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	08/16/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review the facility failed to have psychotropic medication (medications that affect a person's mental state) consents signed and in place prior to residents receiving medications for 2 of 5 sampled residents (Residents 9 and 44) reviewed for psychotropic medication use. This failure placed the residents at risk for adverse side effects and a diminished quality of life. Findings included . Review of a document titled, Nightingale Healthcare, Psychotropic Medications, dated 01/01/2023, showed the facility staff were to monitor the appropriateness, efficacy, and to prevent detrimental side effects from usage of psychotropic medications in the residents at the community. In addition, the facility's team would review all residents, who were started on psychotropic medications for the consent forms. Resident 9 Resident 9 admitted to the facility 01/19/2023 with multiple diagnoses to include dementia, anxiety, and depression. Review of the quarterly minimum data set (MDS, an assessment tool), dated 07/26/2024, showed the resident was able to make their needs known. Review of Resident 9's August 2024 medication administration record (MAR) from 08/01/2024 - 08/12/2024 showed the resident was prescribed and provided fluoxetine (a medication used in the treatment of depression) and memantine (a medication used in the treatment of dementia, impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of Resident 9's electronic health record (EHR) showed no consent forms were completed for either of the provider's ordered fluoxetine or memantine medications. During an interview on 08/14/2024 at 11:15 AM, Staff D, Licensed Practical Nurse/Resident Care Manager, (LPN/RCM), stated their expectation would be the staff contact either the resident or the resident's representative to get the consent form prior to administering the psychotropic medications. (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

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 08/16/2024
NAME OF PROVIDER OR SUPPLIER Puyallup Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23rd Ave SE Puyallup, WA 98372	

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2024 at 11:58 AM, Staff B, Director of Nursing Services (DNS), stated their expectation would be that the consents were obtained and that the risk and benefits were explained to the resident or the resident's representative prior to the licensed staff administering the psychotropic medications. 38344 Resident 44 Review of the EHR showed Resident 44 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, and psychotic disorder (a mental illness that can cause a person to lose touch with reality and have abnormal thinking and perceptions). The resident was able to make needs known. Review of Resident 44's August 2024 MAR from 08/01/2024 - 08/12/2024 showed the resident was prescribed and provided a Citalopram, an antidepressant, at bedtime for depression and Seroquel, an antipsychotic in the morning for dementia with psychosis (to lose touch with reality). Review of Resident 44's form titled, Anti-Depressant Medication Informed Consent, dated 07/17/2023 showed prescribed citalopram; however, the form was not completely filled out. The form was missing the following answers/documentation regarding the medication on the form: 1. Indication for use 2. Related diagnosis 3. Target behavior/symptoms Review of Resident 44's form titled, Anti-Psychotic Informed Consent, dated 07/17/2023, showed the prescribed medication Seroquel; however, the form was not completely filled out. The form was missing the following answers/documentation regarding the medication that were on the form: 1. Indication for use 2. Related diagnosis 3. Medication indicated for the following distressed behavior 4. Potential contributing factors previously addressed During an interview on 08/14/2024 at 9:45 AM Staff D, LPN/RCM, stated Resident 44's informed consents for citalopram and Seroquel did not meet expectation because they were missing documentation and were not completely filled out. During an interview on 08/14/2024 at 11:15 AM Staff B, DNS, stated the expectation was that informed consents be completely filled out. Staff B stated that Resident 44's informed consents dated 07/17/2023 for Citalopram and Seroquel, did not meet expectations. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0300 (3)(a), -0260

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Puyallup Nursing and Rehabilitation Center	516 23rd Ave SE Puyallup, WA 98372

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review the facility failed to provide written explanation of reason the facility initiated a room change or provide opportunity for the resident to see the new location and meet new roommates for 1 of 1 sampled resident (Resident 14) reviewed for resident rights. This failure placed the resident at risk for psychosocial distress and diminished quality of life. Findings included . Resident 14 was admitted to the facility on [DATE] with diagnosis that included Diabetes and Depression. The five-day admission Minimum Data Set (MDS, an assessment tool), dated 07/27/2024, showed the resident was cognitively intact and able to make needs known. During an interview on 08/15/2024 at 9:11 AM, Resident 14 stated they were unhappy with the room move and preferred to be back in their previous room where they were near the window and liked the staff. Resident 14 stated they did not receive advance notice about the move and did not get an opportunity to see the new room before moving. Resident 14 stated they believed the move was due to the other hall being full. Review of the electronic health record (EHR) showed a Room Transfer/New Roommate Change form dated 08/12/2024. No documentation prior to 08/12/2024 was found related to the room change. During an interview on 08/15/2024 at 9:31 AM, Staff G, Social Services Director, said when the facility initiated a resident room change, residents were given a verbal notice in advance if possible. Staff G stated the facility documented room moves with a facility Room Transfer/New Roommate Change Assessment form, however, this form was not provided to the resident or the resident's representative. Staff G stated Resident 14 was not given anything in writing notifying the resident of the room change or explaining the reason for the move. During an interview on 08/15/2024 at 9:36 AM, Staff H, Social Services Assistant, stated they showed Resident 14 the new room, however; they could not recall the date and stated they did not normally document when a resident is shown a room related to a room change. During an interview on 08/15/2024 at 11:47 AM Staff A, Administrator, stated the expectation was that advance notice and written explanation of the move should have been provided. Staff A stated residents who are clinically able should be offered the opportunity to see the new room prior to initiating a move. Reference: WAC 388-97-0580(b)(i)(ii)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to properly notify the Office of State Long-Term Care Ombudsmen (an advocacy group for residents in a nursing home) of discharges for 3 of 3 sampled residents (Residents 54, 76 and 36) reviewed for hospitalization . This failure placed residents at risk for an inappropriate discharge and diminished quality of life. Findings included . Resident 54 Review of Resident 54's electronic health record (EHR) showed the resident was readmitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and was able to make needs known. Review of Resident 54's progress note dated 08/01/2024 showed that Resident 54 was transferred to the hospital via 911 and left the facility at around 3:50 PM. Review of Resident 54's minimum data set (MDS, a required assessment tool) showed that the resident readmitted to the facility on [DATE]. During an interview on 08/15/2024 at 10:33 AM, Staff A, Administrator, stated they were unable to locate documentation that the Ombuds was notified of Resident 54's transfer to the hospital on 08/01/2024 and there should have been. Resident 76 Review of Resident 76's EHR showed the resident admitted to the facility on [DATE] with diagnoses to include acute pyelonephritis (a kidney infection), high blood pressure, and diabetes. The resident was able to make needs known. Review of Resident 76's progress note, dated 06/26/2024, showed the resident and family requested to go to the hospital via 911. The resident was transferred to the hospital. Review of the five-day, discharge MDS, dated [DATE], showed that Resident 76 had an unplanned discharge to the hospital on 06/26/2024. During an interview on 08/15/2024 at 10:50 AM, Staff A, stated they were unable to locate documentation that the Ombuds was notified of Resident 76's transfer to the hospital on 06/26/2024 and there should have been. 46067 Resident 36 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 36 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure (condition that makes it difficult to breathe on your own) and Diabetes. The resident was cognitively intact and able to make needs known. Review of the discharge MDS, dated [DATE], and the entry tracking record MDS dated [DATE] showed that Resident 36 was transferred from the facility to the hospital on 07/14/2024 and readmitted to the facility on [DATE]. During an interview on 08/15/2024 at 11:35 AM, Staff A, ADM, stated they were unable to locate any notification to the Ombudsman for the month of July. Staff A stated the expectation was that monthly notification would be sent and documented. Reference WAC 388-97-0120 (2)(a-d), -0140(1)(a)(b)(c)(i-iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide or thoroughly complete a bed hold notice in writing at the time of transfer to the hospital or within 24 hours of transfer to the hospital for 2 of 3 sampled residents (Residents 54 and 36) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding the right to hold their bed while they were at the hospital and diminished quality of life. Findings included . Resident 54 Review of Resident 54's electronic health record (EHR) showed the resident was readmitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and was able to make needs known. Review of Resident 54's progress note dated 08/01/2024 showed that Resident 54 was transferred to the hospital via 911. During an interview on 08/12/2024 at 11:08 AM, Resident 54 stated they had just returned from the hospital. Resident 54 stated they did not recall ever being offered a bed hold when they went to the hospital on August 1st, 2024. During an interview on 08/15/2024 at 9:05 AM, Staff E, Business Office Manager (BOM), stated that bed holds should be located in the resident's EHR. Staff E stated they were unable to locate documentation of a bed hold for Resident 54's transfer to the hospital on 08/01/2024. During an interview on 08/15/2024 at 10:33 AM, Staff A, Administrator, stated they were unable to locate a bed hold for the transfer to the hospital on 08/01/2024 in Resident 54's EHR and there should have been one. 46067 Resident 36 Review of Resident 36's EHR showed they were admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure (condition that makes it difficult to breathe on your own) and Diabetes. The resident was cognitively intact and able to make needs known. Review of the discharge MDS, dated [DATE], and the entry tracking record Minimum Data Set, dated dated [DATE], showed Resident 36 was transferred from the facility to the hospital on 07/14/2024 and readmitted to the facility on [DATE]. (continued on next page)

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Puyallup Nursing and Rehabilitation Center	516 23rd Ave SE Puyallup, WA 98372

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed a Bed Hold document dated 07/14/2024 with Resident 36's signature indicating Yes to the bed hold. The document was incomplete and did not include the daily rate at which the bed would be held. During an interview on 08/15/2024 at 11:36 AM, Staff E, BOM, stated they followed up with Resident 36 the following day and the bed hold was rescinded because the resident was not aware of the cost. Staff E stated the form should have been completely filled out and explained upon transfer. Staff E stated the conversation to rescind after the information was provided to Resident 36 should have been documented on the form. During an interview on 08/15/2024 at 11:43 AM, Staff A, ADM, stated the expectation was that bed hold forms were filled out thoroughly and explained to the resident within 24 hours so that residents were able to make an informed decision. Reference WAC 388-97-0120 (4)

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	505211	A. Building B. Wing	08/16/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to identify a significant change of condition for 1 of 2 sampled residents (Resident 55) reviewed for Hospice (end of life care) services. Failure to identify the need for significant change in condition assessment Minimum Data Set (MDS, a required assessment tool) placed the resident at risk for unidentified/unmet care needs, and a diminished quality of life. Findings included . Resident 55 was admitted on [DATE], with diagnoses that included dementia (loss of memory and thinking abilities), malnutrition, and adult failure to thrive. The quarterly minimum data set (MDS), an assessment tool, dated 05/22/2024, showed the resident was not able to make their needs known. Review of the electronic health record (EHR) showed resident 55 was receiving Hospice services starting on 06/14/2024. Review of the MDS schedule showed a quarterly MDS dated [DATE], and a second quarterly MDS scheduled for 08/22/2024. There was no change of condition MDS completed after Resident 55 started Hospice services. During an interview on 08/14/2024 at 10:13 AM, Staff S, Licensed Practical Nurse/MDS, stated a change of condition MDS should have been completed after hospice services started. During an interview on 08/15/2024 at 9:32 AM, Staff B, Director of Nursing Services, stated the expectations was for Resident 55 to have a change of condition MDS completed. Reference WAC 388-97-1000(3)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38344 Based on interview and record review the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessment was accurately completed for 1 of 5 residents (Residents 44) reviewed for PASRRs and unnecessary medications. This failure placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included . Resident 44 readmitted to the facility 07/17/2023 with diagnoses to include anxiety disorder, depression, and psychotic disorder (a mental illness that can cause a person to lose touch with reality and have abnormal thinking and perceptions). Review of Resident 44's quarterly minimum data set assessment (MDS), an assessment tool, dated 06/26/2024, showed the resident was able to make needs known. Review of Resident 44's PASRR assessment, dated 07/23/2024, showed no psychotic disorder indicated as a serious mental illness indicator documented on the form. During an interview on 08/13/2024 at 1:51 PM, Staff H, Social Service Assistant, stated Resident 44's PASRR dated 07/23/2024 was not accurate because it should have included Resident 44's psychotic disorder diagnosis. During an interview on 08/13/2024 at 2:07 PM, Staff B, Director of Nursing Services, stated Resident 44 had a diagnosis of psychotic disorder. Staff B stated that Resident 44's PASRR dated 07/23/2024 was not accurate and should have included the diagnosis of psychotic disorder. Staff B stated this did not meet expectations. Reference WAC 388-97-1975

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to formulate baseline care plans within 48 hours of admitting and/or readmitting to the facility for 3 of 9 sampled residents (Residents 28, 54, and 379) when reviewed for care and services. This failure placed residents at risk of a delay in services, avoidable pain, and a diminished quality of life. Findings included . Resident 28 Resident 28 admitted to the facility on [DATE] with diagnoses of end stage renal disease (kidney failure), acute and chronic respiratory failure with hypoxia (a condition that occurs when the lungs have difficulty exchanging gases with the blood, resulting in low oxygen levels in the body), and dependence on renal dialysis (a procedure to remove waste from the blood). Review of provider's orders, dated 07/25/2024, showed that Resident 28 underwent dialysis on Monday, Wednesday, and Friday. Review of Resident 28's care plan, initiated 07/25/2024, showed no focus area for dialysis. Review of provider's orders, dated 07/25/2024, showed Resident 28 received continuous oxygen treatment. Review of Resident 28's care plan, initiated 07/25/2024, showed no focus area for oxygen treatment. During an interview on 08/15/2024 at 9:32 AM, Staff C, Resident Care Manager (RCM), stated Resident 28 underwent dialysis and received oxygen treatments and information related to these services should be in the resident's care plan. Staff C stated Resident 28's care plan did not contain information about the resident's dialysis and oxygen treatment, and this did not meet expectation. During an interview on 08/15/2024 at 10:44 AM, Staff B, Director of Nursing Services (DNS), stated staff were made aware of resident's services, including dialysis and oxygen, by reviewing the care plan. Staff B stated that Resident 28's lack of care plan for dialysis and oxygen did not meet expectation. 38344 Resident 54 Review of Resident 54's electronic health record (EHR) showed the resident was transferred to the hospital on 08/01/2024 and readmitted to the facility on [DATE] with diagnoses to include heart failure, diabetes, and had a surgical wound located on the right lower leg. Resident 54 was able to make needs known. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/12/2024 at 11:08 AM, Resident 54 stated they had just returned from the hospital after having surgery on their right lower leg. Review of Resident 54's provider order dated 08/09/2024 showed a wound treatment for the right lower leg/shin to be provided every morning. Review of Resident 54's current care plan showed no actual skin impairment and/or surgical wound documented in the resident's care plan. During an interview on 08/15/2024 at 12:17 PM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated Resident 54's surgical wound was created/initiated in the resident's care plan on 08/15/2024 (six days after being readmitted) and should have been care planned sooner. During an interview on 08/15/2024 at 12:42 PM, Staff B, DNS, stated a baseline care plan should be created within 24 to 48 hours from admission. Staff B stated that Resident 54's care plan for an actual skin impairment related to their surgical wound was not initiated until 08/15/2024 and should have been created sooner. Staff B stated that this did not meet expectations. 50945 Resident 379 Review of the EHR showed Resident 379 was admitted on [DATE] with diagnoses that included multiple falls, chronic dislocation (when a bone moves out of place) of the left shoulder, and surgery in June of 2024 for a left hip fracture (broken bone). Resident 379 required both physical therapy and occupational therapy five days a week. During an interview on 08/12/2024 at 2:32 PM, Resident 379 stated they were having lower back and left shoulder pain and were going to therapy twice a day. Review of the EHR on 08/13/2024 at 4:37 PM, showed that Resident 379 did not have a triggered care plan for pain. During an interview on 08/15/2024 at 11:22 AM, Staff N, LPN/RCM, stated that Resident 379 did not have a care plan for pain. During an interview on 08/15/2024 at 1:26 PM, Staff B, DNS, stated that a baseline care plan for pain for Resident 379 should have been done within 48 hours of admission. Reference WAC 388-97-1020 (3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview and record review, the facility failed to develop and/or implement a comprehensive care plan for 4 of 18 sampled residents (Residents 24, 44, 129, and 26) when reviewed for care and services. This failure placed residents at risk of a lack of services, avoidable pain, inability to complete activities of daily living, and a diminished quality of life. Findings included . Resident 24 Resident 24 admitted to the facility on [DATE] with diagnoses to include kidney failure and urinary tract infection. During an interview on 08/12/2024 at 9:35 AM, Resident 24 stated their vision was very bad and they used glasses. Review of the admission minimum data set assessment (MDS), an assessment tool, dated 07/14/2024, showed Resident 24 had no visual impairment and used corrective lenses. Review of Resident 24's care plan, initiated 07/11/2024, showed no focus area for vision and no care directives regarding the use of corrective lenses. During an interview on 08/15/2024 at 10:02 AM, Staff N, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated staff were aware of a resident's vision needs by reviewing the care plan. Staff N stated Resident 24's care plan did not include information on Resident 24's use of corrective lenses and this did not meet expectation. During an interview on 08/15/2024 at 10:48 AM, Staff B, Director of Nursing Services (DNS), stated staff were aware of resident vision needs by reviewing the care plan and the use of corrective lenses should be included in the care plan. Staff B stated that Resident 24's lack of care plan for corrective lenses did not meet expectation. 38344 Resident 44 Review of Resident 44's electronic health record (EHR) showed Resident 44 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, and psychotic disorder (a mental illness that can cause a person to lose touch with reality and have abnormal thinking and perceptions). The resident was able to make needs known. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 44's care plan showed no diagnosis of anxiety disorder addressed. The focused care plan initiated on 06/16/2023 showed that Resident 44 took a psychotropic medication for the diagnosis of dementia with behaviors as evidenced by: and did not show documentation of what behaviors or adverse side effects to monitor for related to the antipsychotic medication use. During an interview on 08/14/2024 at 9:27 AM, Staff D, LPN/RCM, stated that Resident 44 had a diagnosis of an anxiety disorder; however, it was not addressed in the resident's care plan and should have been. Staff D stated Resident 44's psychotropic medication care plan initiated on 06/16/2023 was not completed and did not show to monitor for target behaviors and side effects for the use of antipsychotic medication and should have. During an interview on 08/14/2024 at 11:07 AM, Staff B, DNS, stated Resident 44's care plan should have addressed the resident's diagnosis of anxiety disorder and listed target behaviors and side effects to monitor for related to the use of the antipsychotic medication. Staff B stated that Resident 44's care plan needed to be revised. 49926 Resident 26 Resident 26 was admitted to the facility on [DATE] with diagnoses that included dementia (loss of memory and thinking abilities), malnutrition and depression. The significant change in status MDS, dated [DATE], showed Resident 26 was not able to make needs known and was at risk for falls. Review of the EHR showed resident had a fall on 08/06/2024. Review of a care plan focus for risk of falls, showed a new intervention initiated on 08/07/2024 was for Resident 26 to have fall matts (thin mattresses) on the side of the bed to minimize injuries from falling. Multiple observations from 08/12/2024 - 08/15/2024 showed Resident 26 in a low bed in the room without fall matts in place. During an interview on 08/15/2024 at 8:49 AM, Staff T, Certified Nursing Assistant, stated they remembered the fall matts being in place last week, but they have disappeared. During an interview on 08/15/2024 at 8:52 AM, Staff M, LPN, stated the care plan was updated by the person that initiated the new interventions, and it should be followed. Staff M was able to locate the fall matts in Resident 26's bathroom. During an interview on 08/15/2024 at 9:32 AM, Staff B, DNS, stated the expectations were for the care plan to be followed. Reference WAC 388-97-1020(3)

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	505211	A. Building B. Wing	08/16/2024

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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** 49926 Based on interview and record review, the facility failed to review and revise the plan of care after a change of condition for 1 of 2 sampled residents (Resident 55) reviewed for Hospice (end of life care) services. This failure placed the resident at risk of unmet care needs and a diminished quality of life. Findings included . Resident 55 was admitted on [DATE], with diagnoses that included dementia (loss of memory and thinking abilities), malnutrition, and adult failure to thrive. Review of the quarterly minimum data set assessment, an assessment tool, dated 05/22/2024, showed the resident was not able to make their needs known. Review of the electronic health record (EHR) showed resident 55 was receiving care from Hospice services initiated on 06/14/2024. Review of the care plan, initiated 03/23/2023, showed no new interventions or approaches for Hospice services. During an interview on 08/14/2024 at 10:21 AM, Staff D, Licensed Practical Nurse/ Resident Care Manger, stated Resident 55's care plan should have been updated, and was not able to locate any updates. During an interview on 08/15/2024 at 9:32 AM, Staff B, Director of Nursing Services stated the expectations were for care plans to have current updates related to Hospice services. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 2 of 21 sampled residents (Residents 19 and 26) when reviewed for quality of care. The facility failed to ensure the initiation of Resident 19's provider order for Physical and Occupational therapy (PT/OT) and failed to monitor pain/evaluate the effectiveness of pain management for Resident 26 per providers orders. These failures placed the residents at risk of medical complications, unmet needs, and a poor quality of life. Findings included . According to the Lippincott Manual of Nursing Practice, Tenth Edition ([NAME], [NAME] & [NAME], 2014, page 16), The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable. According to [NAME], Duell & [NAME], Clinical Nursing Skills, 6th Edition, page 4, paragraph Nurse Practice Act identified skills and functions that professional nurses perform in daily practice included, in part, to administer treatments per physician's orders. Resident 19 readmitted to the facility on [DATE] with diagnoses to include heart disease, stroke with hemiplegia (paralysis of one side of the body), to the dominant right side of the body and pneumonia. Review of the quarterly minimum data set (MDS, an assessment tool), dated 07/09/2024, showed Resident 19 had a contracture of the right hand and was dependent on staff for activities of daily living (ADLS's). During an observation on 08/12/2024 at 10:02 AM, Resident 19 laid in bed, with their right upper extremity bent upward toward their chest and right hand appeared contracted (frozen joint) with no arm or hand brace on the resident. During an interview on 08/12/2024 at 10:48 AM, Resident 19's family member stated they have been concerned about resident 19's contracture to the right upper arm and lack of use of a splint (a device to prevent muscle contracture) and whether the resident was to start back into PT/OT after a recent hospitalization . Resident 19's family member stated that they had been trying to get in contact with the provider to get answers to these concerns. Review of Resident 19's providers order showed an order dated 07/03/2024 for PT/OT to evaluate and treat the resident. Review of Resident 19's focus care plan, dated 03/06/2024, showed the resident was at risk for further contracture to their right elbow due to a stroke/hemiplegia and had a right elbow contracture. The goal was for the resident to wear their right elbow brace and to have no further contracture to their right elbow daily. Interventions included for the resident to have the splint/brace placed, have a finger separator, to wear for five to six hours daily six to seven times a week and to remove for 15 minutes to inspect the skin under the splint for redness or irritation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 1:08 PM, Staff P, Rehabilitation Director (RD), stated that they had not received the order to restart Resident 19's, PT/OT, or to evaluate or treat since being readmitted back to the facility. During an interview on 08/15/2024 at 1:15 PM, Staff L, Registered Nurse (RN), stated they had printed off a paper copy of Resident 19's PT/OT order to evaluate /treat on 07/04/2024 and hand delivered it to the PT/OT department, but was unable to state who received the provider's order. During an interview on 08/15/2024 at 1:29 PM, Staff B, Director of Nursing Services (DNS) stated that it was their expectation that the PT/OT staff evaluate and treat Resident 19 per provider order. 50945 Resident 26 Resident 26 was admitted [DATE] with diagnoses that included aphasia (language disorder that can cause difficulty using words and sentences, and understanding words and sentences), dementia (group of symptoms affecting memory, thinking, and social abilities), and chronic pain. Review of the Significant Change MDS, dated [DATE], showed Resident 26 never or rarely made decisions, was severely impaired for cognitive skills regarding daily decision making, and was unable to verbalize pain. Review of Resident 26's orders showed an active order, started on 05/02/2019, for staff to document every shift the effectiveness of Resident 26's pain management plan. Review of Resident 26's care plan for pain showed that the staff should monitor pain every shift and during cares. During an interview on 08/15/2024 at 11:48 AM, Staff M, Licensed Practical Nurse, stated they did not see any place to document a pain scale or effectiveness of pain management plan on the medication administration record (MAR) or the treatment administration record (TAR). During an interview on 08/15/2024 at 1:14 PM, Staff B, DNS, stated Resident 26, due to their diagnoses, should have had their pain assessed every shift and as needed. Staff B stated that there were monitoring problems for Resident 26 regarding pain scales and effectiveness of the pain management plan, and their expectation was for documentation to occur. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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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** 34567 Based on observation, interview and record review, the facility failed to consistently monitor and document bowel movements and implement the bowel program when needed for 1 of 2 sampled residents (Resident 3 and 9) reviewed for bowel protocol. Additionally, the facility failed to initiate proper positioning, and re-start Physical and Occupational Therapy (PT/OT) for 1 of 3 sampled residents (Resident 19) when reviewed for limited range of motion. These failures placed the residents at risk for worsening condition, discomfort, and a decreased quality of life. Findings included . <Bowel Monitoring> Review of a document titled, House Bowel Program, dated 01/12/2019 showed the policy was developed to promote natural and predictable elimination of bowels. In addition, the policy showed that bowel movements or lack of were to be recorded by the Certified Nurse Aide (CNA), each shift. The Licensed Nurse (LN) will monitor results and start medication if necessary. The interventions included that the night shift nurse would review bowel records for possible need of intervention and would provide dayshift LNs with a list of residents without a bowel movement (BM) for three days. If no BM on day 3, day shift LN would administer milk of magnesia (MOM), if no BM by day 4, the LN would administer a (laxative) suppository, and if no BM on day 5 the LN was to administer a fleet enema. (a saline laxative administered rectally for constipation.) Resident 3 admitted on [DATE] with multiple diagnoses to include, lung and heart disease, diabetes, depression and malnutrition. Review of the quarterly Minimum Data Set (MDS, a required assessment tool), dated 07/06/2024, showed Resident 3 was able to make their needs known. Review of Resident 3's care plan, dated 12/26/2018, for activities of daily living, showed the resident needed assistance with their daily care and the licensed staff were to provide the resident with toilet use per the facility protocol. In addition, licensed staff were to monitor, document and report, when necessary, any changes and decline in function. During an interview on 08/12/2024 at 11:10 AM, Resident 3 stated that they had diarrhea every day and have been telling the staff of this issue. Review of Resident 3's electronic health record (EHR) bowel movement and continence results showed that the resident had multiple documentations of loose/diarrhea on 07/21/2024, 07/24/2024 - 07/31/2024 and 08/01/2024 - 08/13/2024. During an interview on 08/13/2024 at 12:38 PM, Staff V, Certified Nurse Aide (CNA) stated that Resident 3 did have frequent loose stools and they had informed the LNs of the resident's diarrhea. During an interview on 08/13/2024 at 12:40 PM, Staff D, Licensed Practical Nurse/Residential Care Manager (LPN/RCM), stated that if Resident 3 had frequent loose stools, the provider should have been contacted in order to get some medication for the LN to administer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/2024 at 12:44 PM, Staff B, Director of Nursing Services (DNS) stated that it was their expectation that LNs were to contact the provider to obtain an order for the resident's diarrhea. Resident 9 Resident 9 admitted to the facility 01/19/2023 with multiple diagnoses to include dementia, anxiety, and depression. The resident also had diagnoses of gastroesophageal reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting your mouth and stomach), muscle weakness and protein calorie malnutrition. Review of the quarterly MDS, dated [DATE], showed Resident 9 was able to make their needs known. Review of Resident 9's bowel movement and continence results showed that the staff had documented no BM from 07/15/2024 - 07/21/2024 and from 07/23/2024 - 07/25/2024 but had one BM recorded on 07/26/2024. In addition, the record documented no BM from 08/09/2024 - 08/11/2024. Review of Resident 9's, medication administration record (MAR) dated 07/01/2024 - 07/31/2024 showed Resident 9 had two provider orders, dated 01/19/2023, for staff to administer laxatives for constipation. Milk of Magnesia (MOM) was to be administered, every 24 hours as needed for constipation if the resident had not had a BM in three days or per the resident's request. In addition, Dulcolax suppository was to be administered rectally every 24 hours as needed for constipation if no BM on the shift following the administration of the MOM administration. The MAR showed MOM was administered by an LN on 07/18/2024 and was documented as being ineffective. No further MOM was administered per the documentation for July 2024 for the resident's constipation. A LN had administered a Dulcolax suppository on 07/25/2024 without prior MOM administration. During an interview on 08/14/2024 at 11:40 AM, Staff D, LPN/RCM, stated that if Resident 9 had constipation, then they (LNs) were to administer MOM as ordered and if ineffective within 24 hours another dosage was to be given. During an interview on 08/14/2024 at 11:47 AM, Staff B, DNS stated it was their expectation that the bowel protocol was to be initiated if Resident 9 was documented without a BM and was constipated. <Position/ Mobility> Resident 19 Resident 19 readmitted to the facility on [DATE] with diagnoses to include heart disease, stroke with hemiplegia (paralysis of one side of the body), to the dominant right side of the body and pneumonia. Resident 19's electronic health record showed Resident 19 had a contracture of the right hand and was dependent on staff for activities of daily living (ADLS's) During an observation and interview on 08/12/2024 at 10:17 AM, Resident 19 laid in bed with their right arm contracted at an approximatly 45 degrees angle and with the right hand tightly contracted with the right fingers curled inward toward the palm. No brace or sling was observed being worn. Resident 19 stated that the staff rarely place the sling or brace on them during the day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/2024 at 10:48 AM, Resident 19's family member stated that they were concerned with the resident not wearing their splint/brace and have been trying to get a hold of the provider to restart back into PT/OT. Review of Resident 19's provider orders showed an order, dated 07/03/2024, for PT/OT evaluation and treatment to be conducted. Review of a focus care plan, dated 03/11/2024, showed the resident was at risk for further contracture of their right elbow due to a stroke with hemiplegia and with right elbow contracture. The goal was for the resident to wear their right elbow brace and have no further contractures in their right elbow daily. Interventions included the staff to assist the resident to place the right elbow splint, palm guard and finger separator 6-7 times per week (throughout the day) and to remove for 15 minutes to inspect the skin under the splint for redness or irritation. Review of the August 2024 MAR and the Treatment Administration Record (TAR) had no documentation recorded for staff to place the brace or the splint. During an interview on 08/14/2024 at 11:39 AM, Staff V, CNA stated that Resident 19 had recently returned back from the hospital, but they had not received any order to place the brace and splint back on to the resident. Review of Resident 19's EHR showed an LN had documented that on 07/04/2024 the resident's family had visited and had requested a PT/OT evaluation. During an interview on 08/14/2024 at 12:05 PM, Staff P, PT/OT Director stated they had not received any recent order to re-start Resident 19 back into the PT/OT program for an evaluation or to start back up into treatment. During an interview on 08/14/2024 at 1:07 PM, Staff B, DNS, stated it would be their expectation that the provider's order for Resident 19 should have been initiated in order to get necessary treatment and that the splint and brace be placed on the resident. Reference WAC 388-97-1060(1)(2)(3)(b)(c) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview and record review, the facility failed to have an accurate and current smoking assessment for 1 of 3 sampled residents (Resident 4) reviewed for accidents. This failure placed the resident at risk for avoidable accidents and diminished quality of life. Findings included . Resident 4 was admitted to the facility on [DATE] with diagnoses that included stroke (damage to the brain from interruption of its blood supply), hemiparesis (paralysis) affecting right side of body and hemiparesis affecting left side of body. Review of the Quarterly Minimum Data Set (MDS, a required assessment tool), dated 05/18/2024, showed Resident 4 was able to make their needs known. Observation and interview on 08/12/2024 at 12:18 PM, showed Resident 4 sitting in an electric wheelchair in their room. Resident 4 was able to use their left hand, they gestured and wrote on a paper that that they smoked off of the facility property. There was cigarette odor present on their clothing. Review of the Electronic Health Record (EHR) showed a Smoking Safety Evaluation, dated 12/06/2023, approximatly 5 months prior to the last quarterly assessment, which indicated Resident 4 smoked off facility property and declined smoking cessation. The evaluation did not address how Resident 4 was able to hold, light and extinguish a cigarette. During an interview on 08/15/2024 at 9:27 AM, Staff D, Licensed Practical Nurse/ Resident Care Manger, stated that the smoking evaluation was completed by the nurses. Staff D stated the evaluation was to be completed on a quarterly basis and when there was a change of condition. During an Interview on 08/15/2024 at 9:34 AM, Staff B, Director of Nursing Services, stated the expectation was for smoking evaluation to be completed quarterly (every three months). Reference WAC 388-97-1060(3)(g)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to ensure ostomy (a surgical procedure creating an opening in the body for the discharge of body wastes into a collection bag) care and treatment instructions were provided in the plan of care for 1 of 1 sampled resident (Resident 129) reviewed for ostomy care. This failure placed the resident at risk for unmet care needs, and diminished quality of life. Findings included . Review of Resident 129's electronic health record (EHR) showed Resident 129 admitted to the facility on [DATE] with a diagnosis to include diverticulitis (Inflammation of the large intestine). Resident 129 had an ostomy and was able to make their needs known. During an interview on 08/12/2024 at 1:08 PM, Resident 129 stated the area around their ostomy bag was hurting and they did not believe staff had the proper training to change or empty the bag. Review of Resident 129's provider orders did not show orders related to the ostomy. Review of the August 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed no ostomy care directives for Resident 129. Review of the care plan, initiated 08/07/2024, showed no care planned goals and interventions for ostomy care. During an interview on 08/13/2024 at 1:38 PM, Staff F, Licensed Practical Nurse, stated nurses were the only ones who changed and emptied the ostomy bag. Staff F stated the bag was changed every other day but was unable to locate a provider's order or a care plan in the EHR. During an interview on 08/13/2024 at 1:42 PM, Staff C, Licensed Practical Nurse/Residential Care Manager, stated they were unable to locate any orders or care plan related to the ostomy bag. Staff C stated there should have been orders for changing of the ostomy bag and assessment of the stoma site. Staff C also stated the care plan should have included the ostomy bag but did not. During an interview on 08/15/2024 at 1:54 PM, Staff B, Director of Nursing Services, stated the expectation was that ostomy orders were entered in the EHR and care planned upon admission. Reference (WAC) 388-97-1060 (3)(iii)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review, the facility failed to monitor and accurately document fluid restrictions (a diet which limits the amount of daily fluid intake) for 1 of 1 sampled residents (Resident 36) reviewed for hydration. This failure placed the resident at risk for medical complications and a diminished quality of life. Findings included . Review of the facility's policy titled, Fluid Restriction, undated, showed, It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. It further showed, No water pitcher at bedside unless otherwise care planned. Review of the electronic health record showed Resident 36 admitted on [DATE] with diagnosis to include Chronic Obstructive Pulmonary Disease (a lung disease causing restricted airflow and breathing problems) Chronic Respiratory Failure (condition that makes it difficult to breathe on your own) and Diabetes. The resident was cognitively intact and able to make needs known. During an interview and observation, on 08/12/2024 at 10:01 AM, Resident 36 stated that I'm not sure if I'm on a fluid restriction, I get water and ice throughout the day. Resident 36 had a water pitcher and a clear cup half full of water located within reach on the overbed table. Review of the physician order, dated 07/24/2024, showed that Resident 36 was prescribed a fluid restriction of 2 liters (L, a measurement of volume) that dietary was to provide 1440 milliliters (ml, a measurement of volume) and nursing was to provide a total of 560 ml (day shift 200 ml, evening shift 180 ml, night shift 180 ml) every shift. Observations on 08/12/2024 at 2:51 PM, 08/13/2024 at 8:21 AM, and 08/13/2024 at 10:55 AM showed Resident 36 lying in bed with a water pitcher within reach on the overbed table. During an interview on 08/13/2024 at 11:07 AM, Staff J, Certified Nursing Assistant (CNA), stated there were no residents on the east hall who were on a fluid restriction. During an interview on 08/13/2024 at 11:09 AM, Staff K, CNA, stated they were not aware of any residents on the east hall who were on a fluid restriction. During an interview on 08/13/2024 at 11:42 AM, Staff F, Licensed Practical Nurse (LPN), stated that Resident 36 was not to have a water pitcher because the resident was on fluid restriction. Review of the care plan, dated 07/24/2024, showed no goals/interventions related to the fluid restriction. During an interview on 08/13/2024 at 11:23 AM, after looking at Resident 36's electronic health record, Staff C, Residential Care Manager (RCM), stated the fluid restriction should have been in the care plan and that Resident 36 should not have had a water pitcher at bedside unless a risk and benefits was signed, and the provider was notified. (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	08/16/2024

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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 1:47 PM, Staff B, Director of Nursing Services, stated it was the expectation that provider's orders were care planned and followed. Staff B stated residents on a fluid restriction were not to have water pitchers at bedside. Reference WAC 388-97-1060 (3)(h)

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 08/16/2024

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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide ongoing collaboration and communication with a dialysis provider for 1 of 1 sampled resident (Resident 28) reviewed for dialysis (a procedure to remove waste from the blood). This failure placed the resident at risk of a decline in condition, lack of coordinated dialysis care, and a diminished quality of life. Findings included . Resident 28 admitted to the facility on [DATE] with diagnoses of end stage renal disease (kidney failure) and dependence on renal dialysis. Review of provider's orders, dated 07/25/2024, showed that Resident 28 underwent dialysis on Monday, Wednesday, and Friday. Review of Resident 28's care plan, initiated 07/25/2024, showed no focus area for dialysis. During an interview on 08/12/2024 at 9:57 AM, Resident 28 stated they were transported to dialysis by family and did not remember taking communication forms. Review of Resident 28's communication binder did not show communication forms for the dates of 07/26/2024, 07/29/2024, 07/31/2024, and 08/02/2024. Review showed that the top portion of the communication form for 08/09/2024 was not completed. During an interview on 08/15/2024 at 9:32 AM, Staff C, Licensed Practical Nurse/Resident Care Manager, stated Resident 28 took a communication binder to dialysis to be filled out by dialysis staff. Staff C stated that facility staff would fill out the bottom portion of the form when Resident 28 returned to the facility. Staff C stated this should be done for each occurrence of dialysis treatment and if dialysis staff failed to complete the top portion, then facility staff would call the dialysis provider to obtain the information. Staff C stated they did not have communication forms prior to 08/05/2024 and that the top portion of the 08/09/2024 communication form was not filled out. Staff C stated this did not meet the expectation for dialysis communication. During an interview on 08/15/2024 at 10:44 AM, Staff B, Director of Nursing Services, stated the facility collaborated dialysis care with the dialysis provider by using dialysis communication forms which should be completed with each occurrence of dialysis. Staff B stated Resident 28's lack of dialysis communication prior to 08/05/2024 and the incomplete form for 08/09/2024 did not meet this expectation. Reference WAC 388-97-1900 (1), (6)(a-c)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview and record review, the facility failed to ensure freedom from unnecessary pain medication for 2 of 5 sampled residents (Resident 44, and 36) reviewed for unnecessary medications and 1 of 1 sampled resident (Resident 379) reviewed for pain management. These failures placed the residents at risk for side-effects related to the medications, medical complications, and a diminished quality of life. Findings included . Review of a document titled, Pain Management, dated 07/26/2016 showed that the facility's pain management program was based on the facility's endeavors to provide care and services to effectively manage resident's pain. The facility was to develop and implement interventions, pharmacological and non-pharmacological (the use of medication to manage symptoms or management of symptoms without medications) to manage pain depending on factors such as whether the pain was episodic or continuous. In addition, specific strategies were needed to identify different levels and sources of pain and address both pharmacological and non-pharmacological interventions. Furthermore, pain medication administration was to be documented on the medication administration record (MAR) and document the non-pharmacological interventions attempted. Resident 44 Review of Resident 44's electronic health record (EHR) showed Resident 44 order readmitted to the facility 07/17/2023 with diagnoses to include a stroke, insomnia (persistent problems falling and staying asleep), spondylosis (age-related wear and tear of the spinal disks that may cause pain or muscle spasms) of the lower back. The resident was able to make needs known. Review of Resident 44's provider orders showed an order, dated 07/15/2024, for Melatonin (dietary supplement used to aid in sleep) to be provided at bedtime for sleeplessness. It further showed a provider order dated 10/21/2022 for Tylenol to be provided every six hours as needed for pain. Review of Resident 44's August 2024 monitors record showed, Document hours of sleep every shift (day, evening, and night shift); however, there were no documented hours of sleep or staff initials. The record was blank. The monitors record also showed, Is your pain management plan effective for you? (+) = yes, (-) = no. If no, document interventions in progress note every shift. There was no documentation, the record was blank. Review of Resident 44's August 2024 MAR from 08/01/2024 - 08/13/2024 showed Tylenol was provided on 08/06/2024 at 2:58 PM for pain; however, there was no non-pharmacological interventions documented in the MAR prior to giving the medication. (continued on next page)

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 1:23 PM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated that Resident 44's August 2024 monitors record had no hours of sleep documented and there was no documentation to show if Resident 44's pain management was effective or not and there should have been. Staff D stated that non-pharmacological interventions should be documented in the MAR; however, was unable to locate documentation if Resident 44 was provided non-pharmacological interventions prior to receiving Tylenol on 08/06/2024 for pain. During an interview on 08/14/2024 at 2:02 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that provider orders were to be followed and documented. Staff B stated Resident 44's August 2024 monitor records for sleep monitoring and effective pain management lack of documentation did not meet expectations. Staff B stated Resident 44 should have had documentation that non-pharmacological interventions were provided prior to receiving Tylenol on 08/06/2024 for pain. 46067 Resident 36 Review of Resident 36's EHR showed Resident 36 admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) chronic respiratory failure (condition that makes it difficult to breathe on your own) and diabetes. The resident was cognitively intact and able to make needs known. Review of Resident 36's provider order, dated 07/24/2024, showed the resident was prescribed oxycodone (a narcotic medication for pain) every four hours as needed for moderate pain. In addition, a series of non-pharmacological interventions were to be completed prior to administering the narcotic such as reposition, rest, apply ice or provide a quiet environment. Review of Resident 36's MAR dated 08/01/2024 - 08/31/2024 showed that the resident had received oxycodone daily from 08/01/2024 - 08/13/2024, without any non-pharmacological approaches implemented and/or offered prior to administering the narcotic. During an interview on 08/15/2024 at 1:50 PM, Staff B, DNS, stated that the license nurses were to complete non-pharmacological interventions prior to administering the narcotic and document what intervention was being completed. 50945 Resident 379 Review of the EHR showed Resident 379 was admitted to the facility on [DATE] with diagnoses that included multiple falls, chronic dislocation of the left shoulder (when a bone moves out of place), and surgery in June of 2024 for a left hip fracture (broken bone). Review of Resident 379's provider orders, dated 08/08/2024, showed an order for as needed Tylenol (pain medication for mild to moderate pain) every 6 hours and an order for non-pharmacological interventions as needed for pain (repositioning, rest, ice, quiet environment). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 379's MAR showed on 08/09/2024, Resident 379 had a 4/10 pain level at 8:43 PM without any non-pharmacological interventions documented prior to administration of Tylenol. Observation on 08/14/2024 at 11:24 AM, showed Staff Q, LPN, provided Resident 379 with an as needed dose of Tylenol. Staff Q was observed to enter the room, ask Resident 379 about pain, obtain and administer Tylenol, and then leave the room. No non-pharmacological interventions were observed. During an interview on 08/14/2024 at 1:16 PM, Staff Q stated when a resident is in pain, they should attempt non-pharmacological interventions such as changing a resident's position or adjusting the light, before they would move on to giving medications based on pain level. During an interview on 08/15/2024 at 1:26 PM, Staff B, DNS, was unable to find documentation for a non-pharmacological intervention for Resident 379 for the Tylenol dose on 08/09/2024. Staff B stated that when Resident 379 received Tylenol, their expectation was for staff to have also offered and documented non-pharmacological interventions. Reference WAC 388-97 -1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview and record review, the facility failed to ensure monitoring of potential side effects related to the use of psychoactive medications for four of five residents (Resident's 9, 44, 36 and 26) reviewed for unnecessary medication use. The facility's failure to monitor behavioral monitoring and side effects related to use of an antipsychotic medications placed the residents at risk for adverse side effects, medical complications and a diminished quality of life. Findings included . Review of a policy titled, Psychotropic Medications, dated 01/01/2023 showed staff were to monitor the appropriateness, efficacy, and to prevent detrimental side effects from the usage of psychotropic medications in the residents at the community (facility). In addition, the facility would review residents on psychotropic medications for target behaviors and monitor for any adverse side effects (ASE) of the medications. Resident 9 Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 9 admitted to the facility 01/19/2023 with multiple diagnoses to include dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), anxiety, and depression. The resident also had diagnoses of gastroesophageal reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting your mouth and stomach), muscle weakness and protein calorie malnutrition. The MDS showed the resident was able to make needs known. Review of Resident 9's August 2024 medication administration record (MAR) from 08/01/2024 - 08/12/2024 showed the resident was prescribed and was administered fluoxetine (a medication used in the treatment of depression) and memantine (a medication used in the treatment of dementia that can reduce aggression and psychosis in dementia residents). Review of Resident 9's care plan on 08/14/2024 showed the diagnosis of dementia and anxiety disorder; however, the focused care plan initiated on 08/31/2023 showed the resident was being administered psychotropic medications for the diagnosis of dementia, the care plan did not show documentation of what behaviors or adverse side effects to monitor for related to the psychotropic medication use. Review of Resident 9's, August 2024, monitor record showed staff were to monitor and document antidepressant side effects of the medication (fluoxetine) to include significant dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, increased appetite and to notify the provider if present and write a progress note every shift. In addition, no monitor was created into Resident 9's monitor documentation for staff to assess for ASE related to the medication (memantine). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 11:15 AM, Staff D, Licensed Practical Nurse/Residential Care Manager (LPN/RCM) stated that they were unaware of the monitor (behavior/ASE) document in the residents' electronic health record (EHR) however, they have now been recently made aware of it. During an interview on 08/14/2024 at 11:26 PM, Staff B, Director of Nursing Serivces (DNS) stated that they had recently been made aware of the issue with the lack of behaviors and ASE documentation in the residents EHR monitor documents and that they were now fixing the issue. 38344 Resident 44 Resident 44 readmitted to the facility 07/17/2023 with diagnoses to include anxiety disorder, depression, and psychotic disorder (a mental illness that can cause a person to lose touch with reality and have abnormal thinking and perceptions). The resident was able to make needs known. Review of the order dated 10/21/2022 showed Resident 44 was prescribed citalopram (an antidepressant medication) at bedtime for depression. Review of Resident 44's electronic health record (EHR) showed a provider order dated 10/21/2022 to observe closely for significant antidepressant side effects, dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, and increased appetite. Notify provider if present and write in progress note every shift. Review of Resident 44's August 2024 monitors record showed the order to observe closely for significant antidepressant side effects had no staff initials or documentation and was blank. During an interview on 08/14/2024 at 10:31 AM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated Resident 44's August 2024 monitors record showed no antidepressant side effect observation documentation and there should have been. During an interview on 08/14/2024 at 11:15 AM, Staff B, Director of Nursing Services (DNS) stated Resident 44's order to observe antidepressant side effects in the August 2024 monitors record was blank and there should have been documentation. Staff B stated this did not meet expectations. 46067 Resident 36 Review of the quarterly minimum data set assessment (MDS) showed Resident 36 admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) chronic respiratory failure (condition that makes it difficult to breathe on your own) and diabetes. The resident was cognitively intact and able to make needs known. Review of Resident 36's provider's order dated 07/24/2024, showed an order for sertraline (an antidepressant medication) to be given once a day for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 36's MAR dated 08/01/2024 - 08/31/2024, showed no behavior monitoring for the sertraline. During an interview on 08/14/2024 at 11:35 AM, Staff C, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated behaviors observed were to be documented on the MAR or in the progress notes. Staff C was unable to locate any documentation in the EHR showing Resident 36's behavior had been consistently monitored. During an interview on 08/15/2024 at 1:50 PM, Staff B, DNS, stated the expectation was that an order for behavior monitoring would be initiated with the providers order for the medication. 50945 Resident 26 Review of the EHR showed Resident 26 was admitted [DATE] with diagnoses that included anxiety and depression. Review of Resident 26's orders and medication administration record showed that they were taking twice a day buspirone (an anti-anxiety medication) and daily Remeron (an antidepressant medication). Further review on 08/14/2024 at 11:47 AM showed missing documentation of monitoring for adverse side effects for both anti-anxiety and antidepressant medications. In an interview on 08/15/2024 at 12:48 AM, Staff D, LPN/RCM, was unable to find any documentation for monitoring adverse side effects for antidepressants for Resident 26 in the month of July 2024 and stated that there should have been. In an interview on 08/15/2024 at 1:14 PM, Staff B, DNS, stated Resident 26 was a resident that had an order that was not showing up for staff to monitor side effects, and there was missing documentation before 08/14/2024. Reference WAC 388-97-1060 (3)(k)(i)

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50945 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5 percent for 2 of 6 sampled residents (Residents 1 and 8) reviewed for medication administration. During 25 medication administration observations, four medication errors were identified resulting in an error rate of 16 percent. This failure placed residents at risk of not receiving the full therapeutic effect of their medications, possible adverse side effects, and a diminished quality of life. Findings included . Review of the document titled Medication Administration General Guidelines, dated 01/2024, showed staff were to document on the resident's medication administration record (MAR) immediately following the administration of the medication. The residents should be watched after medication administration to ensure the doses were completely ingested, and if only a partial dose was ingested then this should be noted on the MAR and action should be taken if needed. Medications were to be administered within 60 minutes of the scheduled time. Resident 1 Review of the electronic health record (EHR) showed Resident 1 was prescribed a 0.5 milligram clonazepam (a controlled substance that makes the nervous system less active, prescribed for anxiety) oral disintegrating tablet (medication that dissolves quickly in the mouth), given twice a day, scheduled for 8:00 AM. Observation on 08/14/2024 at 9:43 AM, showed Staff U, Licensed Practical Nurse (LPN), did not administer the clonazepam dose with their medication pass. Staff U stated the narcotic book (log of controlled substances) was with another staff member and they were unable to attempt the dose at that time. During an interview on 08/14/2024 at 10:58 AM, Staff U stated that they now had the narcotic book, and that they had not yet attempted to give the dose. Staff U stated that the clonazepam dose should have been given between 8:00 AM to 10:00 AM. During an interview on 08/14/2024 at 2:18 PM, Staff B, Director of Nursing Services (DNS), stated their expectation for an 8:00 AM dose of clonazepam was to give it an hour before or an hour after it was due. During an interview on 08/15/2024 at 11:33 AM, Staff B stated the nurse should have asked about the narcotic book, in order to administer the medication on time. Review of the EHR showed Resident 1 was prescribed 17 grams of MiraLax powder (a laxative that softens the stool and increases bowel movements, prescribed for constipation), given once a day by mouth in the morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 08/14/2024 at 9:43 AM, Staff U was observed to electronically sign off the morning Miralax dose and proceeded to attempt to give the dose to Resident 1; however, the dose was not given with their medication pass. Staff U stated that the resident sometimes preferred the Miralax dose with a straw and would try again and proceeded to discard Resident 1's Miralax dose. Staff U was then observed to continue on to the next residents medication pass without documenting the discarded medication for Resident 1. Multiple observations on 08/14/2024 from 9:43 to 11:39 AM showed Staff U re-entered Resident's 1 room, without any attempt to administer the Miralax dose as ordered, to the resident. During an interview on 08/14/2024 at 1:01 PM, Staff D, LPN/ Resident Care Manager, stated that residents should drink all of the MiraLax mixture with the nurse present. Staff D stated that their expectation was for staff to obtain the medication, pass the medication first, and then chart off the administration in the electronic record. During an interview on 08/15/2024 at 11:33 AM, Staff B, DNS, stated the nurse should have corrected the documentation if resident did not take the Miralax dose. Resident 8 Review of Resident 8's EHR showed a provider had prescribed 17 grams of MiraLax Powder, to be administered one time a day by mouth, and was scheduled for the morning. Observation on 08/14/2024 at 10:12 AM, showed Staff U, LPN, entered Resident 8's room and handed the Miralax medication cup (the Miralax powder was mixed with water) to Resident 8. Resident 8 was then observed to only sip approximately 1/3 of the Miralax medication mixture. Staff U retrieved the medication from the resident and placed it on a nearby sink counter. Staff U was then observed to administer, to Resident 8, a provider's order for liquid eye drops (a medication prescribed for dry eyes). Staff U retrieved the mixture containing Miralax from the counter and discarded the remaining amount down the sink. During an interview on 08/14/2024 at 3:05 PM, Staff U stated they remembered throwing the Miralax out and that they should have adjusted the administration record since Resident 8 did not take the full amount of the Miralax. During an interview on 08/15/2024 at 11:33 AM, Staff B, DNS, stated the nurse should have offered the resident the remaining amount of the Miralax mixture, and then documented that the resident did not take all the Miralax dose. Review of the EHR showed Resident 8 was prescribed systane ophthalmic solution (eye drops, prescribed for dry eye relief) one drop in each eye, given four times a day, scheduled between 6:30 AM to 9:30 AM and then again from 10:30 AM to 2:00 PM. Observation on 08/14/2024 at 10:12 AM showed Staff U charted off two administrations of the eye drops, the morning and the midday doses. Staff U then was observed to administer one eye drop into each eye for Resident 8. During an interview on 08/14/2024 at 2:53 PM, Staff U stated they only gave one administration of the eye drops and that this was a medication error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 11:33 AM, Staff B, DNS, stated their expectation was that staff would not have documented both eye drop administrations if they had only done one administration. Refence WAC 388-97-1060 (3)(k)(ii)

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 08/16/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable disease and infections by ensuring the proper application of transmission-based precautions (TBP, precautions used with known or suspected infectious diseases/illnesses) for 1 of 2 sampled residents (Resident 23) reviewed for infections. The facility failed to follow recommendations for Enhanced Barrier Precautions (EBP, the use of gowns and gloves for high contact procedures) for 2 of 2 sampled residents (Residents 1 and 54) reviewed for infection control. The facility also failed to maintain sanitary conditions in 1 of 2 medication carts (East Long Hall medication cart) reviewed for medication storage. These failed practices placed residents, visitors, and staff at risk for infection, infection related complications, and a decreased quality of life. Findings included . <Transmission-based Precautions> Resident 23 Resident 23 was admitted to the facility on [DATE] with diagnoses that included heart failure and depression. Review of the annual minimum data set assessment (MDS), an assessment tool, dated 07/05/2024, showed Resident 23 was able to make needs known and was taking an antibiotic (medication to treat infection). Review of Resident 23's current medication orders showed three different types of antibiotic eye drops that were ordered for a methicillin-resistant staphylococcus aureus (MRSA, a germ that is resistant to antibiotics and is easily spread in healthcare facilities) infection. Multiple observations from 08/12/2024 through 08/15/2024 showed Resident 23 in bed, with a darkened room. Resident 23 stated they had a serious eye infection, and their personal doctor was worried about it. There was no sign at the door for TBP or a personal protective equipment (PPE) supply container for staff to use. During an interview on 08/15/2024 at 9:40 AM, Staff B, Director of Nursing Services (DNS), stated the expectations was to have a TBP sign on the door and a container with PPE supply by the door for residents with active MRSA infections. <Enhanced Barrier Precaution> Resident 1 Resident 1 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (disease in which the immune system eats away at the protective covering on nerves, resulting in nerve damage) and pressure skin injury to the buttock. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS, dated [DATE], showed Resident 1 was not able to make needs known. During an observation and interview on 08/12/2024 at 11:00 AM, two staff members put on PPE to enter Resident 1's room. Staff N, Licensed Practical Nurse (LPN)/ Resident Care Manager (RCM), stated they would be doing wound care. Observations from 08/12/2024 through 08/15/2024 showed Resident 1' s room did not have a sign for EBP or a supply cart with PPE for staff to use. During an interview on 08/15/2024 at 9:42 AM, Staff B, DNS, stated the expectation was to have an EBP sign on the door and a container with PPE supply by the door for residents with chronic wounds. 38344 Resident 54 Review of Resident 54's electronic health record (EHR) showed the resident was transferred to the hospital on 08/01/2024 and readmitted to the facility on [DATE] with diagnoses to include heart failure, diabetes, and had a surgical wound located on the right lower leg. Resident 54 was able to make needs known. During an interview and observation on 08/12/2024 at 11:08 AM, Resident 54 stated they had just returned from the hospital after having surgery on their right lower leg. There was no sign posted on the door or at the entrance to the resident's room to show that Resident 54 was on enhanced barrier (EBP) due to having a surgical incision. Review of Resident 54's provider order, dated 08/09/2024, showed a wound treatment for the right lower leg/shin to be provided every morning. Review of Resident 54's current care plan did not show documentation that the resident was on EBP. Observation on 08/14/2024 at 9:57 AM, showed Staff L, Registered Nurse, providing wound treatment to Resident 54's right lower leg. Staff L did not have a gown on during the treatment. During an interview on 08/14/2024 at 10:19 AM, Staff L stated Resident 54 was not on EBP and they did not think it was necessary to wear a gown for Resident 54's wound treatment. During an interview on 08/14/2024 at 1:18 PM, Staff B, DNS, stated that Resident 54 should have been on EBP due to having a surgical wound that required a dressing. Staff B stated that Resident 54 needed to have EBP established with an order, EBP care planned, an EBP sign posted, and an isolation cart at the room. 50945 <East Long Wing Medication Cart> Review of the document titled Medication Storage, dated 01/2024, showed the medication storage areas should be clean and free of clutter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of East Long Wing Medication Cart on 08/14/2024 at 10:00 AM, showed Staff U, LPN, used an unlabeled pill cutter that had prior medication residue on it. Staff U stated they knew it was that resident's pill cutter, since they were the only resident that needed a pill cut. The pill cutter was not observed to be cleaned before or after the medication was cut in two. An observation of East Long Wing Medication Cart on 08/15/2024 at 9:54 AM showed the unlabeled pill cutter still had medication residue on it. The cart was also found to have dermal wound spray (cleanser for wounds) and a resident's urine sample in the bottom drawer. Staff M, LPN, stated the dermal wound spray and the urine sample should not be in the medication cart. During an interview on 08/15/2024 at 10:10 AM, Staff D, LPN/RCM, stated dermal wound spray should be stored in the wound cart, and urine samples should not be stored next to medication. During an interview on 08/14/2024 at 2:18 PM, Staff B, DNS, stated their expectation for staff regarding pill cutters is that staff would clean any residue they see. During an interview on 08/15/2024 at 10:14 AM, Staff B stated that the urine sample should have been stored in the laboratory box, not the medication cart. Reference WAC 388-97-1320 (1)(a)(b)(c), (2)(a)(b)(c)