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	07/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide ensure care and services were provided in a manner that maintained and promoted dignity and respect for 8 of 9 current residents (Residents 3, 4, 5, 6, 7, 10, 12 and 13) interviewed. Failure of the facility to respond to resident's requests in a timely, respectful and professional manner, placed residents at risk for diminished self-worth, frustration, and a decreased quality of life. Findings included . <Resident 3>During an interview on 07/16/2025 at 10:98 AM, Resident 3 shared an interaction with Staff D, Nursing Assistant Certified (NAC) that occurred during care. Resident 3 stated that Staff D was incredibly negative, talking under their breath the entire time and when the resident said sorry to inconvenience you, Staff D said, would you like another aide? , Resident 3 said that would be lovely, and right in the place Staff D stood and screamed down the hall for another aide and left Resident 3 entirely exposed and stomped out of the room.On 07/16/2025 at 11:33 AM, Staff D was observed in the doorway of a resident's room, to yell down the hall to another staff that they needed to change a resident by name, and that they would be there in a minute, before they turned and closed the resident's room door. <Resident 4>During an interview on 07/16/2025 at 11:08 AM, Resident 4 stated that Staff D was always disrespectful. Resident 4 shared a photo of Staff D dated 06/27/2025 at 1:23 PM, with Staff D wearing a T-Shirt with an image of the Rugrat [NAME], who according to Resident 4 was the Mean and bossy one. The caption on the shift was You Stupid Babies. Resident 4 stated, I found it offensive, like she considered us babies. Resident 4 stated it was demeaning to be in a nursing home anyways with a loss of freedom, but to have someone come into your room like that is a nail in the [NAME]. Resident 4 felt Staff D was belittling and came across like they were more important that the residents.During an interview on 07/16/2025 at 11:08 AM, Resident 4 said when they asked the nurses what pills they were giving them, the nurses respond that they don't know and say just take them. <Resident 6>Similar findings were noted with Resident 6 who during an interview on 07/16/2025 at 11:35 AM, stated when they nurses bring their medication, They don't tell you what you're taking. <Resident 5>During an interview on 07/16/2025 at 10:30 AM, Resident 5 stated that the call light response time had been up to two hours, it frequently took a while to get someone to their room in the back of the hall, It's frustrating.<Resident 7>During an interview on 07/16/2025 at 11:42 AM, Resident 7 stated their wait time was 30 minutes to an hour.During an interview on 07/16/2025 at 11:42 AM, Resident 7 stated they had orders for as needed pain medications, but when they asked for them, the nurses just shrug their shoulders and go on, They don't want to be bothered. <Resident 10>During an interview on 07/18/2025 at 9:01 AM, Resident 10 stated that when staff answer the call light some say, You'll have to wait. sometimes they had to wait 45 minutes, Like I'm another nobody in this place. <Resident 12>During an interview on 07/18/2025 at 12:41 PM, Resident 12 stated it sometimes took a half hour or longer for staff to respond to their call light and then they don't give you what you asked for. When asked how that made them feel, Resident 12 said, I don't know. if I can get my own stuff I will. <Resident 13>During an interview on 07/18/2025 at 1:02 PM, Resident 13 stated the staff don't respond to the call lights half the time so they must use the phone and call the front desk. Resident 13 stated when the staff did not answer the call light they felt disappointed and sad. On 07/24/2025 at 2:46 PM, the above was discussed and acknowledged by Staff A, Administrator and Staff B, Director of Nursing Services. REFERENCE: WAC 388-97-0180(1-4).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to convey the refunds of 2 of 3 residents (Resident 8 & 14) to the resident or to the individual or jurisdiction administering the resident's estate, or the Office of Financial Recovery within thirty days of the discharge, transfer or death. This failure placed resident family and/or representatives at risk for financial hardship.Findings included . Review of the facility admission Agreement last updated [DATE], showed the center would issue any refunds to the Resident Group or, in the even of the Resident's death, to the Resident's estate, or applicable state agency within the time required by law. <Resident 8>Resident 8 discharged from the facility on [DATE]. On [DATE] at 8:40 AM Collateral Contact 1 stated the facility overbilled Resident 8 and were withholding payment, stating the funds were already spent, but were unable to articulate if the funds were spent on the resident while they were a resident in the facility. During an interview on [DATE] at 12:26 PM, Staff C, Business Office Manager, stated Resident 8 had a refund due of $489.72. Staff C stated they sent the refund to the Office of Financial Recovery (OFR) on [DATE] (four months after discharge). OFR sent it back [DATE] as they only accept funds for deceased residents. Staff C stated they then resubmitted the check payable to Resident 8 on [DATE]. The facility changed billing accounting services in the end of January, beginning of February 2025. In February, Resident 8's representative stated they had not yet received the check, so it was reissued [DATE] and sent to a different address. Staff C stated on [DATE] they were notified of concerns that the resident did not receive the refund. Staff C stated they contacted the billing office that day, and found out on [DATE] that the check was not cashed. Staff C stated they needed to resubmit a request to have the check reissued. Staff C planned to have it sent to the facility and have Resident 8's representative pick it up there. During an interview on [DATE] at 4:02 PM, Resident 8's representative stated the facility fist told them the funds had been dispersed. Then they had been told the check was mailed, sent to the wrong addressed, cancelled and resent. Resident 8's representative stated they finally got the check as Staff C left it at the facility front desk and they picked it up Thursday ([DATE]). <Resident 14>Resident 14 was a long term care resident who passed away in the facility on [DATE]. During an interview on [DATE] at 10:55 AM, Staff C stated Resident 14 had a trust fund balance of $530.58. Staff C stated they were waiting to hear from the resident representative if they wanted the funds for funeral services and they said no. During an interview on [DATE] at 3:20 PM, Staff C stated Resident 14's account was closed, the refund check printed and they would send the check to OFR. On [DATE] at 2:46 PM, the above was discussed and acknowledged by Staff A, Administrator.REFERENCE: WAC 388-97-0340(5).