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	05/15/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from abuse for 3 of 5 residents (Resident 1, 2 & 3) reviewed for abuse/neglect. Resident 1 experienced sexual abuse when Resident 2 touched their breast without consent. Resident 2 experienced physical abuse when they were hit by Resident 1. Resident 3 experienced mental/verbal and physical abuse when Resident 4 yelled at them and kicked their bed while they were sleeping. This failure placed the residents at risk of experiencing fear, intimidation, mental anguish, and emotional distress.Findings included.Review of the facility Freedom from Abuse Policy, dated March 2025, showed that each resident had the right to be free from abuse. Abuse is the willful inflection of intimidation, with resulting mental anguish, willful means the individual acted deliberately, Mental/Verbal abuse includes verbal assaults including yelling, and/or threatening and sexual abuse is non-consensual sexual contact of any type with a resident, including unwanted intimate touching of any kind, especially of breasts or perineal area.<RESIDENT 1>Review of the 03/11/2026 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 1 had diagnoses including dementia, was sometimes understood, able to communicate concrete requests and was independent in wheelchair mobility.Review of Resident 1's Care Plan (CP), dated 04/14/2026, showed Resident 1 experienced impaired psychosocial well-being, including but not limited to a Resident-to-Resident altercation of inappropriate touching/physical altercation on 04/30/2026.Review of the facility investigation, dated 04/30/2026, showed Resident 1 stated Resident 2 grabbed their breasts unprovoked. Resident 1 stated they screamed and pushed Resident 2 away. Resident 1 denied hitting Resident 2.During an interview on 05/14/2026 at 10:47 AM, Resident 1 stated, He touched my breast. When asked how that made them feel, Resident 1 stated, I didn't like it. When asked what they did in response, Resident 1 stated, hit him.<RESIDENT 2>Review of the 04/09/2026 Annual MDS showed Resident 2 had diagnoses including dementia, had clear speech, was able to understand and be understood, and was independent in wheelchair mobility.Review of Resident 2's CP, dated 04/10/2025, showed Resident 2 experienced impaired psychosocial well-being as evidenced by behaviors requiring intervention, including but not limited to inappropriate touching of another resident on 04/30/2026.During an interview on 05/14/2026 at 10:53 AM, Resident 2 stated, I grabbed one of her ti**ies and she didn't like it. When asked what happened next, Resident 2 stated that Resident 1 slapped them. Resident 2 stated they had been instructed to avoid Resident 1.During an interview on 05/14/2026 at 10:58 AM, Staff C, Licensed Practical Nurse (LPN), stated Resident 2 told them about grabbing Resident 1's breast. Staff C stated neither Resident 1 nor Resident 2 had any memory of when it happened, and both stated they did not report the incident at the time it happened.During an interview on 05/15/2026 at 12:20 PM, Staff A, Administrator, stated neither Resident 1 or Resident 2 remembered when or where the incident allegedly occurred. <RESIDENT 3>Review of the 05/06/2026 admission MDS, showed Resident 3 was assessed as alert and oriented and dependent on staff for bed mobility and transfers.Review of Resident 3's CP, revised 05/12/2026, showed Resident 3 had impaired psychosocial well-being as evidenced by behaviors requiring intervention, including but not limited to a 05/08/2026 resident to resident potential altercation.Review of the facility investigation, dated (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/08/2026, showed Resident 3 was sleeping in their bed when their roommate (Resident 4) started kicking Resident 3's bed. Further review showed the facility concluded that there was no physical contact, injury or psychosocial harm identified, the allegation of abuse and neglect were unsubstantiated.During an interview on 05/14/2026 at 11:34 AM, Staff D, Registered Nurse (RN), stated they entered the room and saw Resident 4 kicking Resident 3's bed. Staff D noted that Resident 4's legs weren't long enough to kick Resident 3. Staff D secured the resident, called for help, and Resident 4 was transferred into a wheelchair and removed from the room.During an interview on 05/14/2026 at 10:06 AM, Resident 3 stated that Resident 4 wouldn't quit yelling, I woke up to her kicking my bed, not too far from my body. Resident 3 stated Resident 4 was almost completely on the edge of their bed, kicking Resident 3's bed. Resident 3 stated it made them feel unsafe and commented if Resident 4 had gotten much closer, I would have had to fight her off! Resident 3 stated they felt very unsafe with Resident 4 in their room. When asked if they felt Resident 4's behavior constituted abuse,Resident 3 stated, Yes, I was waiting for the next episode where (Resident 4) would get angry with me and take a swing at me.<RESIDENT 4>Review of Resident 4's CP, dated 05/07/2026, showed Resident 4 had a diagnosis of Alzheimer's Dementia, with behaviors of agitation, calling out despite needs being met and yelling.On 05/14/2026 at 10:03 AM, Resident 4 was observed in a private room. In an interview at that time, Resident 4 did not recall the incident, and did not recall having previously had a roommate. Resident 4 denied having problems with any other residents and stated they felt safe in the facility.During an interview on 05/14/2026 at 11:46 AM, Staff E, RN, stated Resident 4 exhibited behaviors of yelling out and cussing at staff.During an interview on 05/14/2026 at 12:16 PM, Resident 4's Power of Attorney (POA) stated Resident 4 didn't last a couple of hours in the first room before they were moved to another room. Resident 4's POA stated that Resident 4 yells and swears a lot, but they were not aware of them being violent towards others.During an interview on 05/15/2026 at 12:20 PM, Staff A stated Resident 4 did not make physical contact with Resident 3. REFER TO WAC: 388-97-0640(1)