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	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puyallup Post Acute	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 4 of 4 residents (Residents 1, 2, 3 & 4) reviewed for insurance disenrollment were informed of the risks/benefits, options, and alternative changes in their insurance, in ways that were easy for the residents and/or the residents' representative to understand. The facility failed to develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage, including the need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that they understood the information. Failure of the facility placed residents at risk of non-coverage, increased cost out of pocket, and caused undue stress to residents and/or resident representatives and placed 13 Managed Medicare residents at risk of the facility disenrolling them without their request, consent knowledge or complete understanding.Findings included.Review of the undated, Skilled Nursing Facility admission Agreement showed that the facility was an in-network provider for some Medicare Advantage Plans. If a Resident's care was covered by a Medicare Advantage Plan (Managed Medicare), Resident's skilled nursing care was managed through the insurance company. The needs and services were authorized and managed by the insurance provider's case managers and physicians. The facility participated in the Medicare program. If eligible, Medicare would pay 100% of Resident's costs in a semi-private room for the first twenty (20) days. The next eighty (80) days were known as coinsurance days, which meant the Resident was responsible for paying coinsurance on day 21 forward. According to the admission Agreement, the facility assured Residents all the rights in the Resident's [NAME] of Rights.Review of undated, Resident's [NAME] of Rights, showed the residents had the right to be informed, in advance, of risks and benefits of proposed, care, treatment, treatment alternatives, options and to choose the option they prefer. Additionally, Residents had the right to self-determination, and to manage their financial affairs.<RESIDENT 1>Review of Resident 1's record showed they admitted [DATE] on a Managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident was explained orally and in writing the impact to the beneficiary if they changed coverage.During an interview on 05/19/2026 at 1:09 PM, Resident 1's representative stated they disenrolled from their Managed Medicare plan to Traditional Medicare at the suggestion of facility Social Services Staff. Resident 1's representative stated they were not told if they changed insurance that after 20 days they would have to pay co-insurance. Resident 1's Representative stated their payment was only one (1) dollar different with the two plans, so if they had known, they would not have gone through with it. They said they were also not informed that that when they re-enrolled it would only be effective on the first day of the month, which increased their stress trying to coordinate Resident 1's discharge to ensure they had insurance coverage. Resident 1's representative stated they were not provided with and did not sign any related documents from the facility.During an interview on 05/19/2026 at 1:40 PM ,Staff C, Medical Doctor (MD), stated Resident 1's representative came to them in tears, as they had only 30 days to revert to Managed Medicare, and it had been 20 or 21 days. They had not been informed of the consequences, for (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	example, the Managed Medicare plan was paying for Resident 1's cancer treatments, and with Traditional Medicare they had to pay co-insurance.During an interview on 05/19/2026 at 1:58 PM, Staff D, Business Office Manager, stated Resident 1's Managed Medicare plan paid the same rate as Traditional Medicare, but they often issued Notice of Non-Coverage sooner.<RESIDENT 2>Review of Resident 2's record showed they admitted [DATE] on a Managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Further reviews showed no documentation to support the resident was explained orally and in writing the impact to the beneficiary if they changed coverage.During an interview on 05/20/2026 at 11:57 AM, Resident 2's representative confirmed they recently disenrolled from their Managed Medicare plan at the suggestion of the facility social services staff. Resident 2's representative was unsure if they had a co-pay with Traditional Medicare as that was not disclosed to them. They said they did not have co-pays with their Managed Medicare unless they went out of market. They voiced concerns as they wanted to reenroll in their Managed Medicare plan at discharge but did not know if they had to start all over, pay for prescriptions, I don't know how it works. Resident 2's representative denied receiving information in writing or signing any documentation prior to disenrolling.<RESIDENT 3>Review of Resident 3's record showed they admitted [DATE] on a Managed Medicare plan and transferred to Traditional Medicare effective 05/01/2026. Review of the Managed Medicare plan insurance verification showed the facility was Out-of-Network. Further reviews showed no documentation to support the resident was explained orally and in writing the impact to the beneficiary if they changed coverage.During an interview on 05/20/2026 at 11:06 AM, Resident 3 confirmed they recently disenrolled from their Managed Medicare plan. When asked if someone had talked to them about it beforehand, Resident 1 stated, No, not that I know.During an interview on 05/20/2026 at 1:11 PM, Resident 3's representative stated if the facility left Resident 3 on Traditional Medicare, then they wound have a secondary (supplemental coverage), I hope they switch them back.<RESIDENT 4>Review of Resident 4's record showed Resident 4 was admitted on Managed Medicare then transitioned to Medicaid. There was no documentation of conversations with the resident regarding their insurance.During an interview on 05/20/2026 at 11:09 AM Resident 4 stated the facility staff talked to them about secondary insurance that would cover their stay, but not about who or what. They told me they wanted to make sure what my social security number was because it didn't match, so I had to verify that with them. Resident 4 stated, I didn't understand that either.During an interview on 05/20/2026 at 1:20 PM, Staff A, Administrator, stated the facility social services/case management staff would provide the residents and/or representatives information. Staff A stated it was a conversation and they did not know of any specific paperwork they would review.During an interview on 05/20/2026 at 2:29 PM, Staff A stated they did not have a Policy and Procedure regarding assisting beneficiaries with changing their health care coverage, but they did find a letter they should be providing to them. Staff A stated they did not believe the facility staff were providing the form as it was not readily available.Review of the undated information sheet entitled, Disenrollment from Medicare Advantage and Enrollment in Traditional Medicare showed that switching from Medicare Advantage to Traditional Medicare would likely impact deductibles, co-pays/coinsurance and may result in loss of supplemental coverage. Enrollment in Traditional Medicare will not include prescription drug coverage. Enrollment in the new Medicare health or drug plan will be effective the first day of the month following the plan's receipt of the enrollment request.REFER TO: WAC 388-97-0260, -0300(3)(a)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. Based on interview and record reviews, the facility failed to protect 4 of 4 residents' rights to Medicare benefits. The facility disenrolled three (Residents 1, 2 & 3), and attempted to disenroll one (Resident 4) beneficiaries from Medicare Managed Health Plans without their request, consent, knowledge and/or complete understanding. The facility failed to develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage, including the circumstances under which the facility could assist a beneficiary with a plan change, and the need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change. Failure of the facility placed residents at risk of non-coverage, increased cost out of pocket, and caused undue stress to residents and/or resident representatives and placed 13 Managed Medicare residents at risk of the facility disenrolling them without their request, consent knowledge or complete understanding.Findings included.Review of the undated, Skilled Nursing Facility (SNF) admission Agreement, showed that the facility assured Resident all the rights in the Resident's [NAME] of Rights. Review of the attached, undated, Resident's [NAME] of Rights, showed the residents have the right to be free of interference, coercion, discrimination, and reprisal from the facility.<RESIDENT 1>During an interview on 05/19/2026 at 1:09 PM, Resident 1's representative stated the facility social services staff told them it was better to be on traditional Medicare (Med A) while in a SNF, so the facility would transfer Resident 1 to Traditional Medicare and when they were discharged the facility would automatically transfer the resident back to their Managed Medicare program. Resident 1's representative stated they since had questions and tried to talk to the facility social services staff, but they were off duty, so they came in early to meet with Staff A, Administrator, but were told they were on vacation. Resident 1's representative stated they received a letter from their Managed Medicare plan indicating they had disenrolled, and if this was in error to call immediately. Resident 1's representative called, met with an insurance representative, and planned to have their insurance reinstated effective June 1st.During an interview on 05/19/2026 at 1:40 PM Staff C, Medical Doctor (MD), stated Resident 1's representative came to them in tears, having been told by facility staff to disenroll from Managed Medicare, transfer to Traditional Medicare and when out of the facility to re-enroll in Managed Medicare. Staff C stated Resident 1's representative called their prior insurance and was re-enrolling in their Managed Medicare.<RESIDENT 2>During an interview on 05/20/2026 at 11:57 AM, Resident 2's representative confirmed they recently disenrolled from their Managed Medicare plan. Resident 2's representative stated facility staff approached them, but they could not recall the name of the staff. Resident 2's representative stated the facility told them that by going with Traditional Medicare it would cover more of Resident 2's therapy sessions, and when they got better and left, then they could re-enroll in their Managed Medicare plan. Resident 2's representative stated Resident 2 was in pretty rough shape at the time and all they thought about was them and their needs. Resident 2's representative stated they were planning to talk to someone as Resident 2 was planning to discharge soon and they wanted to find out if the facility was going to switch them back as they said they would.<RESIDENT 3>During an interview on 05/20/2026 at 11:06 AM, Resident 3 confirmed they recently disenrolled from their Managed Medicare plan. When asked if they consented to the change, Resident 3 stated, I don't know and added, I get calls all the time about Medicare. During an interview on 05/20/2026 at 1:11 PM, Resident 3's representative stated they were not aware Resident 3 had been disenrolled until after the fact, noting that the facility chose it upon themselves to do it. Resident 3's representative confirmed they did not request the change. They were informed during a meeting that when residents were in a SNF, the facility change (their insurance) and will change it back when they were discharged . Resident 3's representative did not recall who at the facility told them.During an interview on 05/20/2026 at 1:00 PM, Staff E, Director of (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rehabilitation, stated they provide the same number of days and minutes of therapy with both Managed and Traditional Medicare plans. Staff E stated at the beginning of the month they were told three residents (1, 2 & 3) changed insurances and to schedule new evaluations.<RESIDENT 4>During an interview on 05/20/2026 at 11:09 AM Resident 4 stated their Managed Medicare plan notified the facility they were discontinuing their healthcare coverage and they weren't going to get therapy anymore. The facility staff talked to them about a secondary insurance that would cover their stay, but not about who or what. Resident 4 stated they told them they wanted to make sure what their social security number was because it didn't match, so they had to verify that with them.During an interview on 05/19/2026 at 1:58 PM, Staff D, Business Office Manager, stated the facility tried to assist Resident 4 to switch over to Traditional Medicare, but there were issues with their social security number.During an interview on 05/20/2026 at 1:20 PM, Staff A, Administrator, stated when a resident is served a Notice of Non-Coverage from their insurance, exhaust appeals and still want to receive therapy, they may change insurance coverage to see if they can get more therapy.During an interview on 05/20/2026 at 1:20 PM, Staff A stated the decision for disenrollment had to be resident led, they could choose to or not to. Staff A stated, We can't tell them to go on one insurance or another. When asked how the above residents would be reenrolled in their Managed Medicare plan, Staff A stated, if at any time they want to go back, they have to tell them and they would help. When asked if it would occur automatically at discharge, Staff A stated, no, they had to request the change and ask for help.Review of an undated, Disenrollment Consent Form, provided by Staff A on 05/20/2025 at 2:29 PM showed, if signed by the Resident Beneficiary, and/or Representative, it would attest the beneficiary or representative requested the change and consented to the disenrollment with the assistance of the facility.Review of Resident 1, Resident 2, and Resident 3's record showed no consent forms, or other documentation to support the beneficiary or representative requested the change.During an interview on 05/20/2026 at 2:29 PM, Staff A stated they did not have a Policy and Procedure regarding assisting beneficiaries with changing their health care coverage, but they did find the above document they should be providing them. Staff A stated they did not believe the facility staff were providing the form as it was not readily available.REFER TO: WAC 388-97-0040(2), -1780(1)(2), -0180(4)(c)