STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505211	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puyallup Nursing and Rehabilitation Center	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)
F 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treat residents equally regarding transfer, discharge, and provision of services for all residents, regardless of payment source Based on observation, interview and record review, the facility failed to ensure there was no discrimination against Medicaid funded residents and failed to ensure Medicaid residents were not being discharged because of payment source. These failures caused residents to not have the right to stay in the facility or to be discharged to a facility that they did not want to live in.Findings included . Review of the Nursing Home Facility License Application, dated 07/23/2025, showed a requested Change of Ownership (CHOW), to go into effect on 10/01/2025. The application indicated the purchasing entity was applying for Medicaid Certification (Medicaid Contract). A Notice of Change in Operations letter was addressed to All Puyallup Nursing and Rehabilitation Center Residents, Families and [NAME] of Attorney dated July 24, 2025. The letter was notification that the facility would be sold effective October 1, 2025. Review of the letter showed the purchasing company brought a reputation of Focusing on being the best long-term care and senior living provider . Additionally the statement, Please be assured that there will be no disruption in your care . Review of the new owner's undated admission Agreement showed a change in facility name to Puyallup Post Acute (PPA). The options for the terms of the agreement were only for Month-to-Month or Respite/Short Term Stay. Review of the facility website on 01/15/2026, showed the facility services included Skilled Nursing, Rehabilitation Services, Resident-Centered Activities, and Social Services. The website did not include Long-Term Care (LTC) Services. During an interview on 01/21/2026 at 2:02 PM, Staff A, Administrator stated they had not changed the facility practices. Staff A stated they discharge more than LTC Medicaid Residents, We discharge all kinds of residents. When asked if the facility accepted and retained LTC Medicaid residents, Staff A stated it depended as each resident was different and added they start discharge planning process on admission. During an interview on 01/21/2026 at 11:20 AM, Staff B, Director of Nursing Services, stated social services went and sought out residents who were willing to transfer to other SNFs (Skilled Nursing Facilities), to increase the availability to provide services to the community. Staff B stated they were putting residents on skilled care on the East wings, which previously was LTC. Review of the 01/21/2026 census showed East Short had 18 residents, 14 of which were Medicaid, East Long had 26 residents, 15 of which were Medicaid. Review of Nursing Home discharges from 01/01/2026 to 01/21/2026 showed 9 Residents were discharged to nursing homes, all 9 of them were Medicaid.During an interview on 01/13/2026 at 4:39 PM, an Administrator and DNS from another Nursing Home where residents were being transferred, stated the discharging facility was referring (transferring) Medicaid residents because they now only accepted Medicare residents, not Medicaid, and were making room for more skilled residents. They understood that the discharging facility wanted to increase skilled care and were sending LTC residents to other facilities; they were trying to transition to skilled care only. Review of Resident 1's electronic health record (EHR) showed their primary payor source was Medicaid. During an interview on 01/14/2026 at 4:24 PM, Resident 1's representative stated Staff C told them the facility was no longer going to do (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 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LTC, only rehabilitation, since the change of ownership. During an interview on 01/15/2026 at 1:12 PM, Resident 1's Emergency Contact #2 stated they were told the side of the building Resident 1 was on was Long-Term Care and they had to be discharged . Review of Resident 2's EHR showed their primary payor source was Medicaid. During an interview on 01/15/2026 at 1:38 PM, Resident 2's family member stated they understood the facility was a rehabilitation facility and when the residents reached full potential they would be discharged . The stated it was a short term care facility and no longer a long term care facility. During an interview on 01/16/2026 at 10:06 AM, the Nursing Facility Case Manager (NFCM) stated the new ownership wanted to run the facility like a rehabilitation place, admit as many resident's as they could to fill the beds, then they want to discharge them as soon as possible. During an interview on 01/21/2026 at 10:41 AM, Staff C, Social Services Director, stated they were working on discharge planning options for everyone. During an interview on 01/21/2026 at 11:59 AM, Staff D, Licensed Practical Nurse (LPN), East Resident Care Manager (RCM), stated they were trying to find placement closer to the LTC residents' families, for those residents who were stable and did not need to be in the nursing facility. During an interview on 01/21/2026 at 12:08 PM, when asked why the facility was discharging the LTC Medicaid Residents, Staff E, LPN, RCM, stated that if the resident was stable, and did not need skilled care, they were being transitioned. Staff E stated the facility was moving to a skilled nursing facility, increase the skilled beds. During an interview on 01/21/2026 at 12:39 PM, Resident 4 was aware of where they were discharging to. When asked why they were discharging, Resident 4 stated, They don't want me here. I'm a long-term and they said long-term don't belong. Review of Resident 4's EHR showed their primary payor source was Medicaid.During an interview on 01/21/2026 at 12:46 PM, Resident 10 stated they asked to speak to a social worker because they were moving so many people out they just assumed they would be moving them out too. Resident 10 stated they had been in the facility a couple of years and had no intention of leaving. Review of Resident 10's EHR showed their primary payor source was Medicaid.During an interview on 01/21/2026 at 1:04 PM, Resident 12 stated the facility was getting rid of all the long-term care residents. Resident 12 stated the facility had approached about half of the residents, but had not provided written notices. Resident 12 stated they were a long-term care resident and they were concerned that they would get a phone call eventually asking them to leave, I haven't been called yet, I'm very upset about those that have.In an interview on 01/21/2026 at 1:21 PM, Resident 13's POA stated on Monday (01/19/2026) they received a call from Staff C that they were turning the facility into post acute care and Resident 13 could not stay there as she was not receiving any services. Resident 13's POA stated when the facility was purchased in October 2025 they didn't say they were rehabilitation only. Review of Resident 13's EHR showed their primary payor source was Medicaid.During an interview on 01/21/2026 at 3:55 PM, Resident 11's POA stated the social worker called them and told them the new company wanted to transition to rehabilitation, where residents came in, received rehabilitation and then discharged . Review of Resident 11's EHR showed their primary payor source was Medicaid.During an interview on 01/22/2026 at 3:25 AM, Resident 10's representative stated Resident 10 called in a panic that LTC residents were being moved out of the facility and they were afraid. During an interview on 01/23/2025 at 9:35 AM, an Admissions coordinator from a Nursing Home that had accepted residents from the facility stated they understood the facility was closing down their Long-Term Care and were no longer taking LTC residents. During an interview on 01/23/2026 at 9:43 AM, Resident 8 stated the facility was only going to have short term, they were not going to have long-term residents anymore. Review of Resident 8's EHR showed their primary payor source was Medicaid.During an interview on 01/23/2026 at 10:02 PM, Resident 7's POA stated the facility had been sold and they were now (continued on next page)

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F 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only a short term facility. Review of Resident 7's EHR showed their primary payor source was Medicaid.Refer to F627 Inappropriate Discharge and F628 Discharge ProcessREFERENCE: WAC 388-97-0040 (5)(c)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to permit each resident to remain in the facility and involuntarily discharged 8 of 9 residents (Resident 1, 2, 3, 4, 5, 6, 7 & 8) reviewed for Nursing Home transfers without documentation of the basis for the transfer, and provision of sufficient time and orientation prior to discharge. In addition, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals and was reflected in the plan of care. This failure placed residents at risk of displacement, discrimination based on ability to pay for services, and a decreased quality of life. Findings included .Review of the facility admission Skilled Nursing Facility (SNF) admission Agreement, undated, showed the facility could involuntarily discharge residents by providing written notice to Resident or the Resident Representative for one or more of the following reasons: 1. Resident's documented medical needs cannot be met in the facility; 2. Resident's health improves sufficiently so Resident no longer needs the services provided by the facility; 3. If appropriate to safeguard or other residents from physical or emotional injury; 4. The health of individuals in the Facility would otherwise be endangered; 5. Resident fails, after reasonable and appropriate notice, to pay for charges for Resident's care and stay at the facility; 6. The facility ceases to operate; or 7. Federal or state law otherwise allows. Except for an emergency involving resident health or well-being, no resident shall be transferred or discharged without prior consultation with the resident, their family or representative, and the resident's attending physician. RESIDENT 1Resident 1 interviewed 01/13/2026 at 4:06 PM, stated they were told the facility wanted to change their room to an office or something else. Resident 1 stated they were only given an option to go to a nursing home or another care unit.On 01/12/2026 at 12:44 PM, Resident 1's representative stated they received a phone call 01/08/2026 stating that the facility was no longer taking Long-Term Care (LTC) residents and stated the resident would be transferred to a SNF in Enumclaw or Federal Way.During an interview on 01/13/2026 at 4:06 PM, Resident 1 stated they liked it at their discharging facility, was very comfortable, liked their roommate and they were friends. Resident 1 stated they would have liked to stay, they liked the people and knew the staff, I was happy there and felt at home. Resident 1 stated their friends and church were in Puyallup close by so could visit. In an interview on 01/14/2026 at 4:24 PM, Resident 1's Representative stated they did not want to move Resident 1. As a result of the move, Resident 1 was upset, disoriented a bit and was afraid people wouldn't visit.During an interview on 01/15/2026 at 1:12 PM, Resident 1's Emergency Contact #2 stated, They didn't ask us, they just said she was moving.During an interview on 01/21/2025 at 12:33 PM, Resident 9 (Resident 1's former roommate), stated they came in one night around 4:00 PM and told Resident 1 they were being moved to Enumclaw the next day. Resident 9 stated that Resident 1 was surprised. Review of Resident 1's Care Plan (CP), 12/15/2025, showed Resident 1 wanted to stay at the facility for long-term care.Review of the Department Service Episode Record showed a 12/18/2025 entry that confirmed Resident 1 had no current discharge plan would continue to stay a a long term care resident at Puyallup NH.Review of the Nursing Home Transfer or Discharge Notice (NHTDN) dated 01/09/2026 showed Resident 1 was being transferred on 01/09/2026, and the transfer was appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility.Review of a Discharge Plan of Care, dated 01/09/2026, showed Resident 1 was discharged on 01/09/2026 to another skilled nursing facility by facility bus.During an interview on 01/21/2026 at 10:25 AM, Staff C, Social Services Director, stated they worked with the Resident's Representative, and the resident. When asked why (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 was discharged , Staff C stated, That's the discharge plan we landed on. Staff C stated the resident's representative was aware of the discharge. RESIDENT 2During an interview on 01/13/2026 at 4:20 PM, Resident 2 stated moving was not their idea. Resident 2 said they were told they were going back to [NAME], but they did not have a room available so they [NAME] me here (admitting nursing facility). Resident 2 stated, I wanted to go home, but they brought me here instead. Resident 2 stated they did not get to pack up their own belongings and were missing some items Resident 2 appeared distressed, fixated on their belongings, looking back and forth at boxes and bags in their room. In an interview 01/15/2026 at 10:54 AM, Resident 2's representative stated Resident 2 would probably not have wanted to move. Resident 2 loved the programs at the discharged facility. Resident 2's representative stated Resident 2 needed to have someone help to make decisions as Resident 2 would not know how to advocate for themselves. Resident 2's representative stated the move was a shock to Resident 2 as they thought they were heading to [NAME] Iowa. Resident 2's representative stated they, their mother, and church members were all in Puyallup and Resident 2 was moved far away, making it difficult to visit, We're all she's got.During an interview on 01/15/2026 at 1:38 PM, Resident 2's sister stated the facility did not say why they were moving Resident 2, just that they were moving. Resident 2 would not have been able to make the decision to move as their cognition comes and goes. Resident 2 thought they were going to [NAME]. Resident 2's sister stated Resident 2 had lived at the facility since 2018 or 2019. Resident 2's sister said they asked if the admitting facility was closer or further away from Resident 2's Power of Attorney (POA), and was told they would be 20 miles closer. (The admitting facility is 20 plus miles further away). All of Resident 2's church people and friends live in Puyallup, and they lived there for over 30 years, it is their home ground. Resident 2's sister stated for the elderly moving was very traumatic, and they get disoriented quickly when they don't know where they are.Review of a Discharge Plan of Care, dated 01/03/2026, showed Resident 2 discharged to another skilled nursing facility, by a transport service. Recapitulation of stay showed Resident 2 was a long-term care resident.Review of the face sheet showed Resident 2 admitted in 2022 and resided in the facility for 2,503 days before being discharged on 01/03/2026.During an interview on 01/21/2026 at 10:25 AM, Staff C stated Resident 2 stated they wanted to go to [another city]. During an interview on 01/13/2026 at 4:39 PM, the admitting facility's Administrator and Director of Nursing Services stated the discharging facility was referring (transferring) Medicaid residents because they (new company for discharging facility) now only accepted Medicare residents, not Medicaid, and were making room for more skilled residents. They understood that [new company for discharging facility] wanted to increase skilled care and were sending LTC residents to other facilities. They said they heard [new company for discharging facility] were trying to transition the building to skilled care only. RESIDENT 3Review of Resident 3's CP, dated 08/12/2019, showed Resident 3 wished to reside LTC in the current facility. Review of the census showed Resident 3 resided in the facility since 2017. Review of the Admission/Discharge list, dated for January 2026, showed Resident 3 was transferred to a nursing home on [DATE]. Review of a Discharge Note, dated 01/16/2026 at 11:51 PM, showed, Resident 3 discharged to another facility. Reviewed discharge instruction and medications with husband. Husband verbalized understanding. Resident propelled in wheelchair pushed by husband to facility transport. Facility to send belongings to new facility.During an interview on 01/21/2026 at 10:41 AM, Staff C stated Resident 3 and their representative wanted to stay locally, in Puyallup so they transferred them to another nursing home in Puyallup. When asked why Resident 3 did not remain at the facility, Staff C stated, We're working on discharge planning options for everyone. When asked if resident's could remain in the facility, Staff C stated if it was appropriate, that they (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required nursing home level of care, then yes they could. Again, when asked why LTC resident's were being discharged , Staff C stated, I'm working with residents and family. RESIDENT 4Review of the Department of Home and Community Service Case Management Service Notes, dated 12/18/2024. showed the resident was staying LTC at the facility with no current discharge plan since 02/29/2024. The resident's case was inactive for no current discharge plan. Review of Resident 4's CP, dated 12/24/2025, did not show a documented discharge care plan. During an interview on 01/21/2026 at 11:01 AM, Staff C stated Resident 4 was discharging to another NH in Puyallup today. Staff C stated they had been working with Resident 4 and their family. During an interview on 01/21/2026 at 12:39 PM, Resident 4 stated they were told they would be shipped out at 10:00 AM and it was 12:30 PM but they were still there. Resident 4 was aware of where they were discharging to. When asked why they were discharging, Resident 4 stated, They don't want me here. I'm a long-term and they said long-term don't belong. Resident 4 stated they had moved into the facility approximately three years prior and were planning on staying at the facility. When asked why they chose the facility they chose to be discharged to, Resident 4 stated they didn't, the facility staff chose it because there was an opening there. Resident 4 stated they were told it was the only place with an opening unless they wanted to go to Tacoma and they did not want to go to Tacoma. RESIDENT 5Review of Resident 5's CP, dated 10/28/2025, did not show a discharge plan of care. Review of the progress notes, dated 01/13/2026, showed Resident 5 was discharged to a SNF in Tacoma. Review of Resident 5's electronic health record (EHR), showed Resident 5 was admitted to the facility on [DATE] for nursing and rehab services. Resident 5 had come off skilled services and was transported in the facility bus, to a SNF which was closer to family friend that visited often. During an interview on 01/21/2026 at 10:53 AM, Staff C stated they were working with Resident 5 and their friend to move Resident 5 to a nursing home closer to his friend for a shorter commute. During an interview on 01/23/2026 at 10:11 AM, Resident 5 stated they did not request to move, they were told they were moving. Resident 5 stated they were not given a choice of facility to discharge to. Resident 5 stated their discharge goal was return to their house with their girlfriend. During an interview on 01/23/2026 at 11:38 AM, Resident 5's friend stated the facility said they had to move, they were not given a choice. The move was quick and they did not even have a chance to go pack up Resident 5's belongings, they just put them in the van and took them. RESIDENT 6Review of Resident 6's EHR showed Resident 6 resided in the facility since February 2019.Review of the CP, dated 09/11/2025, showed Resident 6 wanted to stay at the facility for long-term care. Review of a Discharge summary, dated [DATE], showed the facility transported Resident 6 to another SNF. During an interview on 01/21/2026 at 10:53 AM, when asked why Resident 6 had to move, Staff C stated they let them know what their discharge options were. When asked again, Staff C stated, I'm just offering .if they wanted to. During an interview on 01/23/2026 at 10:19 AM, Resident 6 stated they did not even know they were moving until the morning they moved. Resident 6 stated they received no written notice, and was not given a choice of discharge location. When asked if they wanted to return, Resident 6 stated, No, they're mean people. RESIDENT 7Review of Resident 7's CP, dated 11/05/2025, did not show a discharge plan of care. Review of the Discharge summary, dated [DATE], showed the facility transported Resident 7 to another SNF. The recapitulation of stay showed Resident 7 was at the facility for rehab, had completed their skilled stay and was unable to return to their prior level of living. The resident was discharged to a SNF for long term care. During an interview on 01/21/2026 at 10:53 AM, Staff C stated Resident 7's daughter was at the facility, they previously lived together in an apartment and they wanted to be together so Resident 7 was discharged there. During an interview on 01/23/2026 at 9:53 AM, Resident 7 stated they were told they were only short term care and (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were sending them to another nursing home for long term care. Resident 7 stated their POA was in a SNF and acknowledged they wanted to be with them. The facility said that since the facility was short term, they had to go there to be with their daughter. During an interview on 01/23/2026 at 10:02 AM, Resident 7's POA said Resident 7 called them around 7:30 AM and told them the facility wanted to move Resident 7 to a NH in Puyallup or in Tacoma. Resident 7's POA stated they called the facility who told them the facility tried to tell Resident 7 the building had been sold, they were a short term facility now and they were moving Resident 7 that morning. Resident 7's POA stated the facility told them Resident 7 had to leave, that they couldn't stay as it was short term. RESIDENT 8Review of Resident 8's CP, dated 12/16/2025, showed the resident's discharge plan was to discharge to an Assisted Living Facility or an Adult Family Home. Their listed discharge goal was to return home with their roommate. Review of the Discharge summary, dated [DATE], showed Resident 8 was transported in the facility bus to another SNF. Review of the recapitulation of stay showed the resident was admitted for skilled nursing and therapy services, was currently Long-Term Care Medicaid at facility and was transferring to another SNF. During an interview on 01/21/2026 at 10:53 AM, Staff C stated Resident 8 was at the facility for therapy. Staff C stated they worked with Resident 8, offered options of where to go, offered a community assessment, all of which the resident declined and chose the SNF in Tacoma. During an interview on 01/23/2026 at 9:43 AM, Resident 8 stated the facility moved everybody as they're not going to have long-term care residents anymore. Resident 8 stated they were not given a choice of discharge options, they picked one and moved me. Resident 8 stated one day they came in and told them they were making the facility short term and the next day at 9:00 AM someone came in, boxed me up and took me out. Resident 8 denied asking to move. They said they wanted to return home with their roommate, but they moved in with their girlfriend, so now their goal was to move into Assisted Living or an Adult Family Home. During an interview on 01/21/2026 at 12:08 PM, Staff E, Licensed Practical Nurse (LPN), Resident Care Manager (RCM), stated they were not discharging the residents who did not want to leave, as evidenced by they accepted to go somewhere else. During an interview on 01/21/2026 at 2:02 PM, Staff A, Administrator stated that no one had been discharged without agreeing and that they would not discharge people that were not agreeable. Refer to F621 Equal Practices Regardless of Payment Source and F628 Discharge Process.REFERENCE: WAC 388-97-0120 (1)(2).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written transfer notification to the resident/resident representative and notify the Office of the State Long Term Care Ombudsman (LTCO - resident advocates) for 9 of 16 sample residents (Residents 1, 2, 4, 5, 6, 7, 8, 11 & 13) reviewed for Nursing Home Transfers. Failure to notify the LTCO and ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk of a lack of advocacy for not having an opportunity to make informed decisions about their transfer/discharge rights.Findings included .Review of the facility admission Skilled Nursing Facility (SNF) admission Agreement, undated, showed the facility could involuntarily discharge residents by providing written notice to Resident or the Resident Representative for specific stated reasons. According to the agreement, except for an emergency involving resident health or well-being, no resident shall be transferred or discharged without prior consultation with the resident, their family or representative, and the resident's attending physician. If a resident was to be involuntarily discharged from or transferred from the facility, the Facility would provide thirty (30) days' advance written notice to Resident and Resident's Representative .The written notice of transfer shall state the reason for the discharge or transfer and Resident's right, if any, to appeal the transfer or discharge. The facility may not transfer or discharge Resident while an appeal is pending unless failure to discharge or transfer would endanger the safety of Resident or other individuals at the Facility. RESIDENT 1In an interview on 01/14/2026 at 4:24 PM, Resident 1's representative and Emergency Contact #1 stated the facility called them 01/08/2025 to tell them they were moving Resident 1 as they no longer were going to provide long-term care (LTC), only rehabilitation services. The facility called them later that afternoon and told them they were moving Resident 1 the next day. Resident 1's representative stated they did not receive 30 days notice as required and a 24 hour notice was not adequate.During an interview on 01/15/2026 at 1:12 PM, Resident 1's Emergency Contact #2 stated around 4:30 pm on 01/08/2026 the facility told Resident 1 that they were moving the next day. Resident 1's Emergency Contact #2 stated Resident 1 had no time to adjust. Review of the Nursing Home Transfer or Discharge Notice (NHTDN), dated 01/09/2026, showed Resident 1 was being transferred on 01/09/2026, the date documented the notice was given was 01/08/2026. During an interview on 01/21/2026 at 10:25 AM, Staff C, Social Services Director, stated they gave a NHTDN to all resident's at discharge as they were part of the discharge packet. After review with the resident/family the form was uploaded into the resident's electronic record. RESIDENT 2In an interview on 01/13/2026 at 4:39 PM, the Admitting Facility (AF) DNS stated they were aware that Resident 2's Power of Attorney (POA) was not notified of the move.In an interview 01/15/2026 at 10:54 AM, Resident 2's representative stated they did not know Resident 2 was moved until they received a call from the admitting facility asking them to go sign papers. Up and moving her without letting us know was not acceptable. Resident 2's representative stated it was a shock to Resident 2. During an interview on 01/15/2026 at 1:38 PM, Resident 2's sister stated they were called by the facility around 6:30 PM saying they had found a LTC facility for Resident 2 who would be moved the next day. Resident 2's sister stated they asked the facility if they were aware that Resident 2 had a POA, and they said yes they were aware.Review of progress notes showed a 01/02/2026 entry that the Social Worker called Resident 2's sister and informed them they had an accepting long term facility that had accepted resident. Resident sister was in agreeance of transfer to {another nursing facility.] A 01/03/2026 Nurses Notes showed Resident 2 was discharged from the facility. During an interview on 01/21/2026 at 10:25 AM, Staff C, stated the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505211	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puyallup Nursing and Rehabilitation Center	516 23rd Ave SE Puyallup, WA 98372

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