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	07/31/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to investigate an unexpected death to rule out mistreatment for 1 of 4 sampled residents (Resident 52) and failed to investigate an allegation of abuse for 1 of 4 sampled residents (Resident 114) when reviewed for Abuse. This failure placed residents at risk of abuse, neglect, avoidable death, retaliation from staff, and a diminished quality of life. Findings included . Resident 52 Review of the electronic health record (EHR) showed that Resident 52 admitted to the facility on [DATE], discharged on [DATE] and had a diagnosis of essential hypertension (high blood pressure). Review showed that Resident 52 unexpectedly died at the facility. Review of provider's orders showed Resident 52 received amlodipine for high blood pressure to be held if the systolic blood pressure (SBP, top number in a blood pressure reading) was less than 100. Review of the [DATE] medication administrator record (MAR) showed Resident 52 had a blood pressure of , d+[DATE] and was provided amlodipine on the morning of [DATE]. Review of the progress notes, dated [DATE] at 12:12 PM, showed that Resident 52 was very sleepy, pain medications were held, and the provider was notified of the held mediations at 12:12 PM. Review did not show that the provider was notified of Resident 52 receiving medication outside of parameters or of the resident's low blood pressure. Review of a progress note, dated [DATE] at 7:03 PM, showed Resident 52's blood pressure was measured at ,d+[DATE] with respirations of 14 at 5:00 PM, the resident continued to be sleepy, and the nurse held medications. Review showed at 5:30 PM the nurse returned, and Resident 52 was breathing more rapidly and shallowly. Review showed the nurse contacted the on-call provider and was told to monitor Resident 52's vitals every four hours. Review showed the nurse returned and Resident 52 was nonresponsive. Review showed the on-call provider was contacted again, oxygen was applied, CPR was started, and 911 was called. Review showed that Resident 52 died . (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:02 AM, Staff B, Director of Nursing Services (DNS), stated deaths that were completely unexpected would be investigated to rule out abuse, neglect, or mistreatment. During an interview on [DATE] at 10:07 AM, Staff B stated the facility would investigate unexpected deaths to rule out abuse, neglect or mistreatment. Staff B stated they looked over Resident 52's medical records after the death and did not see anything wrong so there was no further investigation. During an interview on [DATE] at 9:49 AM, Staff A, Administrator, stated that unexpected deaths were investigated to rule out malpractice. Staff A stated a death after two days in the facility should be investigated and that the medication error should have been noted during the file review Staff B completed. Resident 114 Resident 114 was admitted on [DATE] with diagnoses that included multiple fractures of the pelvis. The five-day admission Minimum Data Set (MDS), an assessment tool, dated [DATE] showed that the resident was cognitively intact and able to recall. During an interview on [DATE] at 1:08 PM, Resident 114 stated they had told Staff P, Charge Nurse, about an incident they had with a staff member, and had requested that the staff member would not come back into their room. Resident 114 stated that the staff member, although not assigned to Resident 114's room, had come back to threshold of the room and acted childish. Resident 114 stated they now tried to avoid this staff member. Resident 114 was observed to be visibly upset (eyebrows furrowed) as they recalled the events. Review of the Incident Log from February 2024 to [DATE] showed no recorded incident/allegation for Resident 114. During an interview on [DATE] at 9:30 AM, Staff P stated if a resident was reporting a staff member was rude, it should still be reported so that it could be care planned. If an allegation was made against a Certified Nursing Assistant (CNA), the CNA should be sent home and should not work with that resident anymore. Staff P recalled the initial incident with Resident 114 and stated they had had a conversation in the resident's room with the resident, the CNA, and themself, where the CNA was asked to not enter the room anymore. Staff P stated they did not report this to anyone else. During an interview on [DATE] at 10:44 AM, Staff B, Director of Nursing Services, stated for allegations of abuse they should have reported the allegations to the state, investigated, suspended the perpetrator, interviewed residents and staff, and gone from there. During an interview on [DATE] at 3:08 PM, Staff A, Administrator, stated the employee should have been suspended, the resident should have been interviewed and assessed, and that staff and other residents should have been interviewed. Allegations of abuse should be reported to the Complaint Resolution Unit, the family should have been notified, and the patient should have been put on an alert if needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:10 AM, Staff A, Administrator, was informed of the allegations for verbal abuse for Resident 114. On [DATE] the facility provided the investigation report, which did not have any interview/witness statements by Staff P. Reference WAC [DATE](5)(a), (6)(a)(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Sets (MDS), an assessment tool, accurately reflected residents' health status and/or care needs for 2 of 12 sampled residents (Residents 107 and 307) reviewed for resident assessment. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . Resident 107 Resident 107 admitted to the facility on [DATE] with diagnoses of congestive heart failure and atrial fibrillation (abnormal fluttering heartbeat). The resident was able to make needs known. Review of the admission nursing database assessment dated [DATE] showed the resident reported pain level at a 7 out of 10 daily. Review of the medication administration record showed the resident received tramadol (a narcotic pain medication) four times between 07/17/2024 and 07/21/2024 for a reported pain level between 6 out of 10 and 8 out of 10. Review or the providers orders showed the resident received heparin sodium (an anticoagulant/blood thinning medication) injections twice a day from 07/17/2024 through 07/22/2024. Observation and interview on 07/25/2024 at 1:25 PM showed Resident 107 sat in a wheelchair and leaned side to side and stated they were in pain. The resident had a bruise to their face and left hand. Review of the admission MDS, dated [DATE], showed Resident 107 reported no pain and was marked that the resident did not receive an anticoagulant medication. During an interview on 07/29/24 at 10:28 AM, Staff O, Registered Nurse/MDS Coordinator, stated they did not review the records to see if the resident had reported pain during the lookback period. Staff O stated if a resident received an anticoagulant medication one day of the lookback period it should be marked in the MDS. During an interview on 07/29/2024 at 12:12 PM, Staff B, Director of Nursing Services, stated Resident 107's MDS did not accurately reflect the resident's pain and anticoagulant but should have. 49926 Resident 307 Resident 307 was readmitted to the facility on [DATE] with multiple diagnoses to include heart failure and contusion to the left leg. Resident 307 was able to make needs known. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Multiple observations between 07/25/2024 and 07/31/2024 showed Resident 307 in bed with a swollen left lower leg, and large dressing covering the lower part of the left leg. During an interview on 07/25/2024 at 11:44 AM, Resident 307 stated they hurt their leg at home and the nurses were applying dressings at the facility. Review of Resident 307's five-day MDS, dated [DATE], showed Resident 307 did not have any dressings. During an interview on 07/30/2024 at 1:40 PM, Staff O stated that Resident 307's MDS should have been marked yes for dressing changes. During an interview on 07/29/2024 at 2:14 PM, Staff B stated the expectations was to make sure the MDS assessment matched the resident's condition. Reference WAC 388-97-1000(1)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview, observation, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 12 sampled residents (Residents 113, 44, 108, and 306) reviewed for Care Plan. This failure placed residents at risk for unidentified outcomes or goals, inconsistent or lack of interventions, and diminished quality of life. Findings included . Resident 113 Resident 113 was admitted to the facility on [DATE] with diagnoses that included a recent fall with complications, which resulted in orthopedic surgery to the right knee with external fixation (surgery that used pins and wires to keep bones from moving), and surgery to the right leg. The five-day admission Minimum Data Set (MDS), an assessment tool, dated 07/22/2024, showed the resident was cognitively intact, required the use of a wheelchair due to recent surgery, and had not been diagnosed previously with any mental health conditions. Observation and interview on 07/25/2024 at 1:54 PM showed Resident 113 was tearful as they recounted having anxiety in the facility when left alone in the bathroom. Resident 113 stated, I have started telling staff members when they try to leave (the bathroom). The resident stated they told physical therapy and occupational therapy that they believed they had anxiety or possible post-traumatic stress disorder (PTSD). Resident 113's care plan, initiated on 07/18/2024, showed no care plan for anxiety related to toileting. During an interview on 07/29/2024 at 11:30 AM, Staff L, Resident Care Manager (RCM), was unable to find any documentation related to Resident 113's anxiety with being left alone in the bathroom. During an interview on 07/29/2024 at 12:09 PM, Staff M, Occupational Therapist (OT), stated Resident 113 had told them about their fear of being left alone in the bathroom, but Staff M did not report this to anyone else. During an interview on 07/29/2024 at 1:36 PM, Staff B, Director of Nursing Services (DNS), stated their expectation for staff, once aware of the anxiety, was to stay with the resident in the bathroom and to have care planned it. Staff B stated the therapist should tell nursing so the care plan could be updated, and everyone would be aware. 40817 Resident 44 Resident 44 admitted to the facility on [DATE] with a diagnosis of essential hypertension (high blood pressure). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of provider's orders showed an order for oxycodone (a narcotic pain medication) and acetaminophen (a pain medication). Review of Resident 44's care plan, initiated 07/01/2024, showed no focus area for pain or the use of narcotic pain medications. During an interview on 07/29/2024 at 1:53 PM, Staff CC, Registered Nurse/Resident Care Manager, stated the expectation was that residents taking pain medications would have a care plan focus area related to their use and Resident 44 did not meet this expectation. During an interview on 07/29/2024 at 2:05 PM, Staff B, Director of Nursing Services, stated the expectation was residents taking pain medications would have a care plan focus area related to their use and Resident 44 did not meet this expectation. 46148 Resident 108 Resident 108 admitted to the facility on [DATE] for aftercare of surgery for an abdominal aneurism (weak artery wall). Observation and interview on 07/25/2024 at 12:58 PM showed Resident 108 sat at the bedside and had an indwelling urinary catheter (tube placed into the bladder to drain urine). The resident stated they were not sure why they had a urinary catheter. Review of the electronic health record (EHR) showed that Resident 108 had no order or care plan for a urinary catheter. During an interview on 07/29/2024 at 9:43 AM, Staff L, Resident Care Manager (RCM), stated if a resident was admitted with a catheter, they should have a provider order and a care plan. During an interview on 07/29/2024 at 12:07 PM, Staff B, Director of Nursing Services (DNS), stated they were unable to locate an order or care plan for Resident 108's catheter and they should have had both in place. 49926 Resident 306 Resident 306 was admitted to the facility on [DATE] with multiple diagnoses to include anxiety, depression and physical deconditioning. Resident 306 was able to make needs known. Multiple observations between 07/25/2024 and 07/31/2024 showed Resident 306 appeared sad as evidenced by lowered lip corners and slanting inner eyebrows. During an interview on 07/25/2024 at 10:39 AM, Resident 306 stated they had PTSD and were afraid of falling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/29/2024 at 9:34 AM, Resident 306 stated, They are hurting me trying to roll me in this tiny bed. It's terrifying to me. My fear of falling has to be one of the worst feelings. I told everyone about it. Review of Resident 306's care plan and Kardex (care directives for nursing assistants) showed no instructions on how to handle Resident 306's fear of falling and how many staff were needed for bed mobility. During an interview on 07/29/2024 at 12:33 PM, Staff R, Occupational Therapist, stated Resident 306 was a one to two persons assist in bed mobility and their fear was when they were sitting at the edge of the bed. During an interview on 07/29/2024 at 12:38 PM, Staff P, Licensed Practical Nurse, stated they were not sure how Resident 306 was turned in bed. During an interview on 07/29/2024 at 12:42 PM, Staff Q, Certified Nursing Assistant, stated Resident 306 required two men or four women to assist with bed mobility as the resident was very anxious and afraid of falling. During an interview on 07/29/2024 at 2:13 PM, Staff B, Director of Nursing Services, stated the expectations was to have instructions in the care plan about fears, and how many staff were to assist the resident in bed mobility. Reference WAC 1020(1), (2)(a)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 50945 46148 Surveyor: Somal, [NAME] Based on observation, interview and record review, the facility failed to follow provider's orders, ensure medications had safe monitoring and hold parameters, and notify the provider of changes in condition and medication errors for 8 of 10 sampled residents (Residents 52, 44, 206, 8, 112, 1, 107, and 9) when reviewed for Quality of Care. These failures placed residents at risk of decline in condition, lack of timely interventions to prevent death, avoidable side effects, and a diminished quality of life. Findings included . <Blood Pressure Medication Administration> Review of a policy titled Change in a Resident's Condition or Status, revised February 2021, showed the nurse would notify the resident's provider when there had been an accident or incident involving the resident or significant change in the resident's physical/emotional/mental condition. Review of a policy titled Blood Pressure, Measuring, revised [DATE], showed hypotension (low blood pressure) was defined as blood pressure less than 100 / 60 and orthostatic (postural) hypotension was defined as a 20 (or greater) decline in systolic blood pressure (top blood pressure reading) or a 10 (or greater) decline in diastolic blood pressure (bottom blood pressure reading) upon standing. Review showed that hypotension should be reported to the provider. Review of a policy titled Avamere Living: Physician Notification, dated [DATE], showed after determining that the provider needed to be contacted, the date and problem/request would be entered into the progress notes in the electronic health record (EHR) for that resident. Review showed the resident care manager (RCM) or charge nurse was responsible for placing the call or faxing the provider at the earliest possible time. Resident 52 Review of EHR showed that Resident 52 admitted to the facility on [DATE], discharged on [DATE] and had a diagnosis of essential hypertension (high blood pressure). Review showed that Resident 52 unexpectedly died at the facility. Review of provider's orders showed Resident 52 received amlodipine for high blood pressure to be held if the systolic blood pressure (SBP, top number in a blood pressure reading) was less than 100. Review of the [DATE] medication administration record (MAR) showed Resident 52 had a blood pressure of , d+[DATE] and was provided amlodipine on the morning of [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 52's blood pressures and pulses from [DATE] showed: 7:24 AM - 92 / 49, 60 beats per minute (bpm) 10:25 AM - 92 / 49 1:59 PM - 90 / 48, 60 bpm 4:01 PM - 90 / 30, 61 bpm 5:07 PM - 90 / 48, 60 bpm Review of a progress note, dated [DATE] at 12:12 PM, showed that Resident 52 was very sleepy, pain medications were held, and the provider was notified of the held pain mediations at 12:12 PM. Review did not show that the provider was notified of Resident 52 receiving medication outside of parameters or of the resident's low blood pressure. Review of the progress notes on [DATE] from 12:13 PM through 5:00 PM showed no update on Resident 52's status. Review of a progress note, dated [DATE] at 7:03 PM, showed Resident 52's blood pressure was measured at ,d+[DATE] with respirations of 14 at 5:00 PM, the resident continued to be sleepy, and the nurse held medications. Review showed at 5:30 PM the nurse returned, and Resident 52 was breathing more rapidly and shallowly. Review showed the nurse contacted the on-call provider and was told to monitor Resident 52's vitals every four hours. Review showed the nurse returned and Resident 52 was nonresponsive. Review showed the on-call provider was contacted again, oxygen was applied, CPR was started, and 911 was called. Review showed that Resident 52 died . During an interview on [DATE] at 10:07 AM, Staff B, Director of Nursing Services (DNS), stated residents should not receive medications if the vital signs were outside the parameters and Resident 52 received amlodipine despite the resident's blood pressure being below parameters. Staff B stated this did not meet expectation. Staff B stated that staff should contact the provider during a change of condition as soon as the change was noticed, and Resident 52's provider should have been notified of the low blood pressure as soon as it was noticed. Review of an emailed statement, dated [DATE], showed Staff V, Medical Director, stated they were contacted by the facility regarding Resident 52's decline in condition on [DATE] at 5:30 PM. Staff V stated, There could've been better communication from the nursing home staff to me. Resident 8 Resident 8 was admitted on [DATE], with diagnoses that included chronic respiratory failure, heart failure, atrial fibrillation, and high blood pressure. The five-day admission Minimum Data Set (MDS, an assessment tool), dated [DATE], showed the resident was cognitively intact and a fall risk. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed that Resident 8 had a positive orthostatic blood pressure (a change in blood pressure from moving positions, resulting in low blood pressure) during their recent prior admission, admitted [DATE]. Resident 8's orthostatic blood pressure readings were ,d+[DATE] laying down, ,d+[DATE] sitting, and ,d+[DATE] standing. A cardiology progress note showed that they adjusted Resident 8's dose of metoprolol, in response to the positive orthostatic blood pressure. Review of the EHR showed Resident 8 had an order for daily metoprolol with a start date of [DATE]. No monitoring or hold parameters for vitals were found. During an interview on [DATE] at 10:16 AM, Resident 8 stated, Once in a while I have been lightheaded since being here. The resident stated that their lightheadedness symptom was when their blood pressure was low. During an interview on [DATE] at 10:37 AM, Staff J, Certified Nursing Assistant (CNA), stated a blood pressure should be rechecked every two hours if abnormal. Observation on [DATE] showed Staff S, CNA, used a standard sheet from the facility for recording vitals, which included wording that the nurse should be notified immediately for systolic blood pressures of less than 110. During an interview on [DATE] at 12:27 PM Staff T, CNA, stated that the method to take blood pressure was, The cuff goes around the upper arm. I can't remember, pump up to 100 I believe, hear two thumps. During an interview on [DATE] at 12:29 PM, Staff U, CNA, stated they usually used the blood pressure machine, but if the blood pressure was out of range they would use the manual. When asked what a normal range was, Staff U stated, If it goes higher than 120 then that means it is high. Review of the EHR showed 93 blood pressure readings were obtained from [DATE] to the morning of [DATE]. Review of Resident 8's blood pressure readings showed 24 of 93 had a systolic value of less than 110. Of those 24 readings, 20 did not have a repeat blood pressure reading within two hours. On [DATE], a reading of ,d+[DATE] was recorded at 8:35 AM, with no repeated blood pressure read until the following morning, [DATE] at 6:34 AM. Review of the EHR showed on [DATE], [DATE], [DATE], and [DATE], the resident received their morning metoprolol without any morning blood pressure vitals being recorded. In addition, torsemide (a medication that shifts fluid from the body into urine to be excreted, with a possibility to cause a loss of too much fluid) was given on the morning of [DATE], and both the morning and afternoon of [DATE] and [DATE]. On [DATE] at 3:03 PM, the resident had a blood pressure of ,d+[DATE]. The next blood pressure was taken almost 16 hours later at 6:40 AM on [DATE]. During an interview on [DATE] at 10:48 AM, Staff K, Registered Nurse (RN), stated metoprolol should have had hold parameters, and for low blood pressures they had the expectation that staff would hold the medication and alert the provider. During an interview on [DATE] at 11:14 AM, Staff L, Resident Care Manager (RCM), stated they did not see any parameters listed for metoprolol for Resident 8, and was unable to provide any documentation that the provider was made aware of the blood pressure of ,d+[DATE] on [DATE] by staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:32 PM, Staff B, DNS, stated metoprolol should have had a hold parameter, that their expectation was for the CNA to have told the nurse of the low blood pressure, that the nurse should have rechecked the blood pressure, and that they would have notified the physician if the blood pressure was still low. Staff B stated it was not acceptable that the blood pressure, on [DATE], was not rechecked until the next day at 6:40 AM, and that staff should have rechecked and documented the event. Resident 206 Review of the EHR showed Resident 206 admitted to the facility on [DATE], discharged on [DATE], and had a diagnosis of paroxysmal atrial fibrillation (an irregular heart rate) and heart disease. Review of Resident 206's provider's orders showed metoprolol (a blood pressure medication) and to hold the medication for a SBP less than 110. Review of the [DATE] MAR showed metoprolol was provided to Resident 206 on [DATE] evening dose, and [DATE] morning dose, when the SBP was 101, below the hold perimeter. Resident 44 Review of the EHR showed the Resident 44 admitted to the facility on [DATE] with a diagnosis of essential hypertension. Review of Resident 44's provider's order showed isosorbide (a blood pressure medication) and metoprolol to be held if the heart rate was less than 60. Review of [DATE] MAR showed that Resident 44 was provided isosorbide on [DATE] with a heart rate of 58 and [DATE] with a heart rate of 57. Review showed Resident 44 received metoprolol on [DATE] with a heart rate of 59 and [DATE] with a heart rate of 58. During an interview on [DATE] at 10:07 AM, Staff B, DNS, stated Residents 206 and 44 received medications outside of prescribed parameters and this did not meet expectation. Resident 307 Resident 307 was readmitted to the facility on [DATE] with multiple diagnoses to include heart failure. The MDS, dated [DATE], showed the resident was cognitively intact. During an interview on [DATE] at 10:30 AM, Resident 307 stated they received medications, but they did not always know what they are taking. Review of Resident 307's [DATE] MAR showed an order for losartan (a blood pressure medication) and to hold when the SBP was less than 110. Further review of [DATE] MAR showed losartan was documented administered on [DATE] when the blood pressure was ,d+[DATE], on [DATE] when the blood pressure was , d+[DATE] and on [DATE] when the blood pressure was ,d+[DATE]. Review of the EHR showed no documentation that the nurses notified the provider about the blood pressure being outside of parameters. (continued on next page)

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	505529	A. Building B. Wing	07/31/2024

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:15 PM, Staff B, DNS, stated the expectation was for the licensed nurses to follow orders and parameters of medications. Resident 1 Review of Resident 1's EHR showed they admitted to the facility on [DATE] with diagnoses including essential hypertension (HTN), syncope and collapse (dizzy spells) and fall with hip fracture. The resident was able to make needs known. Review of the EHR showed an order for metoprolol daily for hypertension with a start date of [DATE]. There were no instructions attached to the order to monitor blood pressure or pulse prior to administration or notify the provider of low blood pressure/pulse. Review of the EHR showed on [DATE] the resident had a blood pressure of ,d+[DATE]. No documentation was found in the medical record that the blood pressure was re-checked, or the provider was notified. During an interview on [DATE] at 1:12 PM, Staff B, DNS, stated that Resident 1 should have had parameters in place for antihypertensive medications and the provider should have been notified of any low blood pressures. Resident 107 Review of the EHR showed Resident 107 admitted to the facility on [DATE] with a diagnosis of congestive heart failure and atrial fibrillation. The resident was able to make needs known. Review of the EHR showed a provider order for heparin (blood thinning) injection twice a day with a start date of [DATE] and an end date of [DATE]. There was a current order to monitor for adverse effects which included bruising. Observation on [DATE] at 1:12 PM showed a large dark purple bruise to back left hand and scattered other bruises to include facial bruising to the left eye. Review of a current order to monitor for adverse side effects of anticoagulant therapy showed no bruises or adverse side effects were identified between the dates of [DATE] through [DATE]. There was no documentation found in the EHR of Resident 107's bruises. During an interview on [DATE] at 10:42 AM, Staff B, DNS, stated their expectation was that the staff document adverse side effects such as bruising from anticoagulant therapy and that they be monitored until resolved. <Bowel Care> Review of the Avamere Living Bowel Care Protocol, undated, showed if a resident had not had a bowel movement for three consecutive days, a physician order should be obtained, and the bowel protocol should be followed. The protocol showed that evening shift should do a look back report for residents who had not had a bowel movement for two consecutive days, evening shift should give milk of magnesia, and then (if no results) dayshift should give a suppository. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 112 Resident 112 was admitted to the facility on [DATE] with diagnoses including fracture, malnutrition, and cancer. The five-day admission MDS, dated [DATE], showed the resident was cognitively intact and had frequent pain that required pain management interventions. Review of the [DATE] MAR showed Resident 112 had been receiving morphine (a narcotic pain medication, which had a potential side effect of causing constipation) for pain since [DATE]. On admission, the resident had a bisacodyl suppository (a rectal drug that stimulates a bowel movement) ordered for every 24 hours as needed for no bowel movement in three days. On [DATE], an order was placed for daily docusate (a stool softener to help with constipation). Review of Resident 112's bowel log and hospice notes, the resident had no bowel movement from [DATE] through [DATE] and [DATE] through [DATE]. Resident 112 was given a bisacodyl suppository on [DATE] (day 6 of no bowel movement) and [DATE] (day 5 of no bowel movement). The resident had a bowel movement after each suppository. Review of the Resident 112's progress notes showed no documentation related to the resident's constipation on [DATE] through [DATE] (days 3 and 4), or [DATE] through [DATE] (days 3 and 4). During an interview on [DATE] at 11:22 AM, Staff L, Resident Care Manager (RCM), stated their expectation was for staff to monitor bowels every day, every shift, and to have started the protocol if three days without a bowel movement. During an interview on [DATE] at 1:34 PM, Staff B, DNS, stated their expectation was for staff to have documented any intervention or refusal after three to four days without a bowel movement, to have followed protocol or orders, and to have assessed the patient for any stomach pain or abdominal distention (swelling). Reference WAC [DATE](1) 49926

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50945 Based on observation and interview, the facility failed to provide a working doorbell for handicap residents visiting the courtyard for 1 of 1 courtyard reviewed for accident hazards. This failure placed residents at risk for accidents, anxiety, feelings of entrapment, and a diminished quality of life. Findings included . During an interview on 07/25/2024 at 1:55 PM, Resident 113 stated both ends of the courtyard had doors that were too heavy for them to open, and that there was a button that no one responded to. They stated the facility was not offering any handicap options for residents, and they were stuck in the courtyard until a staff member came by. Observation on 07/25/2024 showed the courtyard had doors at each end which were heavy and opened into the courtyard. Observation showed a doorbell next to each door. Observation showed pressing the doorbells did not result in staff response. During an interview on 07/30/2024 at 2:49 PM, Staff N, Maintenance Director, stated they were aware the doorbells in the courtyard did not function and was unsure for how long they had not functioned. Reference WAC 388-97-1060 (3)(g)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide nonpharmacological interventions before administrating as needed pain medications for 2 of 5 sampled residents (Residents 44 and 1) when reviewed for unnecessary medications. This failure placed residents at risk of taking unnecessary medications, experiencing avoidable side effects, and a diminished quality of life. Findings included . Resident 44 Review showed the Resident 44 admitted to the facility on [DATE] with a diagnosis of essential hypertension (high blood pressure). Review of provider's orders showed orders for oxycodone (a narcotic pain medication) and acetaminophen (a pain medication) to be provided as needed (PRN). Review did not show an order for nonpharmacological interventions (NPI, pain interventions that do not use medication, e.g. massage or repositioning). Review of the July 2024 medication administration record (MAR) showed that Resident 44 received oxycodone four times and acetaminophen three times. Review did not show that NPI were provided. During an interview on 07/29/2024 at 1:53 PM, Staff CC, Registered Nurse/Resident Care Manager, stated the expectation was NPI should be used prior to administering PRN pain medication. Staff CC stated Resident 44 did not have orders for NPI, received PRN pain medications, and was not offered NPI. Staff CC stated this did not meet expectation. During an interview on 07/29/2024 at 2:05 PM, Staff B, Director of Nursing Services, stated the expectation was NPI should be used prior to PRN pain medications and Resident 44's PRN pain medications did not meet this expectation. 46148 Resident 1 Resident 1 admitted to the facility on [DATE] with a diagnosis of fall with hip fracture. The resident was able to make needs known. Review of the electronic health record showed the resident had an order for narcotic pain medications PRN for pain. The resident received the narcotic pain medication 33 times from 07/13/2024 - 07/31/2024. No documentation of NPI being offered prior to administration was found in the medical record for 22 of the 33 administrations. During an interview on 07/29/2024 at 9:25 AM, Staff W, Licensed Practical Nurse (LPN), stated nursing staff should have offered and documented NPI in the MAR but they did not see that included in Resident 1's orders. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/29/2024 at 12:01 PM, Staff B, DNS, stated it was their expectation that nursing staff offer NPI prior to giving a narcotic medication and this should be documented in the EHR but Resident 1 did not have that included in the orders and should have. Reference WAC 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49926 Based on observation, interview, and record review, the facility failed to ensure proper storage of medications in 2 of 2 medication rooms (North and South medication rooms) and 2 of 2 medication carts (South High and South Low) when reviewed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective medications, risk for drug diversion and diminished quality of life. Findings included . Review of the facility's policy Nursing Care Center Pharmacy Policy and Procedure Manual, dated 2007, showed controlled substances (addictive medications) stored in refrigerators should be secured in a separately locked, permanently affixed compartment. Medications requiring refrigeration were to be kept between temperatures of 36 Fahrenheit (F) and 46F. The temperature of refrigerators that stored vaccines should be monitored and recorded twice a day. If using a temperature monitoring device (TMD, a digital data logger) that did not record the minimal and maximal temperatures each day, the facility should document current temperatures twice a day at the beginning and end of each workday. Insulin products were to be dated when opened and not frozen. If insulin had been frozen, the facility should not use it. <Medication Rooms> Observation of the south medication room on 07/26/2024 at 11:35 AM with Staff X, Registered Nurse, showed two refrigerators. The one on the right had an emergency kit (Ekit) medication that included Lorazepam (controlled substance) that was not locked and secured in a separate compartment. Observation of the north medication room on 07/26/2024 at 11:41 AM with Staff Y, Registered Nurse, showed a refrigerator with a lock that was not locked and inside there was an Ekit that contained Lorazepam that was not secured. Staff Y stated the Lorazepam should be double locked. Review of the electronic temperature logs for south medication room showed the temperatures were out of required ranges daily for the month of July 2024 with the lowest temperature at 6.8 F on 07/10/2024 and highest at 57.2 F on 07/26/2024. Specific dates for July 2024 showed: 07/01/2024 the temperature was below the required storage medication 36 times out of 81 recordings and was as low as 28.4 F (below freezing). 07/02/2024 there was freezing temperature recorded from 8:39 AM until 9:27 AM and the temperature was recorded above 50 F from 3:31PM until 6:25 PM. 07/03/2024 recorded below freezing from 7:02 PM until 9:51 PM. 07/04/2024 showed temperatures below freezing from 5:02 AM until 7:58 AM and one of the temperatures was recorded at 19.4 F. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/05/2024 the temperature was below freezing from 3:31 AM until 6:18 AM and from 5:19 PM until 7:29 PM. 07/06/2024 the temperature was out of range including freezing for 80 recordings out of 135. Observation of south medication room on 07/30/2024 at 3:08 PM with Staff AA, Licensed Practical Nurse, showed Lorazepam medication with Ekit supplies in both refrigerators that were not secured. Staff AA stated that Lorazepam should have been double locked. During an interview on 07/30/2024 at 3:20 PM, Staff B, stated they did not know how the refrigerator temperature monitoring system worked, but it should maintain required temperatures for the medication storage. They were not aware of any alarms that the TMD would generate and what actions the nurses were to take. Staff B stated that Lorazepam should be double locked in the medication rooms. <Medication Carts> Observation on 07/29/2024 at 11:38 AM showed two multi-dose insulins with no open date or expiration date in the south high medication cart. Observation on 07/29/2024 at 11:46 AM showed two multi-dose insulins with no open dates or expiration date and one multi-dose insulin that was expired in the south low medication cart. During an interview on 07/29/2024 at 11:48 AM, Staff P, Licensed Practical Nurse, stated there should be a date when the insulin was opened. During an interview on 07/29/2024 at 1:10 PM, Staff B stated the expectation was to date opened insulins with the open date and expiration date. Reference WAC 388-97-1300(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to prevent the transmission of communicable diseases and infections by completing the analyzation of infection control data, identifying trends, and completing follow-up activities in response to those trends for 3 of 3 months (April, May and June 2024) reviewed for Infection Control. The facility also failed to implement transmission-based precautions (TBP) for 1 of 2 halls (200 hall) reviewed for TBP. These failures placed residents and staff at risk for communicable diseases and infections, poor clinical outcomes, and a decreased quality of life. Findings included . Review of the facility policy titled Infection Prevention Control Program (IPCP), revised October 2018, showed that the IPCP would be coordinated and overseen by an infection preventionist (IP), and the facility would follow established general and disease specific guidelines such as those of the Center for Disease Control. <TBP> Review of a sign for Aerosol Generating Procedure (AGP) precautions posted on residents' doors dated December 2021 showed for staff to keep the door closed and wear a gown, gloves, an N95 mask and eye protection when entering the room during procedures until three hours after. Observation on 07/25/2024 at 12:13 PM showed a sign posted outside of room [ROOM NUMBER] for AGP precautions and the door was open. There were no N95 masks available in the isolation cart. At 12:22 PM, Staff S, Certified Nursing Assistant (CNA), exited room [ROOM NUMBER] and stated they saw the resident receiving an aerosol generating procedure, so they put a gown on. They did not put on an N95 mask and the door remained open. Observation on 07/26/2024 at 8:42 AM showed room [ROOM NUMBER] with an AGP sign on the door, there was an isolation cart by the door, and there were no N95 masks available for staff to use. The sign was marked for AGP precautions to be in place from 6:00 AM to 9:00 AM. The door was open. Observation on 07/30/2024 at 12:35 PM showed room [ROOM NUMBER] with an AGP precautions sign, the resident was in the bed and receiving an AGP. The door remained open until 2:25 PM. Observation on 07/25/2024 at 11:43 AM showed a contact precautions sign outside of room [ROOM NUMBER]. The sign instructed staff to put on a gown and gloves when entering the room. An unidentified staff member knocked on the door and entered the room, and they did not put on a gown or gloves. During an interview on 07/30/2024 at 10:26 AM, Staff CC, Resident Care Manager, stated AGP should be in place for residents who were receiving nebulizer treatments (aerosolized inhaled medication), the door should remain closed, and PPE worn when entering the room for three hours after. <Enhanced Barrier Precautions> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC document titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) section titled Enhanced Barrier Precautions (EBP) dated 04/02/2024 showed that residents with qualifying criteria would require the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Observation on 07/29/2024 showed a sign posted outside the door of room [ROOM NUMBER] showing EBP required. During observation of wound care, Staff W provided a bandage change to surgical incisions to both hips for Resident 108. Staff W did not wear a gown while providing wound care. During an interview on 07/30/2024 at 10:36 AM, Staff B, Director of Nursing Services, stated it was their expectation that if a resident had a BiPap (a machine that forces air into the lungs while the resident sleeps) machine or nebulizer treatment the doors should have remained closed and N95 and eye protection be worn by staff when entering the room for three hours. Staff B stated if a nurse was doing wound care on a resident who required EBP they should wear a gown and gloves. During an interview on 07/30/2024 at 2:56 PM, Staff A, Administrator, stated it was their expectation that staff followed the directions on the posted transmission-based precautions signs. <Tracking and Trending> Review of the facility infection control line listing for the months of April, May and June 2024 showed no documentation that the infection surveillance data was analyzed, trends were identified, or interventions were implemented to address the identified trends. Review of the July 2024 infection control line listing data showed no mapping of current organisms/infections. The facility did not provide a line listing/map of residents with current or history of colonization with MDRO. During an interview on 07/30/2024 at 10:00 AM, Staff H, Registered Nurse/Staff Development Coordinator, stated the facility staff who was doing the resident infection control tasks should review the in-house infections with the team for antibiotic stewardship daily. Also, that they would analyze the data to look for trends and provide education related the trends monthly. Staff H indicated that Staff CC was covering for the infection preventionist while they were gone. During an interview on 07/30/2024 at 10:17 AM, Staff CC, Registered Nurse/Resident Care Manager (prior facility infection preventionist), stated it was the infection preventionist's job to track and map all new infections in the facility daily and to ensure any needed transmission-based precautions were in place and being followed. Staff CC stated they were not currently covering for the infection preventionist for those tasks. During an interview on 07/30/2024 at 10:30 AM, Staff B, DNS, stated it was their expectation that the infection preventionist review all antibiotic orders for new infections and make sure precautions were in place and followed. Staff B stated the IP should have reviewed the labs for what organisms were present, add that to the log and map daily, compile the data monthly and review for trends to plan for how to address the trends. During an interview on 07/30/2024 at 3:00 PM, Staff A, Administrator, stated that it was their expectation that the infection preventionist review surveillance data monthly to look for trends and provide education such as transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	See F-882 and F-887 for additional information Reference WAC 388-97-1320 (1)(a), (2)(b)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46148 Based on interview and record review, the facility failed to ensure the infection prevention and control program (IPCP) was overseen by a qualified individual with the time and training necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as Quality Assurance and Performance Improvement (QAPI) for 1 of 1 infection control preventionist (ICP, Staff Z) reviewed for infection preventionist qualifications. This failure placed residents, family members and staff at risk of contracting communicable diseases and a decreased quality of life. Findings included . Review of the facility policy titled Infection Prevention Control Program, revised October 2018, showed that the IPCP would be coordinated and overseen by an infection preventionist. During an interview on 07/30/2024 at 10:17 AM, Staff CC, Registered Nurse/Resident Care Manager, stated the expectation for the infection preventionist was to track vaccines, do rounds and make sure appropriate isolation precautions were in place and being followed for residents, review the electronic health records for new infections, make sure the nurses were following criteria, make sure the stop dates were included for antibiotics, track the organisms, update daily infection control logs and maps, provide education to staff related to infection control issues and go to clinical meetings and QAPI. During an interview on 07/30/2024 at 10:00 AM, Staff H, Registered Nurse/Staff Development Coordinator, stated they were only doing staff related infection control. Staff Z, Interim Infection Preventionist, was on vacation and Staff CC was covering for Staff Z while they were gone. During an interview on 07/30/2024 at 10:17 AM, Staff CC, RN/RCM (prior facility infection preventionist), stated they were not currently covering for Staff Z for infection control. During an interview on 07/30/2024 at 10:30 AM, Staff B stated they were not aware they were responsible for the infection control tasks while Staff Z was on vacation but was doing the antibiotic line list. Staff B stated they themselves and Staff Z had not completed infection control training. See associated citation F-880 No associated WAC. .

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to provide education on the benefits and potential side effects of the Covid-19 vaccination prior to offering the vaccine for 4 of 5 sampled residents (Residents 14, 15, 20 and 34) when reviewed for vaccinations. This failure placed residents and their representatives at risk of not being given the opportunity to make an informed decision regarding their medical care, potential complications of a communicable disease, and a decreased quality of life. Findings included . Resident 14 was admitted to the facility on [DATE]. Review of the electronic health record (EHR) showed the resident declined the Covid-19 vaccine on 05/22/2024. There was no documentation found that the resident or their representative was educated on the benefits or potential side effects prior to offering the vaccine. Resident 15 was admitted to the facility on [DATE]. Review of the EHR showed the resident declined the Covid-19 vaccine on 01/08/2024 There was no documentation found that the resident or their representative was educated on the benefits or potential side effects prior to offering the vaccine. Resident 20 was admitted to the facility on [DATE]. Review of the EHR showed the resident declined the Covid-19 vaccine on 05/12/2024. There was no documentation found that the resident or their representative was educated on the benefits or potential side effects prior to offering the vaccine. Resident 34 was admitted to the facility on [DATE]. Review of the EHR showed the resident declined the Covid-19 vaccine on 06/10/2024. There was no documentation found that the resident or their representative was educated on the benefits or potential side effects prior to offering the vaccine. During an interview on 07/26/2024 at 9:24 AM, Staff Z, Interim Infection Preventionist, stated residents should have been educated on the benefits and potential side effects of the Covid-19 vaccines when they were offered but was unable to locate documentation that this happened for Residents 14, 15, 20 or 34. During an interview on 07/29/2024 at 12:30 PM, Staff A, Administrator, stated it was their expectation that all residents received education on the risks and benefits when they were offered the Covid-19 vaccines. See associated citation F-880 No reference WAC