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	11/25/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation and interview, the facility failed to ensure treatment and medication carts were secured/locked when unattended for 4 of 4 treatment carts (Front North 200 hall, Back North 200 hall, Front South 300 hall, and Back South 300 hall) and for 4 of 4 medication carts (Front North 200 hall, Back North 200 hall, Front South 300 hall, and Back South 300 hall) when reviewed for medication storage. This failure placed residents at risk for drug diversion and potential loss of medications/treatments.Findings included. Review of the facility's policy titled, Medication Storage, dated 2007, showed, In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts, Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. Observations on 09/23/2025 at 6:04 AM showed the Front North 200 hall treatment and medication carts, the Back North 200 hall treatment and medication carts, the Back South 300 hall treatment cart, and the Front South 300 hall treatment cart, left unlocked/unsecured while unattended (treatment carts contain medicated creams, ointments, wound cleansers, and treatment supplies such as various types of dressings, and medication carts contain residents' prescribed medications and medical supplies). Observation on 09/24/2025 at 8:02 PM showed the Front South 300 hall medication cart unlocked and unattended. Observation on 09/14/2025 at 8:04 PM showed the Front North 200 hall treatment cart and medication cart unlocked and unattended. Observation on 09/24/2025 at 8:27 PM showed the Back North 200 hall treatment cart unlocked and unattended. During an interview on 09/24/2025 at 9:40 PM regarding the Front South 300 hall medication cart, Staff P, Registered Nurse (RN), stated the medication cart should be locked when unattended. Staff P stated they usually locked the medication cart automatically and leaving it unsecured did not meet expectations and it should have been locked. During an interview on 09/24/2025 at 9:44 PM, regarding the Front North treatment and medication carts, Staff Q, RN, stated they must have forgotten to lock them, and they should always be locked when unattended. Observation and interview on 09/26/2025 at 6:58 AM showed the Back South 300 hall treatment and medication carts not locked and left unattended. Observation showed Staff K, RN, coming out of the medication room and sat at the nurses station. Staff K stated they went into the medication room to check on something but should have locked the medication and treatment carts because they should be locked when unattended. During an interview on 09/26/2025 at 11:26 AM, Staff B, Director of Nursing Services, stated the expectation was treatment and medication carts should be locked/secured when left unattended. Reference WAC 388-97-1300(2), -2340.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently offer/provide showers and oral care for 3 of 4 sampled residents (Residents 14, 84 and 88) when reviewed for activities of daily living (ADL). These failures placed dependent residents at risk for unmet care needs, poor hygiene and diminished quality of life.Findings included . Resident 14Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses of failure to thrive, anxiety (feeling of fear, tension or worry) and neuropathy (nerve damage). During an interview on 09/23/2025 at 8:58 AM, Resident 14 stated they had been at the facility for over a week and had not received a shower. Review of the facility shower sheet showed Resident 14 was to receive showers twice a week. During an interview on 09/25/2025 at 11:19 AM, Staff F, Residential Care Manager (RCM), stated Resident 14 declined showers; however, it was not documented and should have been. Resident 84Review of the EHR showed Resident 84 admitted to the facility on [DATE] with diagnoses of fractured femur (breakage in the thigh bone) and anxiety. Resident 84 required staff assistance for ADLs. During an interview on 09/23/2025 at 8:35 AM, Resident 84 lay in bed with greasy unkempt hair and yellow matter on their teeth. Resident 84 stated they had not been offered a shower and staff did not provide/offer oral hygiene. Review of the facility shower sheet showed Resident 84 was to receive showers twice a week. Review of the EHR showed Resident 84 required set-up assistance with oral hygiene. During an interview on 09/25/2025 at 11:22 AM, Staff J, Certified Nursing Assistant, stated they had not assisted Resident 84 with oral care due to a therapy appointment. During an interview on 09/25/2025 at 2:11 PM, Staff F, RCM, stated the expectation was for staff to assist with oral hygiene set up or assistance daily. Resident 88Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung condition that limits airflow) and diabetes (high blood sugar). Resident 88 required staff assistance with bathing. During an interview on 09/23/2025 at 11:37 AM, Resident 88 stated they had not had a shower in over a week. Review of the facility shower sheet showed Resident 88 was to receive showers twice a week. During an interview on 09/25/2025 at 10:18 AM, Staff F, RCM, stated Resident 88 wanted to be bathed by their caregiver who had not yet been to the facility to visit. Staff F stated the preference had not been care planned but should have been. During an interview on 09/26/2025 at 11:45 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was that residents were offered showers twice per week and staff were to document whether the shower was provided and, if not, the reason why. Staff B stated residents who refused should be reapproached at a later time and that continuous refusals should be documented and discussed with the provider. Reference WAC 388-97-1060 (2)(c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to provide care in a timely manner and complete activities of daily living for 1 of 4 halls (300 hall) when reviewed for sufficient staffing. This failure placed residents at risk for unmet needs, decreased self-worth and a diminished quality of life. Findings included. During an interview on 09/23/2025 at 8:30 AM, Resident 67 (room [ROOM NUMBER]) stated they had turned their call light on last night and waited over an hour. Resident 67 stated they had gone out into the hall and did not see any staff in the hallways. During an interview on 09/24/2025 at 9:25 AM, Resident 32 (room [ROOM NUMBER]) stated they waited 30 minutes with the call light on to ask for pain medicine last night (09/23/2025) and then another 15 minutes for the nurse to bring it. Resident 32 stated That's a long time when you are hurting. Observation on 09/24/2025 at 9:30 AM showed Resident 51 (room [ROOM NUMBER]) in their room with a family member. The family member turned on the call light for assistance with repositioning Resident 51. Observation showed multiple staff walked by the room without answering the call light. At 10:05 AM, a nursing staff answered the call light and assisted the resident (35 minutes wait time). Observation on 09/24/2025 at 8:05 PM showed the call light system at the nurse's station was lit up for Resident 5 (room [ROOM NUMBER]) and showed it had been on for 34 minutes. Observation and interview on 09/24/2025 at 8:29 PM showed Resident 5 (room [ROOM NUMBER]) sat in their wheelchair next their bed and the call light was not on. Resident 5 stated they were upset because they had turned the light on to go to bed half an hour ago and staff turned it off and said they would return. Resident 5 turned the light back on and a certified nursing assistant (CNA) arrived at 8:30 PM and stated, Are you ready? and assisted the resident to bed (55 total minutes wait time). Review of the resident council minutes dated 09/24/2025 showed Resident 4 had reported turning on the call light in the bathroom for assistance and it took too long for staff to come so they had to use their walker without assistance. During an interview on 09/25/2025 at 2:32 PM, Staff C, CNA, stated a call light should be answered in five to ten minutes and staff should not turn the light off unless the resident's needs had been met. Staff C stated the call light did not make a sound at the nurse's station. During an interview on 09/25/2025 at 2:39 PM, Staff B, Director of Nursing Services, stated a call light should be responded to within 10 to 15 minutes and more than 30 minutes was too long. Staff B stated the call light should have a tone at the nurse's station and a light above the door. During an interview on 09/25/2025 at 3:12 PM, Staff A, Administrator, stated more than 20 minutes waiting for a call light to be answered did not meet expectations and staff should not turn the call light off unless they had met the need. Staff A stated the call light system at the nurse's station should be audible.SEE F677 FOR ADDITIONAL INFORMATION Reference WAC 399-97 -1080 (1), 1090 (1)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's request for mobility bars for 1 of 6 sampled residents (Resident 93) when reviewed for choices. This failure placed the resident at risk of fear of falling, inability to sleep, and a diminished quality of life.Findings included.Review of the electronic health record showed Resident 93 admitted to the facility on [DATE] with diagnoses to include spinal stenosis (a condition where the space within the spine that houses the spinal cord and nerve roots becomes narrowed), anxiety, and insomnia (a common sleep disorder characterized by difficulty falling or staying asleep). Resident 93 was able to make needs known. During an interview and observation on 09/23/2025 at 10:28 AM, Resident 93 stated they had fallen at home prior to coming to the facility and continued to worry about falling from their bed at the facility. Resident 93 stated they requested mobility bars be added to their bed so they could reposition themselves in bed, but facility staff had not honored this request. Observation showed Resident 93's bed was in a high position and did not have mobility bars. Review of the care plan, initiated on 09/15/2025, showed Resident 93 was at a high risk for falls with a recent fall, but did not show an intervention for mobility bars. Review of a Safety Device Evaluation and Consent, dated 09/17/2025, showed Resident 93 had a history of falls and recommended mobility bars be placed on the resident's bed. Review showed, Mobility bars are requested to improve bed mobility and independence with positioning and the care plan was reviewed and updated by Staff F, Resident Care Manager (RCM). During an interview and observation on 09/25/2025 at 10:40 AM, Resident 93 stated they kept asking every day for mobility bars and was unsure why they could not have them. Observation showed Resident 93's bed was in a high position and did not have mobility bars. Observation on 09/26/2025 at 11:04 AM showed Resident 93's bed was in a high position and did not have mobility bars. During an interview on 09/26/2025 at 11:28 AM, Staff F, RCM, stated if a resident requested mobility bars, they would be evaluated by physical therapy, a safety evaluation and consent would be completed, and maintenance would be informed of the need to install the mobility bars. Staff F stated this was usually done within 24 hours. Staff F stated they assessed Resident 93 for mobility bars on 09/17/2025, a provider's order for mobility bars was obtained on 09/25/2025, and maintenance was notified of the need for mobility bars. Staff F stated this did not meet their expectation of timely response to Resident 93's request for mobility bars. During an interview on 09/26/2025 at 12:02 PM, Staff B, Director of Nursing Services, stated when a resident requested mobility bars therapy would assess the resident, receive a provider's order, and maintenance would install them. Staff B stated mobility bars should be provided as soon as possible, and Resident 93's mobility bars should have been provided more quickly. Reference WAC 388-97-0900(1)-(4)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a care conference meeting with a resident or responsible party for 1 of 19 sampled residents (Resident 74) when reviewed for care plans and care planning. This failure placed Resident 74 at risk for unmet needs, not being involved or informed of their plan of care, and a decreased quality of life.Findings included . Review of the electronic health record (EHR) showed Resident 74 admitted to the facility on [DATE] with diagnoses to include a broken part of the right hip socket and heart failure. Resident 74 was able to communicate needs. During an interview on 09/25/2025 at 12:35 PM, Resident 74 stated they did not recall ever going to a care conference or being asked to attend a care conference. Resident 74's adult child stated they were not invited to go to a care conference and would have liked to have gone to a care conference with their parent. Review of Resident 74's EHR showed a care conference information form dated 09/09/2025 showed the area for resident or responsible party who were present and who attended was blank/not filled out. Review showed no documentation to indicate Resident 74 or their family had attended a care conference. During an interview on 09/25/2025 at 12:53 PM, Staff L, Social Services Director, stated they were unable to tell from the documentation in the EHR if Resident 74 had attended a care conference. Staff L stated Resident 74 should have attended a care conference on 09/02/2025 and on 09/09/2025. Staff L stated Resident 74's care conference information form dated 09/09/2025 did not show who was present at the care conference and this did not meet expectations. During an interview on 09/25/2025 at 1:11 PM, Staff A, Administrator, stated Social Services were to invite the residents and/or their responsible party to care conferences via phone, email, or in person, and the care conference should be documented in the resident's EHR to include who attended. Staff A stated they were unable to tell who attended Resident 74's care conference scheduled for 09/09/2025 and this did not meet expectations. Reference WAC 388-97-1020 2(f), (4)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a provider order and interventions in place for 1 of 1 sampled resident (Resident 91) when reviewed for a life vest (a device worn under clothing with an attached monitor, designed to protect a person from sudden cardiac arrest/heart stop beating, by monitoring the hearts electrical activity and automatically delivers an electrical shock to correct a dangerous heart rhythm, preventing a potentially fatal event), and failed to ensure care and services were in place to treat a non-pressure skin issue for 1 of 3 sampled residents (Resident 68) when reviewed for general and/or skin conditions. These findings placed residents at risk of unmet needs, worsening conditions, clinical complications, and a decreased quality of life.Resident 91Review of the electronic health record (EHR) showed Resident 91 readmitted to the facility on [DATE] with diagnoses to include infection and swelling reaction due to a cardiac/heart device implant/inserted into the chest area and diabetes (too much sugar in the blood). Resident 91 was able to communicate needs. Observation and interview on 09/26/2025 at 12:04 PM showed Resident 91 laid in bed with the head of the bed elevated and a life vest in place under their tank top. Resident 91 stated they had the life vest on for about two weeks, showed the attached monitor, explained how the vest and the monitor worked, and knew the phone number to call if they had any issues. Resident 91 stated they were told by the cardiologist (heart doctor) they would wear the life vest until November 26th, 2025. Review of the EHR showed Resident 91 had no provider's order for the use of a life vest and had no interventions in place in Resident 91's plan of care related to the life vest. During an interview on 09/26/2025 at 12:13 PM, Staff K, Registered Nurse (RN), stated Resident 91 readmitted to the facility with the life vest. Staff K was able to explain the use of the life vest and stated Resident 91 was fully informed on the life vest. Staff K stated the care plan mentioned Resident 91 had a life vest; however, there were no interventions in place and no provider order for the use of the life vest and there should have been. During an interview on 09/26/2025 at 12:31 PM, Staff B, Director of Nursing Services (DNS), stated Resident 91 was the only resident in the facility with a life vest. Staff B stated Resident 91 did not have a provider order for the use of the life vest or interventions in place and this did not meet their expectations. Resident 68Review of the EHR showed Resident 68 admitted to the facility on [DATE] with diagnoses to include a broken hip, muscle weakness, and was able to make needs known. Observation and interview on 09/24/2025 at 12:46 PM showed Resident 68 laid in bed with their left foot wrapped in gauze. Resident 68 stated their left foot was wrapped and their relative had brought in a cream to apply to the left foot and gave it to a nurse on Monday [09/22/2025]; however, the left foot had not been treated with the medication. During a follow up interview on 09/25/2025 at 1:57 PM Resident 68 stated their left foot was wrapped and still had not been provided with the medicated cream treatment that their relative had brought in. Review of the admission nursing database evaluation dated 09/09/2025 showed Resident 68 had a left plantar foot (the sole of the foot) wart (fleshy bump/growth on the skin caused by a virus) 9 centimeters (cm) by 8 cm in length and width. Review of Resident 68's EHR showed their medication order summary dated 09/25/2025 had no medication treatment order for their left foot. Review showed no interventions documented in Resident 68's plan of care related to the left foot plantar wart. During an interview on 09/26/2025 at 9:43 AM, Staff K, RN, stated they were not aware Resident 68's left foot was wrapped. Staff K was unable to locate a treatment order for Resident 68's left foot. Staff K unwrapped Resident 68's left foot and stated the left plantar raised growth was 6 cm in length by 6 cm in width. Staff K stated Resident 68 had an order for a medicated cream for the left foot when they were admitted to the facility; however, they were informed by the pharmacy that the medication was to be provided by Resident 68. Staff K stated they were not aware that Resident 68's relative had brought in the medicated cream. During an interview on 09/26/2025 at 11:43 AM, Staff B, DNS, stated they were not aware that Resident 68 was not provided treatment for the left foot due to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication not being available. Staff B stated the provider should have been notified and this issue should have been addressed prior to now. Staff B stated this did not meet their expectations. Reference WAC 388-97-1060 (1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 3 sampled residents (Residents 88 and 101) when reviewed for respiratory care. Failure to follow physician orders for oxygen (O2) therapy placed the residents at risk for unmet needs and diminished quality of life. Findings included . Resident 88Review of the electronic health record (EHR) showed Resident 88 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung condition that limits airflow) and diabetes (high blood sugar). Resident 88 was able to make needs known. Observations on 09/23/2025 at 11:55 AM, 09/24/2025 at 1:05 PM and 09/25/2025 at 3:10 PM showed Resident 88 received O2 set to 2 liters (L) per minute via a nasal canula (devise to deliver O2 through a tube into the nose). Review of Resident 88's care plan dated 09/15/2025 showed an intervention for oxygen settings at 1 L continuously. During an interview on 09/25/2026 at 3:15 PM, Staff S, Licensed Practical Nurse (LPN), stated Resident 88's oxygen was set at 2 L but should have been set to 1 L. During an interview on 09/25/2026 at 3:19 PM Staff F, Resident Care Manager (RCM), stated the expectation was for staff to follow the physician's orders. Resident 101Review of the EHR showed Resident 101 was admitted to the facility on [DATE] and was assessed as oxygen dependent. Observation on 09/26/2025 at 2:06 PM showed Resident 101 received O2 set to 1.5 L per minute via a nasal canula. Review of Resident 101's care plan dated 09/22/2025 showed an intervention for oxygen settings at 2 L continuously. During an interview and observation on 09/26/2025 at 2:08 PM, Staff R, Registered Nurse (RN), verified Resident 101's oxygen was set to 1.5 L and the provider's order was for 2 L. Staff R stated they were in the process of weening Resident 101 off oxygen but had not received a new order. During an interview on 09/26/2025 at 11:45 AM, Staff B, Director of Nursing Services, stated the expectation was for staff to follow the provider orders and document accurate information. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a timely medication regimen review on admitting to the facility for 1 of 5 sampled residents (Resident 9) when reviewed for medication regimen review. This failure placed the resident at risk of allergic reaction, receiving contraindicated medication, and a diminished quality of life.Findings included.Review of the electronic health record showed Resident 9 admitted to the facility on [DATE] with diagnoses of hepatic encephalopathy (a syndrome that occurs when the liver is unable to properly metabolize toxins, leading to their accumulation in the brain), diabetes (too much sugar in the blood), and chronic kidney disease. Resident 9 was able to make needs known. Review of a Drug Regimen Review for New Admissions and Identification of Potential Clinically Significant Medication Issues form, dated 09/03/2025, showed Resident 9 had clinically significant medication issues in the areas of Drug Allergy and Other and required a provider's review. Review showed the document was faxed to the facility on [DATE] and reviewed by the provider on 09/24/2025. During an interview on 09/26/2025 at 11:19 AM, Staff F, Resident Care Manager (RCM), stated residents newly admitted to the facility would have a drug regimen review to ensure there were no errors in their medications and the provider would review this report if there were any issues. Staff F stated the facility did not receive Resident 9's medication regimen review until 09/23/2025 and there were issues identified on the report. Staff F stated the review should be received from the pharmacy within 12 hours and, if it was not, the facility should call the pharmacy for the recommendations. Staff F stated Resident 9's medication regimen review did not meet expectations for timeliness. During an interview on 09/26/2025 at 12:04 PM, Staff B, Director of Nursing Services, stated newly admitted residents would have a medication regimen review conducted by the pharmacy and the recommendations should be received within 24 hours. Staff B stated Resident 9's medication regimen review did not meet expectation for timeliness. Reference WAC 388-97-1300 (1)(c)(iii)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide non-pharmacological interventions (NPI, health interventions/approaches used instead of medication) and to have pain level parameters in place prior to giving as needed pain medication for 1 of 5 sampled residents (Resident 45) when reviewed for unnecessary medication use. This failure placed a resident at risk of receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life.Findings included. Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses to include aftercare following knee surgery, heart failure, and diabetes (too much sugar in the blood). Resident 45 was able to make needs known. Review of the September 2025 medication administration record (MAR) from 09/01/2025 - 09/25/2025 showed Resident 45 had an order with a start date of 08/28/2025 for oxycodone hydrochloride (HCl) (medication used to treat moderate to severe pain) every four hours as needed for moderate to severe pain that included to document pain level and NPI attempted first with a code number prior to giving the pain medication. Documentation showed oxycodone HCl was provided using a pain level of 0-10 (with 0 being no pain and 10 being the worst pain) that ranged from 0 (zero) to 7 (seven). Continued review of September 2025 MAR showed Resident 45 had an order with a start date of 09/11/2025 for acetaminophen extra strength (used to treat mild to moderate pain) every four hours as needed for pain. This order showed no pain level parameters or NPI codes. Documentation showed medication was provided with pain levels ranging from 3 (three) to 7 (seven) and no NPI documented as provided prior to giving the medication. Documentation showed multiple times that acetaminophen extra strength was provided at the same time oxycodone HCl was provided. During an interview on 09/25/2025 at 11:35 AM, Staff O, Resident Care Manager (RCM), stated Resident 45's order for as needed acetaminophen extra strength had no pain level parameters and there were no NPI provided when it was provided without the oxycodone HCl and there should have been. Staff O stated Resident 45's pain management documentation did not meet their expectations. During an interview on 09/25/2025 at 12:16 PM, Staff B, Director of Nursing Services, stated NPIs were to be provided and documented prior to giving as needed pain medication. Staff B stated there should be pain level parameters written in the order to guide licensed nurses when to give as needed acetaminophen verses oxycodone for pain management. Staff B stated Resident 74's pain management documentation did not meet their expectations because there were no pain level parameters or NPI documented for the as needed acetaminophen provider's order. Staff B stated Resident 74 had inconsistent documentation regarding why acetaminophen and oxycodone was provided at the same time and did not consistently show in the progress notes that it was due to Resident 74's request. Reference WAC 388-97 -1060 (3)(k)(i)

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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Transitional Care of Puget Sound	630 South Pearl Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to implement the appropriate use of transmission-based precautions (TBP) for 1 of 4 hallways (North front) when reviewed for TBP. This failure placed residents and staff at an increased risk for communicable diseases and a decreased quality of life. Findings included .Observation on 09/23/2025 at 6:15 AM showed room [ROOM NUMBER] with a TBP sign posted on the door. The sign instructed staff to put on an N95 mask, eye protection, a gown and gloves when entering the room and to keep the door closed. Observation and interview on 09/23/2025 at 6:15 AM showed Staff H, Certified Nursing Assistant (CNA), entered room [ROOM NUMBER] in a surgical mask. Staff H did not put on an N95 mask, gown or eye protection. Staff H remained in the room for eight minutes and exited the room with a bag of soiled linens still wearing the surgical mask. Staff H stated the resident in room [ROOM NUMBER] had Covid-19 (a highly contagious respiratory virus). Observation on 09/23/2025 at 11:53 AM showed room [ROOM NUMBER] with the door open and the resident was observed sitting in a wheelchair at the door. The resident did not have a surgical mask on, and multiple staff walked by the resident without an N95 or eye protection. Staff J, CNA, entered room [ROOM NUMBER] without putting on an N95 mask, eye protection, gloves or a gown. During an interview on 09/23/2025 at 12:03 PM, Staff J stated room [ROOM NUMBER] had a sign posted for TBP and they did not wear PPE when entering the room. They thought the resident no longer required TBP. During an interview on 09/26/2025 at 2:24 PM, Staff B, Director of Nursing Services, stated it was their expectation that staff followed the precaution signs' instructions when entering the resident rooms. Reference WAC 388-97 -1320 (2)(b)

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	11/25/2025

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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 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow prepared menus and ensure any changes were reviewed with the registered dietician when reviewed for kitchen. This failure placed residents at risk of not receiving adequate nutritional intake, decrease in weight, and a diminished quality of life.Findings included.Review of the menu for lunch on 09/25/2025 showed parmesan chicken, sweet potato, cauliflower, bread roll, and seasonal fresh fruit as the main meal. Observation on 09/25/2025 at 11:47 AM showed the facility cook serving chicken breast in an orange sauce, sweet potato, green beans, and canned mandarin oranges. Observation showed bread rolls were not provided. Observation of the facility provided test lunch tray on 09/25/2025 at 12:10 PM showed chicken in a sweet orange sauce, sweet potatoes, green beans, and canned mandarin oranges. A bread roll was not provided. During an interview on 09/25/2025 at 12:43 PM, Staff N, Registered Dietician, stated they oversaw the kitchen, the kitchen should follow the provided menus when possible, and any menu changes should be reviewed with them to ensure meals met nutritional needs of the residents. Staff N stated they were unaware of the kitchen's substitution of orange chicken for parmesan chicken, substitution of canned mandarin oranges for seasonal fresh fruit, or lack of bread roll. Staff N stated the provided lunch on 09/25/2025 did not follow the planned menu. Staff N stated there had been five deviations from the menu in the last week. During an interview on 09/25/2025 at 1:18 PM, Staff M, Dietary Manager, stated the kitchen knew what items to prepare by following the facility provided menus. Staff M stated if there needed to be a deviation from the menus, Staff N, Dietary Manager, needed to be informed and agree to the deviation. Staff M stated Staff N should have been contacted regarding the deviations from the lunch menu on 09/25/2025. During an interview on 09/25/2025 at 12:58 PM, Staff A, Administrator, stated the facility's menus were provided by the corporate office. Staff A stated menus should be followed as much as possible and, in an emergency, any deviations from the menu should be discussed by Staff N, Registered Dietician, and Staff M, Dietary Manager. Staff A stated the lack of communication regarding the deviations from the menu at lunch on 09/25/2025 did not meet expectations. Reference WAC 388-97-1160 (1)(a)(b)