

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  05/09/2025
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.

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review, the facility failed to provide an opportunity for a resident to see the new location and meet new roommates for 1 of 1 Sample Resident (Resident 31) when reviewed for room changes. This failure placed residents at risk for psychosocial decline and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 31 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, prevents airflow to the lungs causing breathing issues), generalized muscle weakness and was able to make needs known.</p> <p>During an interview on 05/05/2025 at 2:26 PM, Resident 31 stated they had moved three times within the last few months. Resident 31 stated they were unhappy with the previous room move as they did not have a choice in the move and did not get to see the new room prior to moving.</p> <p>Review of the EHR showed Resident 31 had room moves on 02/18/2025, 02/27/2025 and 04/22/2025.</p> <p>Review of a progress note, dated 02/28/2025, showed Resident 31 voiced to staff the new room was too small and had concerns their personal belongings would not fit in the room. Resident 31 voiced concern their roommates' belongings were hung on Resident 31's portion of the shared wall. Staff documented social services staff were notified.</p> <p>During an interview on 05/08/2025 at 9:41 AM, Staff E, Social Services Director (SSD), stated Resident 31's 02/27/2025 move was an emergency move related to ongoing roommate issues. Staff E stated Resident 31 was not shown the room prior to the move but should have been. Staff E stated there should have been follow-up on Resident 31's concerns related to the room change.</p> <p>During an interview on 05/09/2025 at 8:22 AM, Staff A, Administrator, stated the expectation was residents were offered the opportunity to view the new room prior to moving. Staff A stated the lack of follow-up on Resident 31's concerns did not meet their expectation.</p> <p>Reference WAC 388-97-0580(1)(b)(i)(ii).</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38344</p> <p>Based on interview and record review, the facility failed to obtain a court-appointed guardianship (legal process where a court appoints someone to make decisions for a person who is unable to do so for themselves) and/or to obtain and periodically review a resident's advanced directive (AD, a legal document that establishes a medical decisionmaker if you are unable to make decisions for yourself) for 2 of 3 sampled residents (Residents 14 and 99) when reviewed for advanced directive. This failure placed residents at risk of not having an established decisionmaker, lack of ability to direct care, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 14</p> <p>Review of the electronic health record (EHR) showed Resident 14 initially admitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set (MDS, a required assessment tool), dated 03/21/2025, showed Resident 14 had diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), bipolar disorder, (episodes of mood swings ranging from depressive lows to manic highs) and psychotic disorder (a mental disorder characterized by a disconnection from reality).</p> <p>During an interview on 05/06/2025 at 1:44 PM, Resident 14 stated their spouse, and two children were their durable power of attorney (DPOA, a legal document that establishes a medical decisionmaker); however, they did not know if the facility had the legal paperwork or not.</p> <p>Review of Resident 14's EHR on 05/08/2025 at 3:33 PM showed in the Profile tab, two children were power of attorney (POA, a legal document that allows one person to grant another person the authority to act on their behalf) for Resident 14's financial reasons; however, it did not show that they were DPOA for healthcare. Review showed no documentation of an AD for healthcare.</p> <p>During an interview on 05/08/2025 at 10:38 AM Staff E, Social Services Director (SSD), stated Resident 14's EHR did not contain the DPOA for healthcare and they were unsure why. Staff E stated the AD should have been reviewed the prior quarter on 10/31/2024 or at the most recent care conference. Staff E stated they located a document titled, Physician's Statement Regarding Capacity/Competency that showed Resident 14 was treated/examined on 06/15/2016 and this document was signed by the physician on 07/13/2016 which showed Resident 14 no longer had the capacity to handle their own property, financial affairs and health care decision-making due to physical disability, mental illness, and dementia. Staff E stated they were unable to locate an AD/Guardianship in Resident 14's EHR and the lack of timely follow-up did not meet expectations.</p> <p>During an interview on 05/08/2025 at 11:53 AM Staff A, Administrator, stated residents' ADs were reviewed upon admission, during care conferences, upon request, and as needed. Staff A stated they should have moved forward with Resident 14's guardianship, especially if there was no DPOA for healthcare, and this did not meet expectations.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 99</p> <p>Review of the EHR showed Resident 99 initially admitted to the facility on [DATE] with diagnoses that included high blood pressure and stroke (damage to the brain from interruption of its blood supply). The annual MDS dated [DATE] showed Resident 99 was able to make needs known.</p> <p>During an interview on 05/06/2025 at 1:04 PM Resident 99 stated they did not have an AD in place.</p> <p>Review of Resident 99's last two care conference reports dated 10/31/2024 and 02/18/2025 both showed the following questions answered:</p> <ul style="list-style-type: none"> <li>-AD/DPOA? = None</li> <li>-Surrogate decision maker hierarchy given to resident/family? = left blank</li> <li>-If guardian in place, was it up to date? = Not Applicable (N/A)</li> <li>-Resident cognizant to sign AD/DPOA? = N/A</li> <li>-If resident cognizant, offered assistance for completing AD/DPOA? = N/A</li> </ul> <p>Review of Resident 99's EHR on 05/06/2025 at 3:01 PM showed in the Profile tab, Resident 99 was their own responsible party/health care decision maker. Review showed no documentation of an AD for healthcare.</p> <p>On 05/08/2025 at 10:38 Staff E, SSD, stated they thought Resident 99 had a POA and it should have been scanned into the resident's EHR by now. Staff E stated they were not sure why Resident 99's care conference reports showed AD/DPOA was documented N/A. Staff E stated they were unable to locate an AD for healthcare in Resident 99's EHR and it needed to be followed up on.</p> <p>On 05/08/2025 at 11:53 AM, Staff A stated they were unable to explain why care conferences showed N/A documented for Resident 99's AD/DPOA.</p> <p>Staff A stated the AD should have been in Resident 99's EHR and/or documentation as to why it was not in place.</p> <p>Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51907</p> <p>Based on observation, interview, and record review, the facility failed to prevent the use of chemical restraints for 1 of 5 sampled residents (Resident 83) reviewed for unnecessary medications. This failure placed residents at risk of side-effects from the medications, unnecessary chemical restraints, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 83 admitted to the facility on [DATE] with diagnoses that included vascular dementia (a condition resulting in symptoms such as memory loss, confusion, and difficulty with reasoning and planning) and depression. The quarterly minimum data set (MDS), an assessment tool, dated 03/07/2025, showed Resident 83 was confused and dependent on staff for care.</p> <p>Review of the electronic health record (EHR) showed Resident 83 was taking Seroquel (an antipsychotic medication), dated 03/31/2024, Depakote (an antiseizure medication used for mood stabilization), and Mirtazapine (an antidepressant medication). Review of provider orders showed Resident 83 started on Depakote on 11/21/2024. Review of provider orders showed an increase in the Depakote dose on 01/24/2025. Review showed no dose reduction had been attempted for Seroquel since initiating Depakote.</p> <p>Observation on 05/06/2025 at 1:50 PM, showed Resident 83 was sitting in a wheelchair. Resident 83 was calm, confused, and conversive.</p> <p>Observation on 05/07/2025 at 1:36 PM, showed Resident 83 was with eyes closed.</p> <p>Observation on 05/07/2025 at 2:54 PM, showed Resident 83 was with eyes closed.</p> <p>Observation on 05/08/2025 at 9:07 AM, showed Resident 83 was with eyes closed. Resident 83 did not open their eyes when they were talked to, or their name was called.</p> <p>Observation on 05/08/2025 at 10:39 AM, showed Resident 83 was with eyes open and calm.</p> <p>Observation on 05/08/2025 at 12:53 PM, showed Resident 83 was with eyes open, calm, conversive, and pleasant.</p> <p>Review of progress note, dated 11/21/2024, showed the provider was updated on Resident 83 and evaluation was requested since Seroquel was not effective.</p> <p>Review of provider notes, dated 11/22/2024, showed the goal was to discontinue Seroquel given medication class risk.</p> <p>Review of the monthly psychoactive monitoring summary, dated 12/19/2025, showed Resident 83 was reviewed for a dose reduction of Seroquel. Review showed Seroquel was determined to be mostly ineffective. Review showed no dose reduction was recommended for that month. Rationale for no dose reduction was documented as continue current plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the monthly psychoactive monitoring summary, dated 01/30/2025, showed Resident 83 was reviewed for dose reduction of Seroquel. Review showed Seroquel was documented as mostly ineffective. Review showed changes were not recommended with a rationale as no change in Seroquel.</p> <p>During an interview on 05/08/2025 at 10:41 AM, Staff F, Certified Nursing Assistant (CNA), stated Resident 83 used to have behaviors every day during care. Staff F stated Resident 83 had not had behaviors for about a month. Staff F stated Resident 83 was redirectable with care when behaviors had occurred.</p> <p>During an interview on 05/08/2025 at 12:54 PM, Staff G, Registered Nurse (RN), stated Resident 83 was receiving Seroquel and Depakote for dementia with behaviors. Staff G stated Resident 83 had not had any behaviors that shift.</p> <p>During an interview on 05/08/2025 at 1:04 PM, Staff C, RN/Unit Manager, stated the last dose reduction attempted for Seroquel was February of 2024. Staff C stated no dose reduction was attempted after starting Depakote.</p> <p>During an interview on 05/09/2025 at 8:08 AM, Staff E, Social Service Director (SSD), stated the last dose reduction review for Seroquel was on 01/21/2025. Staff E stated a dose reduction was not attempted because the psychiatric nurse practitioner stated it was clinically contraindicated because Resident 83 was still having behaviors.</p> <p>During an interview on 05/09/2025 at 8:24 AM, Staff J, CNA, stated Resident 83 had not had any behaviors during their shift and had been asleep since the start of their shift. Staff J stated night shift reported Resident 83 had not had any behaviors all night and slept their entire shift.</p> <p>During an interview on 05/09/2025 at 8:26 AM, Staff K, Life Enrichment, stated Resident 83 had not had behaviors in activities. Staff K stated Resident 83 became sleepy at activities and staff had to often wake him up. Staff K stated Resident 83 attended activities one or two times a week but did not attend if they were sleepy.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff H, Nurse Practitioner, stated a decrease in Seroquel had not been attempted since the start of Depakote. Staff H stated if Resident 83 had not had behaviors or had been sleepy the dose of Seroquel should have been decreased.</p> <p>Refer to F-658 Services Provided Meet Professional Standards- for additional information related to failing to accurately document behavior monitoring.</p> <p>Refer to F-744 Treatment/services For Dementia- for additional information related to failing to identify and implement person-centered, individualized interventions for dementia care.</p> <p>Reference WAC 388-97- 0620 (1)(a)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review, the facility failed to identify and report an allegation of abuse for 1 of 1 sampled resident (Resident 31) when reviewed for abuse. This failure placed residents at risk for unidentified and repeated potential abuse, neglect and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 31 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, prevents airflow to the lungs causing breathing issues), generalized muscle weakness, and was able to make needs known.</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation dated October 2022, showed, As part of the resident abuse prevention, the staff will . identify the different types of abuse to include certain resident to resident altercations .immediately investigate . report all alleged violations of abuse within specified timeframes.</p> <p>During an interview on 05/05/2025 at 2:29 PM, Resident 31 stated they recently moved to their current room due to an altercation with their roommate. Resident 31 stated the roommate threw items at them and they had several shouting matches.</p> <p>Review of the facility's incident logs from February 2025 to May 2025 showed no allegation of abuse logged related to Resident 31.</p> <p>Review of a progress note dated 02/26/2025 at 3:08 PM, showed an alert charting note for roommate interaction.</p> <p>Review of a progress noted dated 02/27/2025 at 6:32 AM, showed and alert charting note: Resident and roommate got into a verbal altercation at 10:15 PM. Resident upset wants to keep light on in bedroom, roommate wants lights completely turned off. Resident and roommate shouting at one another. Resident was redirected, resident and roommate being monitored every 15 minutes for behaviors.</p> <p>During an interview on 05/08/2025 at 9:56 AM, Staff L, Unit Manager/Registered Nurse (UM/RN), stated an incident report should have been completed, and the allegation should have been reported to the state but was not.</p> <p>During an interview on 05/09/2025 at 8:29 AM, Staff B, Director of Nursing Services (DNS), stated when a disagreement rises to the level of verbal abuse the expectation was that an investigation was initiated, completed and a report made to the state.</p> <p>Reference WAC 388-97-0640(5)(a)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on observation, interview, and record review, the facility failed to develop and/or implement comprehensive care plans for 5 of 23 sampled residents (Residents 104, 20, 72, 7 and 114) whose care plans were reviewed. Failure to develop/implement a comprehensive care plan related to activities, pain, edema (fluid build-up causing swelling), and personal hygiene placed the resident at risk for unmet needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 104 admitted to the facility on [DATE] with diagnoses that included dementia (a group of cognitive disorders with a decline in memory and thinking that interferes with daily life), diabetes (too much sugar in the blood) and high blood pressure. Resident 104 was rarely understood.</p> <p>Review of the Activity Preference section of the annual minimum data set (MDS, a required assessment tool) dated 03/24/2025 showed listening to music, having magazines, books or newspapers and doing favorite activities were documented as Very Important to Resident 104.</p> <p>Review of Resident 104's Life Enrichment Care Plan dated 03/24/2025 showed Focus enjoys outdoors, bingo, news, listening to music (just about anything), word puzzles, reading adventure, gambling, tv, and visiting with family and friends. Interventions showed, Invite and encourage to attend programs and offer leisure materials/supplies such as books and Daily Chronicles.</p> <p>Observations on 05/06/2025 at 9:38 AM and 1:53 PM showed Resident 104 sitting in a wheelchair in front of the nurses' station with their head down not engaged with staff or residents.</p> <p>Observation on 05/07/2025 at 8:49 AM, 10:22 AM and 12:24 PM showed Resident 104 sitting in a wheelchair in front of the nurses' station with their head down not engaging with staff or residents.</p> <p>During an interview on 05/06/2025 at 1:45 PM, Staff X, Life Enrichment Development Specialist, stated Resident 104 did not participate much since they moved from the dementia unit where there were more appropriate activities.</p> <p>During an interview on 05/07/2025 at 2:03 PM, Staff Y, Community Life Director, stated Resident 104 should have been offered sensory stimulation, music or the opportunity to attend entertainment events such as birthday parties or observations of holidays. Staff Y stated the lack of offering appropriate activities to Resident 104 did not meet their expectations.</p> <p>46148</p> <p>Resident 20</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EHR showed Resident 20 was readmitted to the facility on [DATE] with diagnoses of fibromyalgia (a long-term condition that involves widespread body pain), arthritis (joint pain) and colon cancer. The resident was able to make needs known.</p> <p>During an interview and observation on 05/07/2025 at 9:23 AM, Resident 20 stated My chest and my kidneys hurt every day, it's getting worse. My belly hurts and my legs hurt all the time.</p> <p>Review of Resident 20's plan of care showed a care plan dated 12/01/2024 for The resident has (Specify: acute/chronic) pain r/t Depression, Diabetic neuropathy with an intervention of Monitor/record pain characteristics (FREQ) and PRN. No pain monitor was found in the EHR.</p> <p>Resident 72</p> <p>Review of the EHR showed Resident 72 admitted to the facility on [DATE] with diagnoses of back pain, sciatica (leg nerve pain) and arthritis. The resident was able to make needs known.</p> <p>During an interview on 05/05/2025 at 2:37 PM, Resident 72 stated they take pain medication, but it was not very effective, and they were in a lot of pain yesterday (05/04/2025) that made them cry.</p> <p>Review of the medication administration record for May 2025 showed Resident 72 received Tylenol as needed on 05/04/2025.</p> <p>Review of a pain assessment completed on 04/07/2025 showed Resident 72 complained of headache and buttock pain.</p> <p>Review of the EHR showed no care plan was initiated for Resident 72's pain.</p> <p>During an interview on 05/07/2025 at 9:03 AM, Staff C, Unit manager/Registered Nurse (UM/RN), stated residents with a history of complaints of pain should have a personalized plan of care in place to address pain, but Residents 20 and 72 did not.</p> <p>During an interview on 05/07/2025 at 10:50 AM, Staff B, DNS, stated it was their expectation the care plans be accurate and specific for each resident.</p> <p>51907</p> <p>Resident 7</p> <p>Resident 7 admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (a long term disease where the kidneys cannot filter the blood properly), dependence on renal dialysis (a treatment to remove extra fluid from the body), and localized edema. The minimum data set (MDS), an assessment tool, dated 04/21/2025, showed Resident 7 was able to make needs known.</p> <p>Observation on 05/05/2025 at 2:15 PM showed Resident 7 had moderate to severe swelling in their feet and ankles.</p> <p>During an interview on 05/08/2025 at 11:14 AM, Staff O, Licensed Practical Nurse stated Resident 7 usually had edema in their lower extremities.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EHR showed no care plan was initiated for edema.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff B, DNS stated their expectation was that care plans be completed accurately.</p> <p>Resident 114</p> <p>Resident 114 admitted to the facility on [DATE] with diagnoses that included intracerebral hemorrhage (a sudden bleed in the brain), chronic kidney disease (a condition where the kidneys cannot filter blood properly), dementia, hemiplegia, and hemiparesis (paralysis and severe weakness on one side of the body) of the right side. The MDS, dated [DATE], showed Resident 114 was dependent on staff for all care.</p> <p>Observation on 05/06/2025 at 12:28 PM showed Resident 114 was not shaved. Observation showed Resident 114 had long, unclipped nails.</p> <p>Review of the care plan on 05/06/2025 showed no level of assistance needed or frequency for shaving. Review showed Resident 114's preference for shaving was not on the care plan. Review showed no level of assistance needed or frequency for nail care.</p> <p>During an interview on 05/08/2025 at 10:28 AM, Staff D, Certified Nursing Assistant (CNA), stated Resident 114 frequently refused care. Staff D stated Resident 114 was dependent on staff for shaving and nail care. Staff D stated Resident 114's family would often assist with shaving and nail care.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff B, DNS, stated nail care and shaving should have been on the care plan. Staff B stated failure to care plan assistance needed and preference did not meet their expectations.</p> <p>Reference WAC 388-97- 1020(1), (2)(a)(b)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38344</p> <p>Based on interview and record review, the facility failed to provide and/or maintain documented care conferences in a timely manner for 2 of 3 sampled residents (Residents 72 and 77) when reviewed for care planning. This failure placed residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 72</p> <p>Review of the electronic health record (EHR) showed Resident 72 admitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood) and high blood pressure and was able to make needs known.</p> <p>During an interview on 05/05/2025 at 2:29 PM Resident 72 stated they had not gone to a care conference meeting.</p> <p>Review of Resident 72's EHR on 05/08/2025 showed no documentation that a care conference had occurred.</p> <p>Resident 77</p> <p>Review of the EHR showed Resident 77 admitted to the facility on [DATE] with diagnoses that included heart failure, arthritis (swelling of the joints), and depression. Resident 77 was able to make needs known.</p> <p>During an interview on 05/05/2025 at 1:17 PM Resident 77 stated they did not recall ever going to a care conference.</p> <p>Review of Resident 77's social services progress note dated 04/08/2025 showed the facility care conference was completed and was to be uploaded to the miscellaneous tab in the EHR.</p> <p>Review of Resident 77's EHR, miscellaneous tab, on 05/08/2025 showed no documentation a care conference had occurred on 04/08/2025.</p> <p>During an interview on 05/08/2025 at 11:19 AM, Staff E, Social Services Director (SSD), stated Resident 72 had not had a care conference yet and there should have been one conducted during the initial minimum data set (MDS, a required assessment tool) period and that did not happen and did not meet expectations. Staff E stated Resident 77's progress note dated 04/08/2025 showed Resident 77 had a care conference and the documentation was to be uploaded into the resident's EHR; however, there was no documentation to show the care conference occurred and this did not meet expectations.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/08/2025 at 12:13 PM, Staff A, Administrator, stated resident care conferences were to be held upon admission, quarterly, upon request, and as needed. Staff A stated Resident 72 should have had a scheduled care conference documented with the interdisciplinary team (IDT) and the resident and/or responsible party and the documentation placed in Resident 72's EHR; however, that did not happen. Staff A stated Resident 77 should have had evidence that a care conference occurred in Resident 77's EHR and this did not meet expectations.</p> <p>Reference WAC 388-97-1020 (2)(f), (4)(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** 51907</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice by accurately documenting behavior monitoring for 1 of 3 residents (Resident 83) reviewed for dementia care. This failure placed residents/staff at risk of unmet care needs, unnecessary medications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 83 admitted to the facility on [DATE] with diagnoses that included vascular dementia (a condition resulting in symptoms such as memory loss, confusion, and difficulty with reasoning and planning) and depression. The quarterly minimum data set (MDS), an assessment tool, dated 03/07/2025, showed Resident 83 was confused and dependent on staff for care.</p> <p>Observation on 05/06/2025 at 1:05 PM showed Resident 83 was awake, alert, and pleasantly confused.</p> <p>Observation on 05/07/2025 at 1:36 PM showed Resident 83 was with eyes closed in their wheelchair.</p> <p>Observation on 05/07/2025 at 2:54 PM showed Resident 83 was in bed with eyes closed.</p> <p>Observation on 05/08/2025 at 9:07 AM showed Resident 83 was in bed with eyes closed. Resident 83 did not respond when their name was called.</p> <p>Observation on 05/08/2025 at 10:39 AM showed Resident 83 was in bed, calm and awake.</p> <p>Observation on 05/08/2025 at 12:53 PM showed Resident 83 was in their wheelchair awake. Resident 83 was calm, conversive, and pleasant.</p> <p>Observation on 05/09/2025 at 8:18 AM showed Resident 83 was in bed sleeping.</p> <p>Review of a document titled Behavior Monitoring for May 2025 showed documentation by nursing staff that Resident 83 had continuous behaviors of agitation on 05/01/2025, 05/03/2025, 05/07/2025, and 05/08/2025 on day shift. Review showed Resident 83 had continuous behaviors of aggression on 05/01/2025 and 05/07/2025 on day shift. Review showed Resident 83 had continuous behaviors of agitation on 05/01/2025, 05/02/2025, 05/04/2025, 05/05/2025, 05/06/2025, 05/07/2025, and 05/08/2025 on night shift. Review showed Resident 83 had continuous behaviors of aggression on 05/01/2025, 05/04/2025, 05/05/2025, and 05/06/2025 on night shift.</p> <p>During an interview on 05/08/2025 at 10:41 AM, Staff F, Certified Nursing Assistant (CNA), stated Resident 83 had not had aggressive behaviors for about a month. Staff F stated on 05/07/2025 Resident 83 was asleep for the entire shift on day shift.</p> <p>During an interview on 05/08/2025 at 12:53 PM, Staff G, Registered Nurse (RN), stated they had not seen behaviors from Resident 83. Staff G stated Resident 83 was calm for their shift.</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>During an interview on 05/09/2025 at 8:24 AM, Staff J, CNA, stated Resident 83 had been asleep since the start of their shift. Staff J stated night shift reported Resident 83 had no behaviors overnight and slept through their shift.</p> <p>During an interview on 05/09/2025 at 8:26 AM, Staff K, Life Enrichment, stated Resident 83 had not had behaviors in activities. Staff K stated Resident 83 would converse in group settings with no aggression or agitation.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff B, Director of Nursing Services, stated it was their expectation behavior monitoring would be documented accurately.</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** 46148</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure quality of care was provided for bowel management for 1 of 2 sampled residents (Resident 112) when reviewed for bowel management, for edema for 2 of 3 sampled residents (Residents 20 and 7) when reviewed for edema, and for positioning for 1 of 3 sampled residents (Resident 114) when reviewed for positioning. These failures placed residents at risk of medical complications and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Bowel Management&gt;</p> <p>Resident 112</p> <p>Review of the electronic health record (EHR) showed Resident 112 admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF, when the heart fails to pump enough blood). The resident was able to make needs known.</p> <p>Review of the provider orders showed Resident 112 had an order dated 02/07/2025 for Imodium to be given as needed for loose stools, and an order dated 04/14/2024 for banana flakes to be given as needed for loose stools.</p> <p>Review of the bowel monitor showed Resident 112 had reported loose stools on 04/23/2025, 04/29/2025, 05/02/2025 and 05/05/2025. Review of the administration records showed no as needed medications were provided on the dates Resident 112 reported loose stools.</p> <p>During an interview on 05/08/2025 at 9:34 AM, Staff C, Unit Manager/Registered Nurse (UM/RN), stated Resident 112 had loose stools on and off since admission and had as needed medications for it. Staff C stated they should have received the medications when they reported loose stools but did not.</p> <p>During an interview on 05/08/2025 at 9:54 AM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that residents who had orders for as needed medications for loose stools received them, and this did not happen for Resident 112 and should have.</p> <p>&lt;Edema Management&gt;</p> <p>Resident 20</p> <p>Review of the EHR showed Resident 20 was readmitted to the facility on [DATE] with diagnosis of CHF, respiratory failure and edema. The resident was able to make needs known.</p> <p>During an observation and interview on 05/05/2025 at 10:31 AM, Resident 20 stated they had pain and swelling in both feet. The resident sat in a wheelchair at the side of the bed, and both feet were swollen.</p> <p>Review of the care plan dated 12/04/2025 showed an edema management goal to assess daily for edema.</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>Review of the EHR showed no documentation Resident 20's edema had been monitored daily.</p> <p>During an interview on 05/07/2025 at 9:53 AM, Staff C, UM/RN, stated residents who had a diagnosis of CHF should be monitored daily for edema and it should be documented in the EHR.</p> <p>During an interview on 05/07/2025 at 10:56 AM, Staff B, DNS, stated it was their expectation that residents with edema be monitored daily and documented in the skilled notes or progress notes and notify the provider of changes, but this did not happen for Resident 20 and should have.</p> <p>51907</p> <p>Resident 7</p> <p>Resident 7 admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (a long-term disease where the kidneys cannot filter the blood properly), dependence on renal dialysis (a treatment to remove extra fluid from the body), and localized edema (swelling in specific areas in the body). The minimum data set (MDS), an assessment tool, dated 04/21/2025, showed Resident 7 was able to make needs known.</p> <p>Review of provider orders showed Resident 7 had an order to wear compression stockings every day for edema. Review showed compression stockings were ordered to be put on in the morning and removed at bedtime.</p> <p>Observation on 05/05/2025 at 2:15 PM showed Resident 7 with moderate edema to both feet. Resident 7 was sitting up in their wheelchair with feet on the floor. Resident 7 did not have compression socks on.</p> <p>Observation on 05/07/2025 at 9:25 AM showed Resident 7 did not have their compression socks on.</p> <p>Observation on 05/08/2025 at 1:36 PM showed Resident 7 was sitting up in their wheelchair with feet down on the floor. Moderate edema was noted in both feet. Mild edema was noted in both legs. Resident 7 had compression socks on that were slouched down under their calves on both legs.</p> <p>Review of nurses' notes dated 05/01/2025 through 05/08/2025 showed nursing staff documented no edema was present.</p> <p>Review of provider's notes dated 04/29/2025 and 04/30/2025 showed fluid status was managed by dialysis. There was no documentation for an assessment on edema.</p> <p>Review of EHR showed Resident 7 received dialysis every Tuesday, Thursday, and Saturday. Review showed Resident 7 was on a fluid restriction to manage fluid status.</p> <p>During an interview on 05/08/2025 at 1:36 PM, Staff R, Certified Nursing Assistant (CNA), stated Resident 7's feet looked 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 05/08/2025 at 11:14 PM, Staff O, Licensed Practical Nurse (LPN), stated Resident 7 usually had mild to moderate edema. Staff O stated Resident 7 had orders for compression stockings to be placed on in the morning and removed at bedtime. Staff O stated any edema noted would be documented in the daily skilled nursing notes.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff B, DNS, stated it was their expectation that an assessment for edema be completed every shift by a nurse and documented accurately. Staff B stated compression stocking should be applied as ordered.</p> <p>&lt;Positioning&gt;</p> <p>Resident 114</p> <p>Resident 114 admitted to the facility on [DATE] with diagnoses that included intracerebral hemorrhage (a sudden bleed in the brain), chronic kidney disease, dementia, and hemiplegia and hemiparesis of the right side (weakness and paralysis of one side of the body). The MDS, dated [DATE], showed Resident 114 was dependent on staff for all care.</p> <p>Observation on 05/06/2025 at 9:24 AM showed Resident 114 in bed laying on their back.</p> <p>Observation on 05/06/2025 at 12:52 PM showed Resident 114 in bed, laying on their back. The head of the bed was elevated for lunch.</p> <p>Observation on 05/06/2025 at 1:26 PM showed Resident 114 in bed, laying on their back. The head of the bed was elevated.</p> <p>Observation on 05/06/2025 at 2:25 PM showed Resident 114 in bed, laying on their back. The head of the bed was down.</p> <p>Observation on 05/07/2025 at 8:37 AM, 12:34 PM, 1:33 PM, and 2:50 PM showed Resident 114 in bed, laying on their back.</p> <p>Review of the EHR showed Resident 114 was placed on hospice on 04/17/2025. Review showed Resident 114 was confused and unable to consistently voice their needs.</p> <p>During an interview on 05/08/2025 at 10:34 AM, Staff O, CNA, stated Resident 114 should be turned every two hours.</p> <p>During an interview on 05/08/2025 at 11:54 AM, Staff S, LPN, stated Resident 114 should be turned every two hours.</p> <p>During an interview on 05/08/2025 at 2:13 PM, Staff B, DNS, stated it was their expectation that dependent residents be turned every two hours or as per provider orders.</p> <p>Reference WAC 388-97- 1060 (1)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344</b></p> <p>Based on interview and record review, the facility failed to provide prompt services to maintain vision for 1 of 3 sampled residents (Resident 23) when reviewed for communication/sensory. This failure placed the resident at risk of unmet vision needs, inability to perform activities of daily living, inability to participate in leisure activities and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 23 readmitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood) and depression. The quarterly minimum data set (MDS, a required assessment tool) dated 02/27/2025, showed Resident 23 had adequate vision with corrective lenses.</p> <p>During an interview on 05/05/2025 at 12:56 PM Resident 23 stated that they had gone to the eye doctor sometime in February of this year (2025) and received a prescription for new glasses; however, they had not received them, and staff were aware.</p> <p>Review of Resident 23's neuro-ophthalmology (brain and eye doctor) consultation report dated 02/03/2025 showed the provider recommended new glasses and included Resident 23's prescription for new glasses attached to the report. It showed, Okay to exchange right eye lens of current glasses.</p> <p>During an interview on 05/07/2025, Staff L, Unit Manager/Registered Nurse (UM/RN), stated they worked with the health information/medical records to determine if prescriptions for glasses would be filled by an outside office or by the inhouse optometrist (eye doctor). Staff L stated they had documented in a progress note on 05/05/2025 that showed the provider would review Resident 23's prescription and evaluate if the prescription could be added. Staff L stated Resident 23's prescription for new glasses on 02/03/2025 should have been followed up sooner.</p> <p>During an interview on 05/07/2025 at 1:46 PM, Staff M, Health Information Clerk, stated the timeline from obtaining a prescription for new glasses to getting the new glasses could take anywhere from two to three weeks. Staff M stated the in-house optometrist came to the facility on ce a month. Staff M stated they never received Resident 23's prescription for new glasses from nursing to be able to email it to the in-house optometrist. Staff M stated this did not meet expectations and should have been followed up sooner.</p> <p>During an interview on 05/07/2025 at 2:21 PM, Staff B, Director of Nursing Services, stated they were not aware that Resident 23's 02/03/2025 new glasses prescription had not been filled and should have been addressed sooner. Staff B stated there should have been proper communication between nursing and health information/medical records.</p> <p>Reference WAC 388-97-1060 (3)(a)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received the necessary services to maintain their level of functioning and/or prevent decline for 1 of 3 sampled residents (Resident 31) when reviewed positioning/mobility. This failure placed the residents at risk for decreased range of motion (ROM), increased pain, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 31 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, prevents airflow to the lungs causing breathing issues), generalized muscle weakness and was able to make needs known.</p> <p>Review of the care plan, revised on 02/11/2025, showed Resident 31 had an activities of daily living (ADL) self-care performance deficit related to impaired balance.</p> <p>Review of the admission minimum data set (MDS, an assessment tool), dated 02/17/2025, showed Resident 31 had impairment of lower extremities on both sides.</p> <p>Review of a document titled, Physical Therapy Treatment Encounter, dated 02/12/2025, showed Patient has no interest in therapy services due to preference to lay in bed, watch TV and read a book. Patient limits ROM beyond what he can do for himself thus no restorative program recommended. Based on today's treatment response, patient refused services.</p> <p>Review of a progress noted dated 02/19/2025 showed, during a social service check-in with the resident, Resident 31 stated they wanted to start a restorative therapy program.</p> <p>During an interview on 05/08/2025 at 11:30 AM, Staff E, Social Services Director, stated they were unable to locate documentation of follow up with nursing related to Resident 31's restorative therapy request.</p> <p>During an interview on 05/08/2025 at 10:03 AM, Staff L, Unit Manager/Registered Nurse (UM/RN), stated they were unaware of Resident 31's request to participate in restorative therapy.</p> <p>During an interview on 05/09/2025 at 8:33 AM, Staff B, Director of Nursing Services (DNS), stated a referral should have been made to the restorative nurse and an assessment completed within five days to see if Resident 31 was appropriate for a restorative therapy program. Staff B stated the lack of communication did not meet their expectations.</p> <p>Reference WAC 388-97-1060 (3)(d), (j)(ix)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 observation, interview, and record review, the facility failed to monitor residents' fluid intake and provide the amount of fluid per provider's orders for 2 of 2 sampled residents (Residents 7 and 381) when reviewed for nutrition/hydration. This failure placed residents at risk of fluid overload, avoidable pain, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 7</p> <p>Review of the electronic health record (EHR) showed Resident 7 readmitted to the facility on [DATE] with diagnoses of fracture of the spine, chronic kidney disease, and diabetes (too much sugar in the blood). Resident 7 was able to make needs known.</p> <p>Review of a provider's orders, dated 04/14/2025, showed Resident 7 had a 1200 cubic centimeter (cc) fluid restriction with 420 cc provided by nursing and 780 cc provided by dietary. Review showed a provider's order, dated 04/14/2025, for night nursing to total the fluids provided by nursing and dietary during the day.</p> <p>Observation on 05/06/2025 at 1:21 PM showed Resident 7 laid in bed with a lunch tray on their overbed table with a menu card showing the resident was on a one cup fluid restriction. Observation showed a full glass of water and a half glass of milk on Resident 7's tray.</p> <p>Observation on 05/07/2025 at 9:20 AM showed Resident 7 laid in bed with an empty paper cup, a plastic cup with water, and a plastic cup of water on the overbed table.</p> <p>Observation on 05/07/2025 at 10:28 AM showed Resident 7 laid in bed with an empty plastic cup, two paper cups with water, and a plastic cup of milk on the overbed table.</p> <p>During an interview on 05/08/2024 at 9:17 AM, Staff U, Certified Nursing Assistant (CNA), stated the CNAs were responsible for documenting how much fluid a resident received during meal services and a small cup was 120 cc. Staff U stated they knew which residents were on a fluid restriction by looking at the care directives. Staff U stated Resident 7 was not on a fluid restriction.</p> <p>Review of the EHR showed two care directive monitors, dated May 2025, for the CNA to document Resident 7's fluid intake; one for day and one for night. Review of 05/01/2025 to 05/07/2025 showed the following documented intake for both day and night:</p> <p>05/01/2025 - Total 320 cc</p> <p>05/02/2025 - Total 720 cc</p> <p>05/03/2025 - Total 480 cc</p> <p>05/04/2025 - Total 720 cc</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/05/2025 - Total 340 cc</p> <p>05/06/2025 - Total 320 cc</p> <p>05/07/2025 - Total 840 cc</p> <p>Review of the May 2025 medication administration record (MAR) showed Resident 7 was documented for both dietary and nursing fluid intake and had an area for nursing staff to total fluid intake on the night shift. Review from 05/01/2025 to 05/07/2025 showed the following amounts:</p> <p>05/01/2025 - Dietary 960 cc, nursing 480 cc, and total intake for the day 920 cc</p> <p>05/02/2025 - Dietary 300 cc, nursing 480 cc, and total intake for the day 1200 cc</p> <p>05/03/2025 - Dietary 200 cc, nursing 360 cc, and total intake for the day 860 cc</p> <p>05/04/2025 - Dietary 240 cc, nursing 340 cc, and total intake for the day 1080 cc</p> <p>05/05/2025 - Dietary 360 cc, nursing 360 cc, and total intake for the day 1080 cc</p> <p>05/06/2025 - Dietary 420 cc, nursing 1140 cc, and total intake for the day 1120 cc</p> <p>05/07/2025 - Dietary 540 cc, nursing 560 cc, and total intake for the day 1120 cc</p> <p>[Seven of seven days were not totaled accurately.]</p> <p>During an interview on 05/08/2025 at 11:52 AM, Staff N, Unit Manager/Licensed Practical Nurse (UM/LPN), stated for a fluid restriction the nurse on the cart would monitor the amount provided with medications and the kitchen would provide the amount of liquid on the food tray card. Staff N stated the CNA should know what residents were on a fluid restriction by looking at the care directive and the signage at the head of the bed. Staff N stated the signage was not posted above Resident 7's bed.</p> <p>Observation, interview, and record review on 05/08/2025 at 12:33 PM showed Resident 7's meal tray had a cup of coffee, a cup of apple juice, and a cup of water. Review of the meal card showed to provide eight ounces water and six ounces juice and Resident 7 was on a one cup fluid restriction. Staff N, UM/LPN, stated the menu card indicated to provide one cup fluid restriction but Resident 7 received approximately 420 cc of liquid with lunch.</p> <p>Resident 381</p> <p>Review of the EHR showed Resident 381 admitted to the facility on [DATE] with diagnoses of dementia and diabetes. Resident 381 was able to make needs known.</p> <p>Review of a provider's orders, dated 04/21/2025, showed Resident 7 had a 2000 cc fluid restriction with 600 cc provided by nursing and 1400 cc provided by dietary. Review showed a provider's order, dated 04/21/2025, for night nursing to total the fluids provided by nursing and dietary during the day.</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 05/08/2025 at 10:59 AM showed Resident 381 in bed with a full water pitcher on the overbed table.</p> <p>Review of the EHR showed two care directive monitors, dated May 2025, for the CNA to document Resident 381's fluid intake; one for day and one for night. Review of 05/01/2025 to 05/07/2025 showed the following documented intake for both day and night:</p> <p>05/01/2025 - Total 2,520 cc</p> <p>05/02/2025 - Total 940 cc</p> <p>05/03/2025 - Total 980 cc</p> <p>05/04/2025 - Total 960 cc</p> <p>05/05/2025 - Total 1,560 cc</p> <p>05/06/2025 - Total 2,760 cc</p> <p>05/07/2025 - Total 960 cc</p> <p>Review of the May 2025 MAR showed Resident 7 was documented for both dietary and nursing fluid intake and had an area for nursing staff to total fluid intake on the night shift. Review from 05/01/2025 to 05/07/2025 showed the following amounts:</p> <p>05/01/2025 - Dietary 240 cc, nursing 240 cc, and total intake for the day 120 cc</p> <p>05/02/2025 - Dietary 360 cc, nursing 290 cc, and total intake for the day 2000 cc</p> <p>05/03/2025 - Dietary 480 cc, nursing 240 cc, and total intake for the day 2000 cc</p> <p>05/04/2025 - Dietary 1,250 cc, nursing 600 cc, and total intake for the day 2000 cc</p> <p>05/05/2025 - Dietary 400 cc, nursing 400 cc, and total intake for the day 2000 cc</p> <p>05/06/2025 - Dietary 400 cc, nursing 400 cc, and total intake for the day 2000 cc</p> <p>05/07/2025 - Dietary 680 cc, nursing 370 cc, and total intake for the day 1170 cc</p> <p>[Seven of seven days were not totaled accurately.]</p> <p>During an interview on 05/08/2025 at 12:42 PM, Staff V, Registered Dietician, stated they compiled tray cards on the computer through reviewing provider's orders and interviewing the residents regarding their allergies and preferences. Staff V stated fluid restrictions were put at the bottom on the menu card, so kitchen staff were aware of how much fluid to provide. Staff V stated both Resident 7 and Resident 381's meal tickets instructed staff to provide more than the fluid restriction allowed.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/08/2025 at 2:09 PM, Staff B, Director of Nursing Services, stated Residents 7 and 381 were not provided with fluid restrictions per provider's orders and this did not meet their expectations.</p> <p>Reference WAC 388-97-1060 (3)(i)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 oxygen tubing was dated and regularly changed for 3 of 3 sampled residents (Residents 7, 112 and 87) when reviewed for respiratory care. This failure placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of a facility's policy titled, Oxygen Therapy, dated 1/2020 showed oxygen tubing, cannula or mask, humidification was to be changed weekly by nursing staff. An additional policy titled, Small Volume Nebulizer (SVN, a device used to deliver medication in the form of a fine mist, or aerosol, to the lungs through inhalation) and a Metered-Dose Inhaler, (MDI, a device that delivers a specific amount of medication to the lungs in a form of a short burst of aerosol medication via inhalation), treatment, dated 11/2023 showed the facility's clinical team members were responsible in the delivery of the intermittent aerosol therapy by SVN. The equipment was to be changed weekly, the SVN reservoir was to be rinsed, and the excess fluid shaken from the reservoir and allowed to air dry.</p> <p>Resident 7</p> <p>Review of Resident 7's electronic health records (EHR) showed the resident admitted to the facility on [DATE] with multiple diagnoses to include congestive heart failure (CHF, a chronic condition that results from a weakened heart muscle making it unable to pump blood efficiently throughout the body), asthma (a chronic respiratory disease characterized by inflammation and narrowing of the airways in the lungs which may cause breathing difficulties, wheezing, coughing, and chest tightness), and pleural effusions (a condition that occurs when an abnormal buildup of fluid in the space between the lungs and the chest wall that may result in shortness of breath, coughing and chest pain).</p> <p>Observation on 05/06/2025 at 1:09 PM showed Resident 7's room had SVN equipment uncovered on top of their bedside table. The SVN tubing was undated, and the reservoir was observed to have approximately 2-3 milliliters (mls) of unknown clear liquid noted within the container.</p> <p>During an interview on 05/06/2025 at 1:10 PM, Resident 7 stated the nurses would administer the medication (SVN treatments) to them from time to time due to their shortness of breath.</p> <p>Review of the provider order, dated 05/02/2025, showed Resident 7 was prescribed Ipratropium-Albuterol solution to be inhaled orally via nebulizer (SVN) every 4 hours as needed for wheezing and shortness of breath.</p> <p>Review of Resident 7's medication administration record (MAR) for May 2025 showed the resident had been administered the Ipratropium-Albuterol inhaler on May 2, 2025, at 9:22 PM and May 4, 2025, at 5:01 AM and 9:23 PM.</p> <p>Resident 112</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 112's electronic health records (EHR) showed the resident admitted to the facility on [DATE] with multiple diagnoses to include heart failure (a chronic condition that results from a weakened heart muscle making it unable to pump blood efficiently throughout the body), dyspnea (shortness of breath or difficulty breathing), and pulmonary hypertension (a condition characterized by high blood pressure in the pulmonary arteries, which carry blood from the heart to the lungs. It can be caused by various factors, including heart and lung diseases, and can lead to shortness of breath and other symptoms).</p> <p>During an interview and observation on 05/06/2025 at 12:37 PM, Resident 112 sat up next to their bed eating lunch, an oxygen mask and tubing was observed on the resident bed. The mask was clear and had elastic white straps attached, the mask's tubing was undated and was attached to an oxygen concentrator (a machine that delivers a higher concentration of oxygen who requires supplemental oxygen therapy due to low oxygen levels in their blood) set at 2.5 liter/minute. When asked about the oxygen mask observed on the bed, Resident 112 stated they had just removed the mask to eat their lunch, and they had that oxygen mask at a hospital they were previously at prior to being admitted to the facility.</p> <p>Review of Resident 112's provider order dated 02/07/2025 showed licensed nurses were to administer O2 (Oxygen) at 2-4 liters per minute nasal cannula and to maintain resident oxygen saturations greater than 92 %, every day and night shift for shortness of breath. In addition, staff were to change and label the resident's oxygen tubing and rinse and replace filter once weekly on Wednesday by night shift.</p> <p>During an interview on 05/06/2025 at 12:42 PM, when asked about the undated oxygen tubing and mask, Staff Q, Licensed Practical Nurse (LPN), stated they were an agency nurse and did not know the facility's policy for dating the tubing but stated they believed they were supposed to clean the mask with water and let it air dry.</p> <p>During an interview on 05/06/2025 at 12:44 PM, Staff P, Unit Coordinator/LPN (UC/LPN), stated their expectation would be for the mask to be changed and oxygen tubing dated weekly.</p> <p>During an interview on 05/06/2025 at 12:48 PM, Staff C, Unit Manager/Registered Nurse (UM/RN), stated their expectation would be for staff to date the tubing and changed the mask weekly.</p> <p>Resident 87</p> <p>Review of Resident 87's EHR showed the resident admitted to the facility on [DATE] with multiple diagnoses to include heart failure and acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately transfer oxygen into the bloodstream or remove carbon dioxide from the blood and results in low blood oxygen levels).</p> <p>Observation and interview on 05/05/2025 at 2:28 PM showed Resident 87 in their room and had an oxygen condenser set at 2 liters/minute with a small clear plastic humidifier attached, no date was observed on the oxygen tubing. Resident 87 stated the plastic water bottle (humidifier) would get changed routinely but was not sure how often.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 87's EHR showed a provider's order for oxygen to be set at 2 liter/minute via nasal canula (plastic rubber tubing) and to keep the residents oxygen saturations greater than 92% or greater for comfort and shortness of breath; however, there was no order for the oxygen tubing or humidifier to be changed.</p> <p>During an interview on 05/06/2025 at 1:28 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation the tubing (oxygen) was changed by the staff weekly and there was an order in the resident's chart (EHR).</p> <p>Reference WAC 388-97-1060 (3)(j)(vi)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148</b></p> <p>Based on observation, interview, and record review the facility failed to accurately assess and monitor pain for 2 of 4 residents (Residents 20 and 89) when reviewed for pain management. This failure placed the residents at risk for unidentified and unmanaged pain and a decreased quality of life.</p> <p>Findings included .</p> <p>Resident 20</p> <p>Review of the electronic health record (EHR) showed Resident 20 was readmitted to the facility on [DATE] with a diagnosis of chronic kidney disease with heart failure and was admitted to hospice (end of life care) services 01/16/2025. The resident was able to make needs known.</p> <p>During an interview and observation on 05/07/2025 at 9:23 AM, Resident 20 stated My chest and my kidneys hurt every day. It's getting worse. My belly hurts and my legs hurt all the time. I don't request pain medication unless I can't bear the pain because they are too busy.</p> <p>Review of the monthly pain management review dated 4/30/2025 showed a total of six as-needed (PRN) narcotic pain medications administered in the month of April.</p> <p>Review of the administration record for April 2025 showed Resident 20 received as needed narcotic pain medications a total of ten administrations. The resident also received as needed non-narcotic pain medications seven times in the month of April.</p> <p>Review of Resident 20's plan of care showed an intervention dated 12/01/2024 for staff to monitor and record pain characteristics to include severity, location, onset, and duration.</p> <p>Review of the EHR showed no documentation that Resident 20's pain was monitored.</p> <p>During an interview on 05/07/2025 at 9:03 AM, Staff C, Unit Manager/Registered Nurse (UM/RN), stated the facility used a pain management assessment every four hours and if Resident 20 had pain and received pain medications, it should be in their provider orders. Resident 20's pain monitor was discontinued 01/27/2025 and should not have been.</p> <p>During an interview on 05/07/2025 at 10:50 AM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that staff assessed residents with pain at least daily and documented it in the EHR.</p> <p>51907</p> <p>Resident 89</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 89 admitted to the facility on [DATE] with diagnoses that included spinal stenosis (a condition that puts pressure on the spinal cord or nerves), degenerative disc (changes in the bones of the back) with back pain and lower extremity pain, spondylosis (changes in the bones of the back), carpal tunnel syndrome (pressure in the nerves of the wrist), osteoarthritis (a form of arthritis) of the right knee, sciatica (pain in the nerve of the back and legs), and fibromyalgia (a chronic disorder characterized by pain, stiffness, and tenderness in the body). The minimum data set (MDS), an assessment tool, dated 05/01/2025, showed Resident 89 was able to make needs known.</p> <p>During an interview on 05/06/2025 at 10:20 AM, Resident 89 stated they had chronic pain and were waiting to talk to a doctor about it. Resident 89 stated they were on pain medications that were not effective enough overnight and had not been able to sleep the previous night.</p> <p>Review of the provider's orders, for May 2025, showed no order to monitor Resident 89's pain level.</p> <p>Review of the progress notes, dated May 2025, showed no documentation of Resident 89's pain level.</p> <p>During an interview on 05/08/2025 at 7:55 AM, Staff N, Unit Manager/Licensed Practical Nurse, stated a pain monitor was in place upon admission for seven days and a pain assessment was completed. Staff N stated Resident 89 was no longer on a pain monitor.</p> <p>During an interview on 05/07/2025 at 10:50 AM, Staff B, DNS, stated it was their expectation that staff assessed residents with pain at least daily and document it in the EHR.</p> <p>Reference WAC 388-97-1060 (1)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>38344</p> <p>Based on observation, interview, and record review, the facility failed to post the scheduled and actual hours worked for the nursing staffing hours daily for 4 of 4 observed days during the survey period (05/05/2025-05/08/2025) when reviewed for nurse staff posting. This failure prevented the residents, family members, and visitors from exercising their rights to know the scheduled and actual numbers of available nursing staff in the facility.</p> <p>Findings included .</p> <p>Observations of the daily posted nurse staffing information on 05/05/2025, 05/06/2025, 05/07/2025, and 05/08/2025 showed no scheduled or actual hours worked documented for each discipline on each shift.</p> <p>During an interview on 05/08/2025 at 12:45 PM, Staff T, Staffing Coordinator, stated they kept track of schedule and actual hours worked; however, they did not post them. Staff T stated once the nursing staffing hours were posted daily, they rarely got updated once posted for the day.</p> <p>During an interview on 05/08/2025 at 1:11 PM, Staff A, Administrator, stated the Staffing Coordinator was responsible for the daily nursing staffing postings. Staff A stated they were not aware that the daily postings did not include the scheduled and actual nursing hours worked and were not updated each shift. Staff A stated this did not meet expectations.</p> <p>No Associated WAC</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51907</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who experienced dementia-related behaviors received care and services to attain the highest practicable physical, mental, and psychosocial well-being when it did not identify and implement person-centered, individualized interventions for 1 of 3 sampled residents (Resident 83) when reviewed for dementia care. This failure placed residents at risk of unmet care needs, unnecessary medications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 83 admitted to the facility on [DATE] with diagnoses that included vascular dementia (a condition resulting in symptoms such as memory loss, confusion, and difficulty with reasoning and planning) and depression. The quarterly minimum data set (MDS), an assessment tool, dated 03/07/2025, showed Resident 83 was confused and dependent on staff for care.</p> <p>Review of the EHR showed Resident 83 was taking Seroquel (an antipsychotic medication) for a diagnosis of dementia with behaviors. Review showed Resident 83 was taking Depakote (a seizure medication used for mood stabilization) for vascular dementia and Namenda (a medication used to treat dementia) for dementia with behavioral disturbance.</p> <p>Review of the care plan, dated 03/18/2025, showed Resident 83 had a care plan for impaired cognitive function related to dementia. Review of the care plan showed the following interventions for dementia: administer medications as ordered, communicate with the resident/family/caregivers regarding residents capability and needs, engage the resident in simple, structured activities that avoid overly demanding tasks, the resident prefers (specify activities) [no activities where specified], keep the resident's routine consistent, provide the resident with a homelike environment, the resident requires approaches that maximize involvement in daily decision making and activity, and use task segmentation to support short term memory deficit. Review showed there were no resident specific interventions for dementia care and preferences were not documented.</p> <p>Review of a document titled Behavior Note dated 11/21/2024 at 11:47 AM showed Resident 83 became combative during care. Resident 83 agreed to care then punched at the staff caring for them. Review showed the staff tried to get Resident 83 into a safe position then stepped back to allow Resident 83 to calm down.</p> <p>During an interview on 05/08/2025 at 10:41 AM, Staff F, Certified Nursing Assistant (CNA), stated when Resident 83 had behaviors, staff would leave and reapproach Resident 83 at a different time.</p> <p>During an interview on 05/08/2025 at 1:04 PM, Staff C, Unit Manager, stated Resident 83 would become resistive to care and curse at staff. Staff C stated Resident 83 had behaviors almost continuously. Staff C stated Resident 83's behaviors would be triggered when care was being done by staff.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/08/2025 at 2:13 PM, Staff B, Director of Nursing Services (DNS), stated Resident 83 continued to have behaviors with aggression and agitation with multiple incidents. Staff B stated interventions such as distraction, offering fluids, and redirection had been attempted. Staff B stated their expectation was preferences and personalized needed be considered when care planning and treating dementia residents.</p> <p>Reference WAC 388-97-1040 (1)(a-c)</p>		