STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505529	A. Building B. Wing	03/19/2026

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 1 of 3 residents (Resident 1) reviewed for assessments. The failure to ensure accurate assessments placed residents at risk for unidentified and/or unmet care needs and diminished quality of care/quality of life. Findings included . <Resident 1>Review of Resident 1's admission Nursing Database-Skin Integrity, dated 12/04/2025, showed they admitted with two wounds on the coccyx, identified as skin tears. Review of a daily skilled progress note, dated 12/08/2025 at 4:14 PM, showed Resident 1 had a PU/PI with a small amount of drainage and dead tissue on the wound bed. The documentation did not indicate the anatomical location, stage, or measurements of the PU/PI. Review of Resident 1's 12/10/2025 admission Minimum Data Set (MDS-assessment tool) showed Resident 1 was at risk of developing PU/PIs and had no unhealed PU/PIs. Review of the 12/15/2025 PU/PI Care Area Assessment (CAA-a standardized process for evaluation of each resident's functional capacity and care needs to help develop a resident-centered care plan) did not provide documentation to show the facility's rationale for care plan decisions (that included complications, risk factors, or resident centered care needs). Review of Resident 1's Significant Change MDS, dated [DATE], showed Resident 1 had one Stage IV PU/PI that was present on admission. Review of Resident 1's 12/10/2025 admission MDS modification #1, dated 01/27/2026, showed Resident 1 had one unstageable PU/PI on admission. In an interview on 03/06/2026 at 2:00 PM, Staff B, Director of Nursing, stated the admission Nursing Database-Skin Integrity was inaccurately documented, showing Resident 1 had two skin tears on the coccyx. Staff B stated Resident 1 admitted with two Stage II PU/PIs on the coccyx, and the admission MDS was incorrect. < MDS Modifications>Review of the 12/20/2025 admission MDS modification #2, dated 02/11/2026 (one day after Resident 1 discharged), showed Resident 1 had one unhealed PU/PI but no coded number or stage of wound(s). In an interview on 03/19/2026 at 12:41 PM, Staff E, Registered Nurse-MDS Coordinator, stated they reviewed the clinical record and found no documentation to show Resident 1 had a PU/PI on admission. Staff E stated the 12/10/2025 admission MDS modification #1, dated 01/22/2026, was incorrectly coded as an unstageable PU/PI present on admit with no supporting documentation. Staff E submitted the 12/10/2025 admission MDS modification #2 on 02/11/2026 to correctly reflect Resident 1 had a PU/PI that was not present on admission. Staff E stated they could not code a stage for the wound due to insufficient wound documentation. Review of the 01/22/2026 Significant Change MDS Modification, dated 02/11/2026, showed Resident ?s Stage IV PU/PI was not present on admission. In an interview on 03/19/2026 at 12:45 PM, Staff E stated the 01/22/2026 Significant Change MDS was modified on 02/11/2026, to correctly reflect Resident 1 had one Stage IV PU/PI that was not present on admission. Staff E stated the coccyx Stage IV PU/PI developed at the facility. <New PU/PI>Review of the Wound Care Consultant's (WCC) Wound Tracker Form, dated 02/05/2026, showed Resident 1 had a new DTI (deep tissue injury) PU/PI on their right heel. Review of the 02/10/2026 Discharge Return Not Anticipated MDS showed Resident 1 had one Stage IV PU/PI that was not present at admission but did not show Resident 1 had one DTI, also not present on admission. In an interview on 03/19/2026 at 12:50, Staff E stated the WCC Wound Tracker Form, dated 02/05/2026, was not in the clinical record at the time (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they completed the Discharge MDS. Staff E stated the MDS should accurately show coding for the new DTI PU/PI but did not. REFER TO F686 REFERENCE: WAC 388-97-1000-(1)(a)(b)(c), (2)(l).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment and services consistent with professional standards of practice to prevent the development and/or promote healing of PU/PI (Pressure Ulcers/Pressure Injuries) for 1 of 3 Residents (Resident 1) reviewed for PU/PIs. Resident 1 experienced harm when the facility failed to accurately assess, develop/implement/update a resident-centered care plan (CP) for PU/PIs (that included timely interventions consistent with professional standards of care for PU/PI prevention and care), consistently monitor, and accurately follow physician orders (PO) for wound care and prevention and experienced an avoidable worsening of their two coccyx (tailbone) Stage II PU/PIs (partial-thickness skin loss) to a Stage IV PU/PI (full thickness loss of skin with exposed muscle/tendon/bone in the wound bed) and developed an avoidable Deep Tissue Injury (DTI-persistent non-blanchable deep red, maroon, or purple discoloration where the extent of tissue damage is unknown) on their right heel after admission to the facility. These failures placed residents at risk for new PU/PI development, delayed healing, unnecessary discomfort, infection, and diminished quality of life/quality of care.Findings included.<POLICY>Review of the facility's undated Skin and Wound Management policy showed the facility would provide necessary treatment and care according to professional standards of practice (cited reference: the National Pressure Injury Advisory Panel [NPIAP]) to promote healing, prevent infection, and prevent development of new ulcers. The nurse manager/designee would evaluate any new skin integrity problems and document their findings in the clinical record. To determine the risk of developing (or determine risk of worsening) PU/PIs, the facility would routinely complete a Braden Risk Assessment (a standardized assessment tool used to estimate risk of developing PU/PIs by evaluating six key criteria: sensory perception, moisture, mobility, nutrition, and friction/shear to help prioritize preventative measures for CP development). After comprehensive assessment, a resident-centered care plan would be developed. PU/PI wounds were evaluated weekly with documentation that would include measurements, wound characteristics, progress, treatments, and CP interventions/revisions. The Interdisciplinary Team (IDT) would review wounds weekly which included discussion of residents' needs and revise the CP as appropriate. According to the NPIAP Pressure Injury Prevention Points: Risk Assessment, updated 2016, use of a structured risk assessment at routine intervals (such as the Braden Risk Assessment) to identify individuals at risk for PU/PIs should be used to develop a CP based on the areas of risk, rather than on the total risk assessment score and provided potential interventions to consider based on each risk category.Review of the facility's Pressure Injuries Overview and Wound Staging policy, revised March 2020, showed PU/PIs occurred because of intense and/or prolonged pressure or pressure in combination with shearing of the skin. These could also be affected by skin temperature, moisture, nutrition, perfusion, other health problems, and other skin conditions. An avoidable PU/PI occurred when the resident developed a new or worsening PU/PI and the facility failed to perform one or more of the following: evaluate the resident's clinical condition and risk factors;, define or implement CP interventions consistent with residents needs/goals, and professional standards of practice;, monitor or evaluate of the impact of the interventions;, or revise CP interventions as appropriate. <RESIDENT 1>Review of the 12/10/2025 admission Minimum Data Set (MDS-assessment tool) showed Resident 1 admitted to the facility on [DATE], had problems with cognition, had no behaviors or rejection of care, required substantial assistance for activities of daily living (bed mobility, transfers, repositioning, and toileting), and was frequently incontinent of bowel. Resident 1's diagnoses included urinary tract infection with sepsis (systemic blood infection), anemia, malnutrition, diabetes, and dementia. Resident 1 was assessed to have no unhealed PU/PIs and was at risk of developing PU/PIs.Review of the admission Nursing Database, dated 12/04/2025, showed Resident 1 admitted with two skin tears on the coccyx. One skin tear measured 0.5 cm x 0.5 cm x no depth measured and the other skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	tear measured 2 cm x 0.5 cm x no depth measured. The documentation did not provide evaluation of the wound's characteristics. Review of the 12/04/2025 Braden Scale showed Resident 1's risk score was 14 (moderate risk) due to problems with moisture, activity, mobility, and friction/shear. Review of the 12/04/2025 Skin Integrity CP showed Resident 1 had actual skin impairment due to skin tears on their coccyx. Interventions included: keeping skin clean and dry, use of lotion, encouraging good nutrition, complete weekly skin assessments, monitor/document the wound location, size, and treatment of skin injury and report abnormalities, report any new skin impairments, and complete treatments as ordered by the physician. The CP did not show resident-centered interventions to address their risk for development of PU/PIs (including problem areas identified on their Braden assessment). Review of the December 2025 Treatment Administration Record (TAR) showed a PO dated 12/04/2025, for Wound #2-coccyx skin tears, to cleanse with normal saline, pat dry, and apply foam dressing every day and as needed. The TAR showed the dressing was changed daily from 12/05/2025 to 12/17/2025, with one omission on 12/09/2025. Review of Resident 1's Progress Notes and Wound Care Evaluations between 12/04/2025 and 12/18/2025 did provide documentation to show wound monitoring was conducted weekly or that the physician evaluated the wounds on the coccyx. The progress notes showed inconsistency in documentation of skin conditions as follows: A daily skilled nursing progress note dated 12/07/2025 at 3:54 PM, showed Resident 1's skin was intact and there were no wounds present.A daily skilled nursing progress note dated 12/08/2025 at 4:14 PM, showed Resident 1 had a PU/PI with a small amount of drainage and slough on the wound bed. The documentation did not show wound measurements. A weekly skin audit note dated 12/10/2025 at 8:24 PM, showed Resident 1 had no irregularities. An SBAR (alert note to the provider) progress note dated 12/11/2025 at 5:19 AM, showed Resident 1's buttocks had excoriation that spread out on both buttocks, and they needed more aggressive treatment. A History and Physical physician note dated 12/11/2025 at 11:42 AM that showed Resident 1's skin was warm, dry, with age related changes but did not show an evaluation of the coccyx wounds or plan for treatment. A daily skilled nursing progress note dated 12/12/2025 at 9:26 PM, showed Resident 1 had no wounds present.A daily skilled nursing progress note dated 12/14/2025 at 9:11 PM, showed Resident 1 had no wound(s) present.An SBAR progress note dated 12/16/2025 at 6:04 AM, showed staff requested the provider to evaluate Resident 1's coccyx; it had worsened and needed wound team attention.A Nurse Practitioner progress note dated 12/17/2025 at 8:01 PM that showed Resident 1's skin was warm and dry but did not show an evaluation of the coccyx wounds or treatment plan. A weekly skin audit note dated 12/17/2025 at 9:50 PM that showed Resident 1 had a previously identified skin irregularity with extensive excoriation of the buttocks and open areas to the coccyx that required daily dressing changes. There were no wound measurements or characteristics documented. Review of the WCC wound evaluation, dated 12/18/2025 (14 days after admission) showed Resident 1 had one unstageable (a PU/PI that is covered with dead fat/tissue to the extent that the amount of tissue damage cannot be confirmed until removal of the dead tissue, revealing either a Stage III [full-thickness skin loss without extending to the bone/muscle/tendon/ligaments] or Stage IV PU/PI) PU/PI on the coccyx that measured 10.0 cm x 9.0 cm x no depth recorded. The wound bed contained 70 percent black eschar (dead tissue/fat). The WCC's treatment plan included: wound care orders for dressing changes twice daily, an air mattress, and to turn/reposition Resident 1 every two hours. Review of a nursing CP progress note, dated 12/18/2025, showed Resident 1 had an unstageable coccyx PU/PI that required daily skilled nursing services for ongoing assessments and monitoring of the wound, complex wound care management, and extensive staff assistance with positioning, bed mobility, and pressure offloading of the coccyx area. Review of the Skin Integrity CP, dated 12/18/2025, showed an updated intervention for an air mattress. The CP did not show documentation of Resident 1's unstageable PU/PI on the coccyx, pressure offloading interventions, repositioning every two hours, or other person-centered interventions based on the risk areas identified on Braden assessment. Review of the WCC wound evaluation, dated 12/22/2025, showed Resident 1's coccyx PU/PI remained (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	unstageable and measured 7.5 cm x 7.0 cm. The wound bed was covered with 80 percent black eschar that required surgical removal. The WCC's treatment plan included: daily wound care with medical honey, foam dressing, and frequent turning/repositioning.Review of the Skin Integrity CP, dated 12/22/2025, showed no new revisions/updates to promote healing of the PU/PI or prevent new PU/PIs.Review of the December 2025 TAR showed a PO, dated 12/23/2025, for coccyx PU/PI wound care: cleanse with normal saline, pat dry, apply Medical Honey with foam dressing twice daily. The TAR documentation showed the PO was only scheduled for once a day at 8:00 AM and not twice a day as directed in the PO. Review of Resident 1's clinical record did not show weekly facility and/or WCC evaluations of the coccyx PU/PI for the weeks of: 12/29/2025 or 01/05/2026.Review of Resident 1's facility Wound Evaluation #1, dated 01/08/2026 at 12:51 PM (17 days after the last wound evaluation), showed Resident 1's unstageable coccyx PU/PI measured 6.5 cm x 5.2 cm, with additional recommendations for pressure relieving device for the chair, and the CP was reviewed/updated.Review of Resident 1's Skin Integrity CP, dated 01/08/2026, did not show any revisions or updates, including an intervention for pressure reduction cushion for their chair, as documented in the facility Wound Evaluation that same day. Review of the WCC wound evaluation, dated 01/15/2026, showed Resident 1's unstageable coccyx PU/PI was now a Stage IV PU/PI that measured 6.0 cm x 4.5 cm x 0.5 cm, and the wound bed contained 60% dead tissue/fat that required surgical removal at the bedside. The WCC's treatment plan showed to perform wound daily: cleanse with an acidic wound cleanser and leave on the wound for 10 minutes prior to applying a clean dressing of medical honey covered with foam dressing and turn/reposition every two hours. Review of the January 2026 TAR showed a PO dated 01/16/2026, for coccyx PU/PI wound care: cleanse with the acidic wound cleanser, pat dry, apply medical honey and foam dressing twice daily. The TAR transcription of the PO showed the wound care schedule duplicated for 8:00 AM daily. Additionally, the PO was not transcribed as recommended by the WCC to leave the acidic solution on the wound bed for 10 minutes prior to application of the clean dressing daily. Review of Resident 1's Skin Integrity CP, dated 01/15/2026, showed no new CP updates/revisions. <WORSENED COCCYX PU/PI >Review of the clinical record did not provide documentation to show a weekly wound evaluation by either the facility or the WCC for the week of 01/22/2026.Review of the WCC wound evaluation, dated 01/29/2026 showed Resident 1's Stage IV coccyx PU/PI worsened and measured 8 cm x 8 cm x 0.6 cm. The WCC treatment plan included: cleanse with the acidic wound cleanser and allow the solution to sit on the wound for 10 minutes at each dressing change, apply medical honey, cover with a foam dressing twice daily, and turn/reposition every two hours.Review of the January TAR showed a PO, dated 01/29/2026, for coccyx wound care: cleanse with the acidic wound cleanser, pat dry, apply medical honey and cover with a foam dressing twice daily and as needed. The TAR transcription of the PO order transcribed did not include leaving the Named Cleanser to sit on the wound for 10 minutes before completing the dressing as directed by the WCC.In an interview on 03/19/2026 at 1:15 PM, Staff B stated the transcribed wound care POs on December 2025 and January 2026 TARS did not match WCC's treatment plan and were incorrectly transcribed and/or scheduled. Staff B stated the POs should have been clarified and correctly transcribed but were not. Review of Resident 1's Skin Integrity CP, dated 01/29/2026, did not provide documentation to show the CP was updated or revised. < CONTINUED WORSENING OF COCCYX WOUND AND DEVELOPMENT OF NEW HEEL PU/PI>Review of the WCC wound evaluation, dated 02/05/2026 showed Resident 1's Stage IV coccyx PU/PI continued to worsen and measured 10 cm x 11 cm x 1.5 cm. The wound bed was covered with 90 percent eschar that required surgical removal at the bedside. The WCC's treatment plan was changed to a Named antimicrobial cleansing solution at 1/4 strength-soaked gauze to be placed on the wound bed and covered with a foam dressing twice daily and as needed after each stool incontinence episode and turn every two hours. Resident 1 developed a new DTI (deep tissue injury-persistent non-blanchable deep red, maroon, or purple discoloration caused by intense and/or prolonged pressure and shear forces) PU/PI on the right heel that measured 3.0 cm x 3.0 cm x no (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	depth measured. The WCC's treatment plan included daily treatment with an unnamed skin protectant, heel protectors, and keeping the heels off the bed. Review of Resident 1's Skin Integrity CP, dated 02/05/2026, showed an intervention (dated 02/02/2026) for care staff to offer/encourage/assist with repositioning/turning frequently but did not indicate how frequently. The CP showed a 02/05/2026 intervention to elevate heels when in bed and apply Named pressure relieving boots when in bed or sitting in a chair. The CP did not show that Resident 1 had a Stage IV PU/PI on the coccyx or a DTI on the right heel. Review of a nursing progress note dated 02/10/2026 at 8:49 PM showed Resident 1 was transferred to an acute care hospital related to evaluation of their urine catheter. Review of Resident 1's 02/10/2026 Discharge Return Not Anticipated MDS showed they discharged with one Stage IV PU/PI that was not present on admission. The MDS did not show Resident 1 had a right heel DTI (not present on admission to the facility).In an interview on 03/06/2026 at 10:30 AM, Resident 1's Responsible Party (R1RP) stated they stayed with Resident 1 most days due to his cognitive decline. R1RP stated during the first month or so of Resident 1's stay at the facility, they did not observe Resident 1 repositioned every two hours, they remained in bed most of the day and were not assisted out of bed for meals. R1RP stated the facility did not change Resident 1's PU/PI dressing after each incontinent episode and stool contaminated the wound most of the time, so they discussed their concerns with the facility. R1RP stated they observed an increase in repositioning after they reported their concerns, but it was after their wounds worsened or developed. In an interview on 03/06/2026 at 2:01 PM, Staff C, Registered Nurse (RN), stated they were assigned to be the new wound team coordinator approximately three weeks ago. [NAME] asked to review the facility's wound tracking log, Staff C stated they had no information on the wound care program or log of wounds prior to three weeks ago and just started tracking facility wounds when they were assigned to lead the wound program. Staff C stated weekly wound evaluations were required for all PU/PI's and documented in the chart. Staff C stated the WCC they used during December 2025 through February 2026 did not consistently come to the facility every week, so they found a different WCC that just started seeing patients. Staff C stated their expectation was that the PU/PI CP should include all PU/PIs with their stage and include interventions that addressed positioning, moisture, shearing, offloading, nutrition, and risk for future development of PU/PIs.In an interview on 03/06/2026 at 3:00 pm, Staff B, Director of Nursing, stated they investigated Resident 1's coccyx PU/PI on 02/05/2026. Staff B determined through their investigation that the admission assessment on 12/04/2025 incorrectly identified Resident 1's two coccyx wounds as skin tears that were actually two Stage II PU/PIs on the coccyx that worsened after admission, that weekly wound evaluations were not routinely done, and progress notes contained inconsistent documentation, so they initiated a Performance Improvement Plan. Staff B stated they expected the licensed nurse staff to conduct wound evaluations for each PU/PI weekly and document their findings in the clinical record. The wound evaluations should include wound type/stage, location, measurements, wound bed characteristics, condition of skin around the wound, current treatment, CP interventions, evaluation of the effectiveness of the interventions, and wound progress. Staff B stated the wound evaluations should be completed whether the contracted WCC was in the facility or not. Staff B stated, It was just a bad start for Resident 1. REFER TO F641REFERENCE WAC: 388-97-1060 (1), (3)(b).