucinex cough syrup as needed every four hours with a start date of 08/12/2021 and an order for albuterol inhaler every four hours as needed for wheezing. Resident 2 had an order for oxygen with instructions to notify the provider if new cough or change in respiratory status.</p> <p>Review of the May 2024 medication administration record showed the resident did not receive any as needed cough medicine or albuterol inhalation for the month of May. Review of the June 2024 MAR showed the resident received two doses of cough medicine and one albuterol inhaler on 06/01/2024, and one dose of cough medicine on 06/02/2024.</p> <p>During an interview on 06/03/2024 at 11:52 AM, Staff F, Agency Licensed Nurse, stated they were aware of the resident's cough and had given the resident cough medicine but had not reported to the provider.</p> <p>Review of the progress notes showed no documentation that the provider was notified of new cough or change in respiratory status. A Social services note dated 06/03/2024 showed the resident reported being congested and not feeling well and that the nurse was aware.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 06/04/2024 at 10:48 AM showed Resident 2 laid in bed and was having difficulty breathing. The resident stated they still had a cough and it hurt to breath. Staff G, Unit Coordinator/Change Nurse, assessed the resident and stated that the resident should have been assessed to include testing for Covid-19 and the provider should have been notified of the respiratory symptoms.</p> <p>During an interview on 06/04/2024 at 11:22 AM, Staff C, Registered Nurse/Unit Manager, stated if a resident had new or worsening respiratory symptoms staff should have assessed the resident, notified the provider and placed the resident on alert.</p> <p>During an interview on 06/04/2024 at 11:49 AM, Staff B stated that floor staff should have alerted the provider as soon as possible when a change in respiratory status was identified for Resident 2.</p> <p>49926</p> <p>Resident 30</p> <p>Resident 30 admitted to the facility on [DATE] with multiple diagnoses to include acute kidney failure (condition when the kidneys suddenly cannot filter waste from the blood) and edema (swelling). Resident 30 was able to make needs known.</p> <p>Observation and interview on 06/02/2024 at 11:45 AM showed Resident 30 sat in their wheelchair in their room with red non-skid socks on and stated their feet were swollen.</p> <p>Review of Resident 30's provider notes, signed on 05/20/2024, showed edema management to include to use TED hose stockings (compression stockings to reduce swelling in the legs), elevate legs when sitting for prolonged periods of time, and use of Lasix (medication that treats fluid retention) daily as needed for edema.</p> <p>Review of medication administration record showed no Lasix was administered for the month of May and June 2024.</p> <p>Review of Resident 30's EHR showed no care plan focus area that addressed the edema management and no documentation related to the resident's swelling of the feet.</p> <p>During an interview on 06/05/2024 at 11:30 AM, Staff B stated their expectation as that nursing staff would follow provider's orders.</p> <p>Resident 78</p> <p>Resident 78 admitted to the facility on [DATE] with multiple diagnoses to include Parkinson's disease (brain disorder that causes unintended or uncontrollable movements and difficulty with coordination), asthma, and depression. Resident 78 was able to make needs known.</p> <p>Observation on 06/02/2024 at 11:15 AM showed Resident 78 used a tilt in space wheelchair (w/c). Resident 78 leaned to the front right, a staff member repositioned the resident, and tilted the w/c back.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE  1301 N Highlands Parkway Tacoma, WA 98406	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Multiple observations on 06/02/2024 through 06/05/2024 showed Resident 78 sat in the w/c and leaned towards the front and right side of the w/c.</p> <p>Review of Resident 78's care plan, initiated 03/03/2023, showed no instructions regarding positioning or sitting.</p> <p>Observation on 06/05/2024 at 1:23 PM showed Resident 78 was severely leaning toward the front right with their head on the right armrest and right hand was on the floor.</p> <p>During an interview 06/05/2024 at 2:22 PM, Staff C stated that Resident 78 was not positioned appropriately and appeared uncomfortable.</p> <p>During an interview on 06/05/2024 at 2:38 PM, Staff B stated the expectation was to have a clear care plan on resident's mobility and positioning.</p> <p>Reference WAC 388-91-1060(1)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49926</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary treatment to heal pressure injuries for 1 of 3 sampled residents (Resident 7) reviewed for pressure injuries. This failure placed the resident at risk for worsening pressure injury, infection, and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 7 admitted to the facility on [DATE] with multiple diagnoses to include Alzheimer's disease (brain disorder that destroys memory and thinking skills), adult failure to thrive, and abnormal weight loss. Resident 7 was unable to make needs known.</p> <p>Observation and interview on 06/05/2024 at 1:24 PM, during a dressing change, showed Resident 7 had a dressing on the right outer ankle area that was dated 05/31/2024. Staff L, Licensed Practical Nurse, stated the dressing was not changed on 06/03/2024 as ordered.</p> <p>Review of Resident 7's treatment administration record for June 2024 showed missing documentation for multiple orders on 06/03/2024 during day shift.</p> <p>During an interview on 06/05/2024 at 2:35 PM, Staff B, Director of Nursing Services, stated the expectation was for nurses to follow orders for dressing changes.</p> <p>Reference WAC 388-97-1060(3)(b)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40817</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident environments were free from accident hazards for 3 of 6 sampled residents (Residents 121, 68, and 4) when reviewed for accident hazards. The facility failure to secured medications (Resident 121), investigate falls and implement fall precautions (Resident 68), and ensure bedrails were firmly installed (Resident 4) placed residents at risk of avoidable injury, hospitalization , and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Unsecured Mediations&gt;</p> <p>Observation on 06/02/2024 at 10:07 AM showed a refrigerator in the Narrows dining room with a lunch bag. Observation showed that the lunch bag contained a lidocaine patch (a topical medication to reduce pain).</p> <p>During an interview on 06/02/2024 at 10:42 AM, Staff A, Administrator, stated all medications should be locked in a medication cart or medication room and should not be accessible to residents. Staff A stated the lidocaine patch should not be left in the resident refrigerator.</p> <p>Observation on 06/04/2024 at 1:09 PM showed a lidocaine patch on Resident 121's bedside table unopened.</p> <p>During an interview on 06/04/2024 at 1:15 PM, Staff J, Licensed Practical Nurse, stated that Resident 121 was not assessed to be able to self-administer medications and should not have any medications at bedside. Staff J stated Resident 121 had a lidocaine patch at bedside and it should not have been there.</p> <p>During an interview on 06/05/2024 at 1:35 PM, Staff B, Director of Nursing Services, stated the facility ensured residents did not have access to medications by ensuring that they were secured inside medication carts or medication rooms. Staff B stated the lidocaine patch in the resident refrigerator and at Resident 121's bedside did not meet expectation.</p> <p>&lt;Fall Investigation/Prevention&gt;</p> <p>Resident 68 admitted to the facility on [DATE] and had diagnoses of heart failure, morbid obesity, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and psychotic order with hallucinations.</p> <p>Observation on 06/03/2024 at 9:13 AM showed Resident 68 had a transfer pole installed next to the bed and fall mats to either side of the bed.</p> <p>Review of the provider's orders showed Resident 68 had an order for a transfer pole with horizontal bar for transfers dated 11/03/2021.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of assessments showed Resident 68 was assessed to be safe to use the transfer pole on 11/03/2021.</p> <p>Review of Resident 68's progress notes showed the following fall incidents:</p> <p>(1) 06/09/2023 - Resident 68 thought the window was open, decided to get up and close it, lost balance, and fell .</p> <p>(2) 06/21/2023 - Resident 68 did not remember why they got out of bed and fell .</p> <p>(3) 01/29/2024 - Resident 68 got out of bed to stretch and fell .</p> <p>(4) 02/27/2024 - Resident 68 got out of bed without assistance and fell .</p> <p>(5) 03/25/2024 - Resident 68 got out of bed without assistance and fell .</p> <p>Review of the care plan, initiated 07/13/2022, showed Resident 68 was at risk of falling due to confusion, deconditioning, balance problems, and psychoactive (affecting the brain) medication use and was unaware of their own safety needs.</p> <p>Review of the annual minimum data set assessment, dated 05/17/2024, showed Resident 68 required substantial/maximal assistance to transfer from sit to stand and from bed to wheelchair.</p> <p>Review of the fall investigations for the falls listed above showed the following conclusions:</p> <p>(1) 06/09/2023 - Resident 68 was closing the window and fell . This investigation did not show that Resident 68 was attempting to stand when they fell .</p> <p>(2) 06/21/2023 - Resident 68 was attempting to get out of bed due to impulsivity.</p> <p>(3) 01/29/2024 - Resident 68 had a trend of falls due to attempting to self-exit the bed. This investigation showed that Resident 68 was stretching in bed and not self-exiting the bed.</p> <p>(4) 02/27/2024 - Resident 68 was suspected to have self-exited bed and fell .</p> <p>(5) 03/25/2024 - Resident 68 got up and fell due to self-exiting.</p> <p>Review showed that none of these investigations considered the accident risk posed by the transfer pole.</p> <p>During an interview on 06/05/2024 at 11:33 AM, Staff C, Registered Nurse/Unit Manager, stated Resident 68 used the assistance of one person, the transfer pole, and a gait belt to transfer from the bed to the wheelchair. Staff C stated Resident 68 thought they could get up on their own and would attempt to self-transfer. Staff C stated that, due to behaviors, Resident 68 required two staff to be present when providing care and that the transfer pole provided the resident a level of independence. Staff C was unsure whether the transfer pole was considered as a cause for the previous falls when investigated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/05/2024 at 2:44 PM, Staff B, Director of Nursing Services, stated Resident 68 should have been re-assessed for the safe use of the transfer pole after falls resulting from impulsively attempting to self-exit the bed. Staff B stated nursing staff assumed the transfer pole was safe because it was assessed by physical therapy in 2021, and physical therapy was not aware a new assessment should be completed as nursing did not inform physical therapy of Resident 68's falls. Staff B stated the communication between the nursing staff and physical therapy did not meet expectation.</p> <p>&lt;Bed Rail&gt;</p> <p>Review showed Resident 4 admitted to the facility on [DATE] with diagnoses of amputation, muscle wasting, dementia, and hemiplegia (inability to move) the left side.</p> <p>Observation on 06/02/2024 and 06/05/2024 showed Resident 4 had bedrails on both sides of the bed and the bedrails were able to move approximately an inch and a half back and forth.</p> <p>During an interview on 06/05/2024 at 11:33 AM, Staff C stated Resident 4's bedrails were loose and needed to be tightened. Staff C stated there was no regular system for inspecting bedrails and staff were expected to notice loose bedrails and notify maintenance.</p> <p>During an interview on 06/05/2024 at 1:37 PM, Staff B stated staff were to notice loose bedrails and notify maintenance. Staff B stated loose bedrails were a safety risk for entrapment and Resident 4's loose bedrails did not meet expectation.</p> <p>Reference WAC 388-97-1060 (3)(g)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40817</p> <p>Based on interview and record review, the facility failed to ensure a fluid restriction for provided and monitored for 1 of 3 sampled residents (Resident 54) reviewed for nutrition. This failure placed the resident at risk of fluid overload, avoidable swelling, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 54 admitted to the facility on [DATE] with diagnoses of pulmonary edema (water in the lungs) and kidney failure.</p> <p>Review of Resident 54's provider's orders showed a fluid restriction of 1500 milliliter (ml) with nursing to provide 600 ml and dietary 900 ml.</p> <p>Review of Resident 54's medication administration record (MAR) showed two sections to document the amount of fluid consumed. The first section showed for nursing and dietary to document the amount consumed from 6:00 AM with no end time. The second section showed for nursing and dietary to document the amount consumed from 6:00 PM to 6:00 AM. There was no location to total the daily amount consumed and no instructions on how much liquid to give per section.</p> <p>Review of the May 2024 MAR showed seven days where Resident 54 was provided more than 1500 ml of fluid.</p> <p>Review of the June 2024 MAR on 06/05/2024 showed three days where Resident 54 was provided more than 1500 ml of fluid.</p> <p>During an interview on 06/05/2024 at 10:57 AM, Staff C, Registered Nurse/Unit Manager, stated Resident 54 was on a 1500 ml fluid restriction and was receiving too much fluid. Staff C stated this did not meet their expectation.</p> <p>During an interview on 06/05/2024 at 1:30 PM, Staff B, Director of Nursing Services, stated Resident 54's fluid restriction documentation was confusing and there was no way to accurately monitor fluid intake. Staff B stated that the fluid restriction did not meet expectation.</p> <p>Reference WAC 388-97-1060 (3)(i)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49926</p> <p>Based on interview and record review, the facility failed to ensure as needed (PRN) psychotropic medications (affecting the mind) were limited to 14 days for 1 of 5 sampled residents (Resident 6) when reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary psychotropic medication, avoidable medication side effects, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 6 admitted to the facility on [DATE] with multiple diagnoses to include dementia (brain disorder that impairs memory and thinking skills), anxiety, and congestive heart failure. Resident 6 was unable to make needs known.</p> <p>Review of Resident 6's provider's orders showed an order for lorazepam (an antianxiety medication) every 2 hours PRN started on 05/04/2024 and without a stop date.</p> <p>Review of Resident 6's pharmacy recommendations dated 05/14/2024 showed a recommendation to stop lorazepam PRN after 14 days.</p> <p>Review of Resident 6's medication administration record showed that Resident 6 was administered lorazepam nine times in the month of May 2024 and one time in June 2024.</p> <p>During an interview on 06/05/2024 at 11:35 AM, Staff B, Director of Nursing Services, stated the expectation was for staff to follow pharmacy recommendations and Resident 6's lorazepam order did not meet this expectation.</p> <p>Reference WAC 388-97-1060(3)(k)(i)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49926</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper labeling of insulins in 1 of 4 medication carts (700-hall Medication Cart) reviewed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective medications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observation on 06/05/2024 at 9:22 AM showed two multi-dose insulin pens with no open date or expiration date in the 700-hall medication cart.</p> <p>During an interview on 06/05/2024 at 9:35 AM, Staff N, Licensed Practical Nurse, stated insulin pens should be dated when opened and there were two undated pens in the 700-hall medication cart.</p> <p>During an interview on 06/05/2024 at 11:10 AM, Staff B, Director of Nursing Services, stated the expectation was to date open insulins with the open date and expiration date.</p> <p>Reference WAC 388-97-1300(2)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817</b></p> <p>Based on observation and interview, the facility failed to ensure foods were sanitarly stored in the kitchen and 3 of 4 resident refrigerators (Ocean, Mountain, and Narrows Dining) when reviewed for kitchen. These failures placed residents at risk of consuming contaminated foods, avoidable foodborne illness, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observation on [DATE] at 9:38 AM showed the facility walk-in refrigerator had four bags of raw chicken sitting in approximately one inch of bloodied water, one container of minced garlic without date label, a container of pudding with no date, a package of bacon with a use by date of ,d+[DATE], a salad uncovered, undated, and severely dried, four trays of raw fish on a rack uncovered and undated, and a container of sliced tomato without date label. The walk-in freezer showed a rack with several types of raw meat left exposed to the air and severely dried.</p> <p>During an interview on [DATE] at 9:47 AM, Staff Q, Dietary Aid, stated the container of garlic, pudding, and bacon needed to be thrown out. Staff Q stated the rack of meats in the freezer did not look right.</p> <p>Observation on [DATE] at 9:48 AM showed a container of granola with no date and NR, a bottle of syrup with a use by date of [DATE], and a container with croutons with a date of ,d+[DATE].</p> <p>Observation on [DATE] at 10:07 AM showed the Narrows dining room resident refrigerator had two packaged lunches with no name or date.</p> <p>Observation on [DATE] at 10:12 AM showed the Mountain resident refrigerator had a Styrofoam container with unidentifiable food inside with a foul smell and white substance growing, a bag of foods all with a [DATE] use by date, a facility meal tray with dried food covered with dome with no date, a bag of fast food with no date, a plate with a sandwich and salad with tomato with white substance growing, and a bag with raspberries growing white substance with no date.</p> <p>Observation on [DATE] at 10:21 AM showed the Ocean resident refrigerator had a sandwich with use by date of ,d+[DATE], a plate of lasagna stored on paper plate and loosely covered with tinfoil with no date, a paper plate with an omelet, rice, and a sausage which was soaked through without date, a container of unidentifiable food with white growth and no date, a plate of meatloaf, gravy and green beans covered with tin foil with white growth and no date.</p> <p>During an interview on [DATE] at 10:42 AM, Staff A, Administrator, stated that expired foods should not be in the resident refrigerators. Staff A stated that the lunch bag in the Narrows dining resident refrigerator belonged to staff and should not be stored in the resident refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 10:52 AM, Staff O, Executive Chef, stated the rack of meats exposed to the air and dried out in the walk-in freezer were from a party, were freezer burned, and should have been thrown out. Staff O stated that the chicken in bloody water was defrosting and had been received on [DATE].</p> <p>Observation on [DATE] at 11:23 AM showed a container of granola with no date and NR in dry storage.</p> <p>Observation on [DATE] at 11:26 AM showed four bags of raw chicken sitting in a container with approximately one inch of bloodied water.</p> <p>During an interview on [DATE] at 12:04 PM, Staff P, Senior Food and Nutrition Services Director, stated stored foods should be labeled and dated and thrown away when expired. Staff P stated that the facility's food storage did not meet expectation.</p> <p>During an interview on [DATE] at 12:19 PM, Staff A stated the facility followed the 2024 Food Code and that the storage of resident foods did not meet expectation.</p> <p>Reference WAC [DATE] (3), -2980</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</b></p> <p>Based on interview and record review, the facility failed to offer, educate, and obtain consent for influenza and/or pneumococcal vaccines for 5 of 5 residents (Residents 74, 90, 102, 108, and 120) when reviewed for influenza and pneumococcal immunizations. These failures denied residents the opportunity to make an informed decision regarding receiving immunizations and/or placed the residents at risk for communicable diseases, complications of other medical conditions, hospitalization , and death.</p> <p>Findings included .</p> <p>Review of the facility policy titled Vaccination for Residents dated 01/28/2022 showed that all residents would be offered vaccines that aided in preventing infectious diseases. Prior to receiving a vaccination, the resident or their representative would be provided information and education on the benefit and potential side effects of the vaccination and documented in the resident's medical record.</p> <p>Review of Resident 74's electronic health record (EHR) showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and provided education on the risks and benefits of the pneumococcal vaccination.</p> <p>Review of Resident 90's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and provided education on the risks and benefits of the influenza vaccination.</p> <p>Review of Resident 102's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and provided education on the risks and benefits of the pneumococcal vaccination.</p> <p>Review of Resident 108's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and provided education on the risks and benefits of the influenza vaccination.</p> <p>Review of Resident 120's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and provided education on the risks and benefits of the influenza vaccination.</p> <p>During an interview on 06/05/2024 at 11:49 AM, Staff H, Infection Preventionist/Registered Nurse, stated they did not have a consistent process in place for educating and obtaining consent for resident influenza and pneumococcal vaccines.</p> <p>During an interview on 06/05/2024 at 11:56 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff would provide education on risks and benefits prior to offering and obtaining consent for influenza and pneumococcal vaccines for all residents.</p> <p>Reference WAC 388-97- 1340 (1), (2), (3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</b></p> <p>Based on interview and record review, the facility failed to offer, educate, and obtain consent for Covid-19 vaccinations for 5 of 5 residents (Residents 74, 90, 102, 108, and 120) when reviewed for immunizations. This failure denied residents the opportunity to make an informed decision regarding receiving Covid-19 vaccines and/or placed the residents at risk for complications, hospitalization , and a decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled Vaccination for Residents dated 01/28/2022 showed that all residents would be offered vaccines that aided in preventing infectious diseases. Prior to receiving a vaccination, the resident or their representative would be provided information and education on the benefit and potential side effects of the vaccination and this would be documented in the resident's medical record.</p> <p>Review of Resident 74's electronic health record (EHR) showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and/or provided education on the risks and benefits of the Covid-19 vaccine.</p> <p>Review of Resident 90's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and/or provided education on the risks and benefits of the Covid-19 vaccine.</p> <p>Review of Resident 102's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and/or provided education on the risks and benefits of the Covid-19 vaccine.</p> <p>Review of Resident 108's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and/or provided education on the risks and benefits of the Covid-19 vaccine.</p> <p>Review of Resident 120's EHR showed the resident admitted to the facility on [DATE]. No documentation was in the EHR that staff offered and/or provided education on the risks and benefits of the Covid-19 vaccine.</p> <p>During an interview on 06/05/2024 at 11:49 AM, Staff H, Infection Preventionist/Registered Nurse, stated they did not have a process in place for educating and obtaining consent for resident Covid-19 vaccines.</p> <p>During an interview on 06/05/2024 at 11:56 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff would provide education on risks and benefits prior to offering and obtaining consent for all resident Covid-19 vaccines.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE  1301 N Highlands Parkway Tacoma, WA 98406	

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No Reference WAC</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE  1301 N Highlands Parkway Tacoma, WA 98406	
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>40817</p> <p>Based on observation and interview, the facility failed to maintain kitchen equipment in safe working order for a griddle/oven combo unit and 1 of 4 freestanding refrigerators when reviewed for kitchen. These failures places residents at risk of eating contaminated food, avoidable foodborne illness, fire injury, smoke inhalation, and a diminished quality of life.</p> <p>Findings included .</p> <p>Observation on 06/02/2024 at 9:35 AM showed a freestanding refrigerator with a tray of sandwiches inside. Observation showed standing water on the bottom of the refrigerator and droplets of condensation gathered on the ceiling. A metal container was on a crossbar inside the refrigerator and had approximately two inches of water and a small screwdriver and screws inside.</p> <p>Observation on 06/02/2024 at 9:48 AM showed a griddle/oven combo unit with a grease trap which stuck out approximately one and a half inches. Below the grease trap there was dried grease on the side of the unit and on the ground underneath.</p> <p>Observation on 06/04/2024 at 11:21 AM showed the freestanding refrigerator continued with water on the floor and droplets on the ceiling, contained a rack of resident foods, and the container with water, screwdriver, and screws was on the crossbar.</p> <p>During an interview on 06/04/2024 at 11:21 AM, Staff P, Senior Food and Nutrition Services Director, stated the freestanding refrigerator was not in working order and should not be used to store resident foods.</p> <p>Observation on 06/04/2024 at 11:45 AM showed the griddle/oven combo unit had brown grease actively leaking down the side of the unit. Observation showed an area below the grease trap which had accumulated grease which leaked down.</p> <p>During an interview on 06/04/2024 at 1:57 PM, Staff A, Administrator, stated there were no work orders open for the kitchen.</p> <p>During an interview on 06/04/2024 at 1:59 PM, Staff M, Maintenance Director, stated they were made aware of the broken freestanding refrigerator and griddle/oven combo unit on 06/04/2024.</p> <p>During an interview on 06/05/2024 at 12:04 PM, Staff P stated that they had put in a work order for the freestanding refrigerator but thought it had been fixed. Staff P stated the refrigerator should not be used until it was repaired.</p> <p>During an interview on 06/05/2024 at 12:19 PM, Staff A stated staff should inform them if there were needed repairs to kitchen equipment.</p> <p>Refence WAC 388-97-2100</p>		

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

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>40817</p> <p>Based on observation and interview, the facility failed to inspect bedrails as part of a regular maintenance program. This failure placed residents at risk of falling, entrapment, avoidable injury, and a diminished quality of life.</p> <p>Findings included .</p> <p>During an interview on 06/05/2024 at 11:33 AM, Staff C, Registered Nurse/Unit Manager, stated there was no regular system for inspecting bedrails and staff were expected to notice loose bedrails and notify maintenance.</p> <p>During an interview on 06/05/2024 at 1:37 PM, Staff B, Director of Nursing Services, stated staff were to notice loose bedrails and notify maintenance.</p> <p>During an interview on 06/05/2024 at 2:40 PM, Staff M, Maintenance Director, stated there was no system for regular inspection of bedrails. Staff M stated staff would inform maintenance that bedrails needed tightening as they were discovered.</p> <p>During an interview on 06/05/2024 at 3:05 PM, Staff A, Administrator, stated that inspection of bedrails should be part of a regular preventative maintenance schedule.</p> <p>SEE F689</p> <p>Reference WAC 388-97-2100</p>