| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505529 | A. Building<br>B. Wing | 09/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avamere Transitional Care of Puget Sound | 630 South Pearl Street<br>Tacoma, WA 98465 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and report an allegation of abuse for 1 of 3 sampled residents (Resident 1) reviewed for abuse. This failure placed all residents at risk for unidentified and ongoing abuse/neglect and lack of protection from abuse.Findings included .Review of the Nursing Home Guidelines, The Purple Book, revised in 2015, showed that facilities are to report all staff-to-resident allegations of abuse, neglect, mistreatment, sexual and/or physical abuse/assault to the State hotline, report to law enforcement and to document on the State incident reporting log within five days. Review of the facility's policy titled, Abuse and Neglect - Clinical Protocol, undated and provided to surveyor on 09/15/2025, under Assessment and Recognition, documented, The nurse will assess the individual and document related findings. Assessment data will include injury assessment (bleeding, bruising, deformity, swelling, etc.), pain assessment, current behavior, . vital signs . Under Cause Identification, the policy also showed that staff would investigate alleged abuse and neglect to clarify what happened and identify possible causes. The policy further showed that management and staff would address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. The protocol also showed that staff would monitor individuals to address any issues regarding their medical condition, mood, and function. Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] for skilled nursing and rehabilitation after a recent hospitalization with multiple diagnoses that included a stroke, a history of back surgery and an implanted nerve stimulator (a medical device that blocked pain signals for management of pain), generalized weakness, and was able to make their needs known. On 09/10/2025 at 10:04 AM, Resident 1 said during the night shift on 08/12/2025 a facility Certified Nurse Assistant (CNA) was rough when they provided personal care and said the CNA had a hard time trying to get the resident's brief off and tried to yank the brief off. Resident 1 said the CNA tugged on the resident's brief, and yanked the resident up and down, and would not listen to the resident when they asked them to stop. Resident 1 said their whole bed was soaked and the CNA should have just gotten them up to the wheelchair to have easily changed the sheets instead of having Resident 1 roll all over the place. Resident 1 said they felt like a rag doll being tossed all over the place like that. Resident 1 said they had bruising due to the rough care. Resident 1 said they reported the incident to a provider the next morning. Resident 1 said after that, Staff B, a Registered Nurse (RN) and the Director of Nursing Services, came in and spoke to them about the incident. Resident 1 said Staff B asked them what the resident thought should be done about the staff member. Review of the facility's incident logs for August 2025 showed no allegation of abuse logged related to Resident 1. Review of a grievance form, dated 08/13/2025, signed by Staff C, a Social Services Assistant no longer at the facility, showed Resident 1 had reported that during the night shift, around 2:00 AM, they had wet themself and soiled the bed. Resident 1 said the CNA who came to assist them did so in a rough way and described them tugging on and tossing them around. Resident 1 said they tried to tell the CNA that they could help to hold themselves up and move around, the CNA disregarded the resident's words and continued to handle the brief change roughly. On 08/14/2025, Staff B documented, as resolution of the grievance, that the facility would provide education with the CNA, to pay attention to what the residents say and move slower, and take a break if needed. Staff B documented that Resident 1's care plan was updated and the resident was to be independent with bed mobility transfers and ambulation. Review of Resident 1's EHR did not show a progress note or other documentation by a provider, Staff B, or Staff C about the resident's report of rough care or documentation of any interviews with the resident. No skin assessment or evaluation was located after the allegation referenced in the grievance. On 09/11/2025 at 2:09 PM, Staff D, an RN, when asked their response to a resident report that someone had been rough with them or yelled at them, said they would get a statement, let the Resident Care Manager (RCM) know and, if it was a CNA, switch the CNA's assignment so they were not working with the resident anymore, and do a note in the resident's chart. On 09/11/2025 at 2:49 PM, Staff E, an RN, said if a resident made an allegation of rough care, they would grab a grievance form and have the resident fill it out and would let Staff B, the DNS, know. When asked whether the staff member would continue to work with the resident, Staff E said they did not think it was within their scope of practice to suspend or reassign a CNA. When asked, Staff E was unclear about notifications, reporting, and documentation of allegations in the resident's record. On 09/15/2025 at 1:38 PM, Staff F, a Licensed Practical Nurse (LPN), said if a resident told them that someone |