

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/25/2025
NAME OF PROVIDER OR SUPPLIER  Puyallup Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  516 23rd Ave SE Puyallup, WA 98372	

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)
<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>.</p> <p>Based on interview and record review, the facility failed to obtain laboratory services according to professional standards of practice for 6 of 18 Residents (Residents 3, 9, 10, 11, 12 &amp; 13 ) reviewed for COVID-19 testing. The facility failure to obtain Physician Orders to conduct COVID-19 testing placed residents at risk of delayed identification/diagnosis of COVID-19.</p> <p>Findings included .</p> <p>COVID-19 is an infectious virus which causes respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death.</p> <p>&lt;Resident 3&gt;</p> <p>Review of the June 2025 COVID-19 Reporting Line Listing showed Resident 3 tested positive for COVID-19 on 06/10/2025.</p> <p>Review of Progress Notes showed on 06/10/2025 at 4:54 AM, Resident was administered Tylenol for a fever of 101.9 degrees Fahrenheit (dF). A 06/10/2025 5:59 AM Nursing Note showed the resident had been coughing all night. Although the positive results were documented, the COVID-19 test was not documented when it was done or by who.</p> <p>Review of the June 2025 orders and Medication Administration Record (MAR) showed no orders for COVID testing, and no documented testing.</p> <p>&lt;Resident 9&gt;</p> <p>Review of progress notes showed on 06/22/2025 Resident 9 started feeling crummy late last night, requested cough medicine. A COVID-19 test was done at that time due to symptoms and tested positive.</p> <p>Review of the June 2025 MAR showed there were no PRN (as needed) orders for COVID-19 testing in the event of symptoms.</p> <p>&lt;Resident 10&gt;</p> <p>(continued on next page)</p>

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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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of progress notes showed on 06/22/2025 Resident 10 had a low temp beginning evening shift at 99.2 dF, resident was administered Tylenol and reported feeling tired. According to the note, a COVID-19 test was negative.</p> <p>Review of the June 2025 Treatment Administration Record (TAR) showed there were no PRN orders for COVID-19 testing in the event of symptoms.</p> <p>&lt;Resident 11&gt;</p> <p>On 06/25/2025 at 2:28 PM, Emergency Medical Technicians were observed taking Resident 11 out of the facility. Resident 11's room was posted with Aerosol Contact Precautions (ACPs) and the resident was heard coughing.</p> <p>During an interview on 06/25/2025 at 2:33 PM, Staff L, Licensed Practical Nurse (LPN), stated they tested Resident 11 for COVID-19 three times during the day, with one result that was iffy and two that were negative.</p> <p>Review of Resident 11's electronic health record showed no order for PRN COVID-19 testing. None of the three COVID-19 tests were documented as done.</p> <p>&lt;Resident 12&gt;</p> <p>Review of a 06/24/2025 Nursing Note showed Resident 12 was coughing overnight, the RN (Registered Nurse) swabbed for COVID and the test was positive at 3:10 AM. Review of the MAR/TAR showed no PRN COVID-19 testing orders.</p> <p>&lt;Resident 13&gt;</p> <p>Review of a 06/25/2025 12:20 PM Nursing Note, showed Resident 13 was noted with restlessness, runny nose and coughing, no fever or shortness of breath. COVID-19 test was done and was positive.</p> <p>Review of the June 2025 MAR/TAR showed no PRN COVID-19 testing orders.</p> <p>On 06/25/2025 at 1:43 PM, Staff C, Licensed Practical Nurse (LPN), Infection Preventionist, stated there should be physician orders for COVID-19 testing PRN symptoms and staff would document testing and results on the administration records and/or the progress notes.</p> <p>During an interview on 06/25/2025 at 2:03 PM, Staff D, LPN, Resident Care Manager (RCM), stated if residents showed signs and symptoms of COVID-19, they were tested. If tested, the floor nurse documented the test and results in the progress note or in the PRN COVID testing order.</p> <p>On 06/27/2025 at 2:04 PM, Staff B, Director of Nursing, stated the facility previously had standing orders to conduct COVID-19 testing and they planned to re-implement them.</p> <p>REFERENCE: WAC 388-97-1340 (1)(2)(3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases, including COVID-19 and other infections for 18 of 32 Residents, (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 &amp; 18) reviewed for infection control. COVID-19 is an infectious disease by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death.</p> <p>The facility failed to do contact tracing, to identify those who may have been exposed to COVID-19. For those residents (2, 4, 5, 6, 7, 8 &amp; 11) identified as exposed, the facility failed to initiate exposure testing and place those exposed on Transmission Based Precautions (TBPs). The facility failed to conduct broad-based testing when they were unable to identify all exposed contacts. The facility failed to take precautions to prevent potential spread of COVID-19 when they continued concurrent therapy (the treatment of two residents at the same time, who are performing different activities) in the therapy gym, which placed Residents 15, 16, 17 &amp; 13 at risk of contracting COVID-19. The facility failed to implement universal source control on the unit or area for both staff and residents. The facility failed to ensure the staff followed the posted precautions including wearing a fit tested N95 respirator (a filtering facepiece that can filter out at least 95% of airborne particles) and eye protection. Failure of the facility placed residents and staff at risk of illness, isolation and hospitalization.</p> <p>Findings included</p> <p>Review of the facility COVID-19 Precautions and Outbreak Procedure updated 05/17/2024 showed recommendation to staff to visit the Department of Health (DOH) website for the COVID-19 toolkit. Asymptomatic patients with close contact with someone with SARS-CoV-2 infection (the illness caused by COVID-19) should have a series of 3 viral tests for COVID-19. Testing is recommended immediately (but not earlier than 24 hours after the exposure), and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the 2nd negative test. This will typically be at day 1 (where day 0 is day of exposure), day 3 and day 5. If an employee tests positive begin contact tracing, identify all residents and staff members that employee was in contact with in less than 6 feet distance, for greater than 15 minutes (cumulative in 24 hours) in the last 48 hours before symptoms started, or if asymptomatic in the 48 hours prior to positive test results.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The April 2024 DOH COVID-19 Preparedness and Outbreak Control Checklist for Long Term Care Facilities Outbreak interventions included identifying asymptomatic residents and/or staff members who had been exposed to COVID-19 and take precautions to prevent potential spread including tested on post exposure day 1, day 3, and day 5 if they had not recovered from COVID-19 infection in the last 30 days. Identify new cases by testing all residents and staff who have been in close contact with a COVID-19 positive individual. If all potential contacts cannot be identified, then broad based testing is recommended (unit wide). Continue re-testing all appropriate residents and staff who previously tested negative every 3-7 days for a minute of 14 days from most recent positive result, or until the Local Health Jurisdiction (LHJ) recommends ending outbreak. Residents who tested positive for COVID-19 should be placed on Aerosol Contact Precautions (ACP) for at least 10 days. Staff entering the resident's room should follow the posted precautions including wearing a N95 respirator, a gown, gloves and eye protection. Ensure all staff members that provide care to residents are fit tested and trained in appropriate N95 respiratory use. Implement universal source control on the unit or area for both staff and residents, source control for healthcare providers can be a NIOSH (National Institute for Occupational Safety and Health) approved N95 respirator or a well-fitting face mask. For N95s to be effective, fit testing and training are needed. Surgical masks may be more appropriate source control for residents</p> <p>&lt;Resident 1&gt;</p> <p>Review of progress notes showed Resident 1 was sent to the Emergency Department on 06/09/2025 with increased confusion, lethargy and abnormal laboratory results. A 06/10/2025 progress note showed the hospital alerted the facility that the resident tested COVID-19 positive at the hospital. The facility obtained orders to place Resident 1 on ACPs upon their return, through 06/20/2025.</p> <p>Review of the facility investigation, June 2025, showed the facility failed to identify that Resident 1's roommate was exposed.</p> <p>On 06/25/2025 at 11:21 AM, Resident 1 was observed self propelling themselves down the [NAME] 1 unit hallway, through doors off the unit and into a common area towards the reception area. Resident 1 was not wearing a mask. During an interview at that time, Resident 1 denied they tested positive for COVID-19, I never had it. I don't know why they keep saying it.</p> <p>&lt;Resident 2&gt;</p> <p>Review of the facility census showed Resident 2 moved into Resident 1's room on 06/06/2025, three days before Resident 1 tested positive for COVID-19.</p> <p>Review of Resident 2's electronic health record (EHR) showed a 06/07/2025 order for a COVID-19 test one time only for Post 7 days admission, which was done as ordered on 06/07/2025 with negative results. When the facility became aware on 06/10/2025 that Resident 1 exposed Resident 2 to COVID-19, they failed to place Resident 2 on documented monitoring, ACPs, or other Transmission Based Precautions (TBPs), or schedule recurrent COVID-19 testing post exposure. Further record review showed a 06/10/2025 order that Resident 2 was cleared to ambulate with SPC (single point cane) without supervision in their room and the west unit every shift.</p> <p>Review of a 06/12/2025 progress note showed Resident 2 ambulated around the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;Resident 3&gt;</p> <p>Review of the COVID-19 Reporting Line Listing showed Resident 3 tested positive for COVID-19 on 06/10/2025.</p> <p>Review of Progress Notes showed on 06/10/2025 at 4:54 AM, Resident was administered Tylenol for a fever of 101.9 degrees Fahrenheit (dF). A 06/10/2025 5:59 AM, Nursing Note showed the resident had been coughing all night. Although the positive results were documented, the COVID-19 test was not documented when it was done or by who.</p> <p>Review of the orders and Medication Administration Record (MAR) showed no orders for COVID-19 testing, and no documented testing.</p> <p>Review of physician's orders for June 2025, showed Resident 3 was placed on ACP precautions from 06/10/2025 through 06/21/2025.</p> <p>On 06/25/2025 at 12:14 PM, Resident 3 was in their room, wearing a surgical mask. During an interview at that time, Resident 3 stated they had COVID-19 and it had resolved.</p> <p>&lt;Residents 2, 4, 5, 6, 7, and 8&gt;</p> <p>On June 10, 2025 a letter to the facility residents, family members and responsible parties was written by Staff A, Administrator. The letter was notified them the facility had another resident test positive with COVID-19 and they were symptomatic with common cold symptoms. Presently we have two in-house acquired cases which is considered by the Department of Health to be an outbreak. Operationally, we have implemented universal masking on our [NAME] wing. Our staff wear N-95 masks .</p> <p>Review of the COVID-19 Reporting Line Listing showed on 06/12/2025 Staff F, Nursing Assistant Certified (NAC), tested positive for COVID-19. Review of the facility investigative summary, June 2025, showed that Staff F cared for a resident who had a positive COVID-19 test result on 06/10/2025. The facility investigation identified the resident's who were assigned to Staff F's care on 06/12/2025, (Residents 2, 4, 5, 6, 7 &amp; 8) and obtained orders to monitor for signs and symptoms of COVID-19 due to recent exposure, every shift for five days. The investigation did not include contact tracing to identify other residents and/or staff that may have been exposed in the 48 hours prior to Staff F testing positive.</p> <p>On 06/25/2025 at 10:34 AM Staff C, Licensed Practical Nurse (LPN), Infection Preventionist, stated those (Residents and Staff) who were exposed were tested. When asked, Staff C stated they did not have a surveillance line list, or record of residents or staff who were tested. Staff C stated residents exposed were put on monitoring and should have been put on ACP for 5 days as a precaution.</p> <p>Review of the records of those identified as exposed, showed no TBPs, and no exposure testing were implemented for Residents 2, 4, 5, 6, 7, and 8.</p> <p>During an interview on 06/25/2025 at 2:03 PM, Staff D, LPN, Resident Care Manager (RCM), stated they don't test for COVID-19 unless the resident is symptomatic.</p> <p>&lt;Resident 9&gt;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of census records showed Resident 9 was admitted into Resident 8's room on 06/12/2025.</p> <p>Review of progress notes showed on 06/22/2025 Resident 9 started feeling crummy late last night, requested cough medicine. A COVID-19 test was done at that time due to symptoms and tested positive. The resident was placed on TBPs and interested parties notified.</p> <p>Review of the 06/23/2025 orders showed the resident was placed on ACP with instructions to staff to use appropriate PPE, including N95. All services provided to be provided in the room, including meals, therapy, activities, and nursing until 07/01/2025.</p> <p>On 06/27/2025 at 10:47 AM Resident 9's room was observed with posted ACP and the door was closed.</p> <p>&lt;Resident 10&gt;</p> <p>Review of census records showed Resident 10 admitted to the west wing on 06/14/2025.</p> <p>Review of the Treatment Administration Record (TAR) showed day 1 post admission COVID-19 Testing was conducted and negative on 06/15/2025, and day 7 post admission on [DATE].</p> <p>Review of progress notes showed on 06/22/2025 Resident 10 had a low temp beginning evening shift at 99.2 dF, resident was administered Tylenol, and reported feeling tired. According to the note a COVID-19 test was negative. A 06/23/2025 3:33 PM Physician Note showed Resident with a fever and cough, tested positive for COVID-19 just now. Orders for medications and TBP were written.</p> <p>On 06/25/2025 at 11:09 AM, Resident 10's room was observed with posted TBPs.</p> <p>&lt;Resident 11&gt;</p> <p>Review of census records showed Resident 11 was readmitted to the facility into a room with Resident 10 on 06/16/2025.</p> <p>After Resident 10 tested positive for COVID-19, orders were obtained 06/23/2025 to monitor Resident 11 for signs and symptoms of COVID-19 due to exposure on 06/23/2025. Review of the record showed no TBPs, and no exposure testing was implemented. Resident 11 was moved to a private room on 06/24/2025 at their family's request. On 06/25/2025 Resident 11 was transferred to the hospital at the resident's family's request.</p> <p>On 06/25/2025 at 12:24 PM, Resident 11's room was observed with posted ACPs. The door was closed with an Infection Control cart observed outside the door.</p> <p>&lt;Resident 12&gt;</p> <p>Review of census records showed Resident 12 readmitted to the facility on [DATE].</p> <p>Review of a 06/24/2025 Nursing Note showed Resident 12 was coughing overnight, the RN (Registered Nurse) swabbed for COVID-19 and the test was positive at 3:10 AM. The resident was placed on TBPs at that time. Orders for posted ACP to start 06/24/2025 until 07/05/2025.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/25/2025 at 10:47 AM Resident 12's room was observed with posted ACP and the door was closed.</p> <p>&lt;GROUP THERAPY, Residents 15, 16, 17 &amp; 13&gt;</p> <p>On 06/25/2025 at 10:53 AM, Staff I, Physical Therapy Assistant (PTA) was observed assisting Resident 15, without a mask, from their room, off the unit into a therapy room. Posted on the exit door was a sign directing staff to discard mask prior to leaving the unit. On the other side of the door was a posted Stop sign directing staff to to discard their masks in the garbage can. Staff I did not remove their mask and did not discard the mask in the garbage as directed.</p> <p>On 06/25/2025 at 10:58 AM, Staff I was observed ambulating down the hall and out the unit doors with Resident 16. Again Staff I did not remove and discard their mask.</p> <p>On 06/25/2025 at 11:00 A.M., Resident 17 was observed in the gym. At 11:01 AM, two other therapy staff brought another resident (Resident 13) into the gym, to work on the parallel bars. Resident 13 was not wearing a mask and was observed to cough at 11:06 AM.</p> <p>On 06/25/2025 at 11:05 AM there were four residents (Residents 15, 16, 17 &amp; 13) and four therapy staff observed in the therapy room, at the same time.</p> <p>In an interview on 06/25/2025 at 10:53 AM, Staff I stated they were doing concurrent therapy. Staff I stated they were told by their director and the director of the building that concurrent therapies were still okay, as long as they were different activities.</p> <p>On 06/25/2025 at 1:43 PM, Staff C stated for resident who tested positive for COVID-19 therapy was conducted in their rooms. The therapy gym was dedicated to west side of the building so the facility kept the gym open for non COVID-19 positive residents.</p> <p>&lt;Resident 13&gt;</p> <p>Resident 13 admitted to the facility on [DATE]. The admission day 1 COVID-19 test was negative.</p> <p>On 06/25/2025 at 11:01 AM, two therapy staff were observed assisting Resident 13 to stand up from their wheelchair and walk on the parallel bars in the gym. Neither staff was wearing gowns or gloves.</p> <p>On 06/25/2025 at 11:14 AM, posted outside Resident 13's door was a sign that the resident was on Enhanced Barrier Precautions (EBP). Review of the sign showed staff were directed do wear gloves and gowns for high-contact resident care activities, including transfers. There was no Infection Control Cart with Personal Protective Equipment (PPE - gowns, gloves, masks, etc.) in the immediate area within reach of staff.</p> <p>At 11:15 AM, Resident 13 was brought back to their room by a therapy staff. The staff positioned Resident 13 in their wheelchair with a pillow from the resident's bed, clipped the call light to the resident, rearranged the linen on the bed, moved the bedside table, and turned on the television, all without gloves or a gown. Prior to exiting the room, the staff washed their hands in the sink, turned off the water without a barrier, and then dried their hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 06/25/2025 12:20 PM Nursing Note, showed Resident 13 was noted with restlessness, runny nose and coughing, no fever or shortness of breath. COVID-19 test was done and was positive. Resident was immediately placed on TBPs.</p> <p>&lt;Resident 14&gt;</p> <p>Record review showed Resident 14 admitted to the facility on [DATE] with diagnoses including COVID pneumonia. On the day 1 post admission COVID-19 Testing scheduled for 06/07/2025, Resident 14 tested positive. According to the progress notes, the facility placed the resident on ACP starting 06/07/2025, but review of the Physician Orders showed a start date of 06/09/2025. On the day 7 post admission COVID-19 testing, Resident 14 tested negative, and the facility discontinued TBPs.</p> <p>On 06/25/2025 at 10:50 AM, Staff G, NAC, entered Resident 14's room which was located on the dedicated COVID-19 unit without a N95 or wearing any mask.</p> <p>&lt;Resident 15&gt;</p> <p>On 06/25/2025 at 12:21 PM, Resident 15 was observed seated in the hallway, without a mask, next to the nurses medication cart. Staff had served the resident their lunch meal and prepared them to eat in the hallway.</p> <p>&lt;Resident 18&gt;</p> <p>Review of a 06/19/2025 Nursing Notes showed Resident 18 was up in wheelchair out in the hall working with therapies. Similar notes on 06/20/2025. Resident continued working with therapies on 06/22/2025, 06/23/2025, and 06/24/2025. Review of a 06/26/2025 Physician Note showed Resident 18 was one among other residents tested positive for COVID-19 in the building today., Resident 18 claimed they started having some cough three days ago .</p> <p>On 06/25/2025 at 10:47 AM, three staff were observed in the unit's activity room seated at a table. The staff were holding masks in their hands, not wearing masks. During an interview on 06/25/2025 at 1:59 PM, Staff C stated they were holding Orientation in the Activity Room. Staff C stated they noted the staff were not wearing masks and they corrected them.</p> <p>On 06/25/2025 at 10:51 AM, Staff H, Registered Nurse, was observed wearing a KN95 (respirator not approved for use in healthcare settings). On 06/25/2025 at 1:43 PM, Staff C, stated they checked the daily staffing on the unit to ensure they were fit tested. Staff C stated Staff H was up to date with their fit testing. Review of the paperwork showed Staff H was fit tested on [DATE]. When informed Staff H was not wearing the N95 they were fit tested for, Staff C stated they would take care of that. On 06/25/2025 at 2:16 PM, Staff H, was observed wearing a N95, but not the one they were fit tested for.</p> <p>On 06/25/2025 at 1:43 PM, Staff C stated staff on the unit were expected to wear a N95 when they entered and exited the unit. Staff were also expected to replace their N95 respirators when they entered and exited COVID-19 positive rooms (on posted ACPs). Staff C stated when the outbreak started broad based testing on the unit should have been performed on days one, three and five.</p> <p>On 06/25/2025 at 2:16 PM, Staff J, NAC, was observed sitting at the nurses station wearing a KN95.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/25/2025 at 2:18 PM, Staff K, RN, was observed at the medication cart with Staff H. Staff K was wearing only a surgical mask. In an interview at that time, Staff K stated they just walked onto the unit and found out they needed a N95. Staff K stated they entered the unit from an outside door in the activity room.</p> <p>On 06/25/2025 at 2:22 PM, the door from the unit activity room to the outside was observed in the company of Staff D. The door had a key pad for a code to enter and exit. The door opened and an alarm sounded when Staff D entered the building. There was no sign posted informing staff that they were entering a COVID-19 unit and/or that they would need to put on Personal Protective Equipment (PPE) prior to entering.</p> <p>On 06/25/2025 at 2:33 PM, Staff L, LPN, was observed wearing a N95, but not the one they were fit tested for. When questioned, Staff L stated they would change it and left the unit looking for a different N95.</p> <p>On 06/25/2025 at 2:46 PM, Staff B, Director of Nursing stated they facility would start monitoring and training all staff immediately.</p> <p>REFERENCE: WAC 388-97-1320 (1)(a), (2)(b).</p>		