STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaska Gardens Health and Rehabilitation	6220 South Alaska Street Tacoma, WA 98408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39501 Based on interview and record review, the facility failed to notify the resident's representative of a change in medication orders for two of four residents (Residents 1 and 2) reviewed for notification of changes. This failure prevented the residents' representatives from being included in the plan of care and having the ability to provide input and make decisions on the resident's behalf. Findings included . Resident 1 Resident 1 admitted to the facility on [DATE]. Review of the Significant Change Minimum Data Set (MDS, an assessment tool), dated 07/29/2024, showed Resident 1 began receiving hospice (end-of-life) support and services on 07/24/2024. The MDS showed Resident 1 had a diagnosis of Alzheimer's dementia (a progressive disease that destroys memory and other important mental functions) and was severely cognitively impaired. Review of the medical record showed that Resident 1 had a Durable Power of Attorney (DPOA, a legal document that allows someone to make decisions for another person), dated 12/14/2023, which designated someone to make healthcare decisions for them. Review of the physician orders showed that a new medication: morphine (an opioid pain medication) was ordered for Resident 1, on 07/27/2024, to be administered as needed. Review of the July, 2024 and August, 2024 medication administration records (MAR) showed that morphine was administered to Resident 1 on 07/28/2024 at 3:05 PM, 07/30/2024 at 2:30 PM, 08/02/2024 at 12:31 PM and 4:31 PM, and 08/03/2024 at 11:06 AM. Review of the medical record showed no documentation that Resident 1's DPOA was notified of the new order for morphine. Resident 2 Resident 2 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 2 had a diagnosis of dementia, and was severely cognitively impaired. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed that Resident 2 had a DPOA, dated 02/11/2016, which designated someone to make healthcare decisions for them. Review of the physician orders showed an order, dated 07/18/2024, to increase Resident 2's Depakote (a medication for seizures) from 250 milligrams (mg) twice a day to 500 mg twice a day. Review of the July 2024 MAR showed that Resident 2 received the increased dose of Depakote beginning the evening of 07/18/2024. Review of the medical record did not show Resident 2's DPOA was notified of the change in Depakote dose. In interview on 08/12/24 at 3:25 PM, Staff B, Licensed Practical Nurse (LPN), stated that when there were order changes for a resident, staff would let the resident know, and let the family know, and document the communication in a progress note. In interview on 08/12/24 at 3:28 PM, Staff C, LPN, stated that when there were order changes for a resident, staff were supposed to notify the resident and the resident's responsible party/representative, and were supposed to document it in a progress note. In interview on 08/12/2024 at 3:37 PM, Staff A, Director of Nursing Services (DNS), stated that when there was an order for a new medication or medication changes, the expectation was that the resident would be informed of the change and, if applicable, their responsible party would be notified as well. The DNS stated that these notifications should have been documented in the medical record for Resident 1's morphine and Resident 2's Depakote, however no documentation was provided to show that Resident 1 or Resident 2's responsible parties were notified of these medication changes. Reference WAC 388-97-0320 (1)(c)