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| 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 09/15/2025 |
| NAME OF PROVIDER OR SUPPLIER Puyallup Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 516 23rd Ave SE Puyallup, WA 98372 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident's bed fit them for 1 of 1 sampled resident (Resident 84) when reviewed for accommodation of need. This failure placed residents at risk of inability to sleep, decreased condition, and a diminished quality of life. Findings included. Review of the electronic health record showed Resident 84 admitted to the facility on [DATE] with diagnoses to include hemiplegia (difficulty moving one side of the body), repeated falls, and diabetes (too much sugar in the blood). Resident 84 was able to make needs known. Observation on 09/10/2025 at 9:53 AM showed Resident 84 laid in bed. Observation showed the footboard of the bed had been removed and Resident 84's feet hung off the bed with the back of the ankles resting on the bed. Observation on 09/15/2025 at 12:40 PM showed Resident 84's representative speaking with Staff M, Maintenance Director. Resident 84's representative stated Resident 84 had been waiting three weeks for a longer bed and Staff M stated they had been trying to locate a longer bed, but they were a hot commodity. Staff L stated the facility had bariatric beds (a specialized hospital bed designed for patients who are overweight or obese), but they were for patients that needed them so Resident 84 would have to wait. During an interview on 09/15/2025 at 1:10 PM, Resident 84's representative stated they had told the facility that Resident 84's bed was too short, and the facility had removed the footboard of the bed. Resident 84's representative stated Resident 84 would slide down in bed and they had to help them reposition in bed. Resident 84's representative stated Resident 84 was 6'3. During an interview on 09/15/2025 at 1:57 PM, Staff L, Licensed Practical Nurse/Resident care Manager, stated the facility provided beds that fit a resident by looking at their height and weight, and could rent additional bariatric beds if none were available. Staff L stated the expectation was that all residents would fit in their bed. Staff L stated Resident 84 could not reposition themselves in bed. During an interview on 09/15/2025 at 2:14 PM, Staff B, Director of Nursing Services, stated the expectation was all residents would fit in their bed, and this expectation was not met for Resident 84. Reference WAC 388-97-0860(2)</p> | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 505211 |
| | | If continuation sheet Page 1 of 16 |

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on interview and record review, the facility failed to have a system in place to address grievances/concerns raised by the Resident Council group for 4 of 8 months (January, March, April and September 2025) when reviewed for resident council. Failure of the grievance official to report back to the resident or council in writing with a response, rationale and action taken on grievances, placed residents at risk for continued concerns, unmet needs and a diminished quality of life. Findings included . During an interview on 09/10/2025 at 9:26 AM, Resident 40 stated when a concern was brought up in Resident Council, Resident 40 would be the one to take initiative and resolve the concern. Resident 40 stated they were unaware if the concerns were documented as a grievance. Review of the Resident Council meeting minutes for January, March, April and September 2025 showed there were a total of eight concerns voiced by residents that required a resolution. Review of the facility's Resident/Family Grievance Log from January 2025 through September 2025 showed there were no grievances related to the eight concerns discussed in Resident Council. During an interview on 09/11/2025 at 2:53 PM, Staff A, Administrator, stated grievances should have been filled out by the facilitator at the Resident Council meeting, logged and followed up on. Reference WAC 388-97-0920(1-6).</p> |

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| <p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a homelike environment in 2 of 2 halls (East and [NAME] Halls) when reviewed for environment. This failure placed residents at risk of decreased mood, feelings of worthlessness, and a diminished quality of life. Findings included. Observation on 09/09/2025 at 2:22 PM showed the closet door in room [ROOM NUMBER] without a closet door for bed A. Observation on 09/09/2025 at 12:50 PM showed a plastic bag tied to the overbed light cord in room [ROOM NUMBER] bed A. Observation on 09/09/2025 at 1:47 PM showed a plastic bag tied to the overbed light cord in room [ROOM NUMBER] bed B. Observation on 09/09/2025 at 3:18 PM showed a sock tied to the overbed light cord in room [ROOM NUMBER] bed A. Observation on 09/10/2025 at 9:42 AM showed a plastic bag tied to the overbed light cord in room [ROOM NUMBER] bed A and B. Observation on 09/10/2025 at 9:57 AM showed the baseboard molding near the bathroom peeling away from the wall in room [ROOM NUMBER]. Observation on 09/15/2025 at 11:45 AM showed a plastic bag tied to the overbed light cord in the following rooms: 153 bed B, 127 bed B, 119 bed A, 136 bed A, and 141 bed B. Observation showed the following rooms with overbed light cords less than three inches long: 186 bed B and 127 bed A. Observation showed a plastic bag braided into a cord and affixed to the back of the bathroom door in room [ROOM NUMBER]. During an interview on 09/15/2025 at 12:28 PM, Staff M, Maintenance Director, stated there were maintenance books at each nursing station where floor staff could inform maintenance of needed repairs. Staff M stated plastic bags should not be tied to overbed light cords and they were unaware of the peeling baseboard molding in room [ROOM NUMBER] or the missing closet door in room [ROOM NUMBER]. During an interview on 09/15/2025 at 2:17 PM, Staff A, Administrator, stated there were maintenance books at each nursing station where floor staff could inform maintenance of needed repairs. Staff A stated plastic bags should not be used to extend overbed light cords and the observations of needed maintenance did not meet expectations. Reference WAC 388-97-0880</p> |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p> |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly investigate and notify law enforcement for a physical abuse allegation with injuries for 1 of 3 sampled residents (Resident 45) reviewed for abuse and neglect. This failure placed residents at risk of physical and emotional harm, feelings of rejection and impaired quality of life. Findings included. Review of the Electronic Health Record (EHR) showed Resident 45 was readmitted to the facility on [DATE] with diagnoses to include acute respiratory failure, malnutrition (lack of sufficient nutrients in the body), depression, anxiety and seizure disorder (uncontrolled jerking, loss of consciousness, and other symptoms caused by abnormal electrical activities in the brain). Resident 45 was able to communicate needs. Observation and interview on 09/10/2025 at 9:45 AM showed Resident 45 in their room sitting on their wheelchair with worried facial expression and furrowed eyebrows. Resident 45 stated My knee hurts and they are not doing anything about it. Observation and interview on 09/11/2025 at 9:49 AM showed Resident 45 with a purple bruise to their right knee extending from below the knee to the upper thigh area, and stated the staff hurt them by hitting them for no reason. Review of a progress note, dated 09/06/2025, showed Resident 45 reported pain in their right thigh and stated a staff member punched them. Documentation showed a raised bruise on the right thigh area. Interventions were to start providing care in pairs and Tylenol as need it. Review of the admission minimum data set (MDS), an assessment tool, dated 07/22/2025 showed Resident 45 had no behaviors. Review of the social history and discharge plan dated 04/01/2025, showed Resident 45 had no history of trauma and under mental health needs were documented as not applicable. During an interview on 09/12/2025 at 11:32 AM, Staff G, Certified Nursing Assistant, stated Resident 45 experiences pain and was crying on the morning of 09/06/2025. Staff G assisted Resident 45 to use the bathroom (usually Resident 45 goes by their self) and observed fresh raised bruised and swollen area on the right thigh. Staff G stated the resident reported a staff member hitting them. Staff G stated additional bruises on the right knee and right inner thigh were not there on the morning of 09/06/2025, but Resident 45 had them the next day and was related to a different event. During an interview on 09/12/2025 at 12:24 PM, Staff K, Licensed Practical Nurse, stated Resident 45 had a bruise on the right thigh, and now Resident 45 has a bruise on the right inner thigh and right knee. Staff K stated Resident 45 was reporting that they were getting hit by a lady. Staff K was not sure how the bruises occurred and was not aware of any falls. Review of EHR showed Resident 45 was seen by Psychiatry (medical specialty dedicated to diagnose, treatment and prevention of mental, emotional and behavioral disorders) on 09/12/2025 at 12:24 PM and notes stated Impression [they] appears to continue to suffer harm from reported harm. Recommendation [their] report should be investigated and taken seriously. [They] does not appear psychotic or confused and appears to have suffered significant injury. Review of the incident log for September 2025, showed Resident 45 had an occurrence on 09/06/2025 with injury of small bruises and it was reported to the state hot line, and a second occurrence on 09/10/2025 with injuries of bruises that are in an area not generally vulnerable to trauma reported to state hot line. Review of Resident 45 's allegation of physical abuse investigation of 09/06/2025 showed the root cause of the Injuries were related to cognition and diagnoses and Resident 45 having untrue statements, and abuse and neglect was ruled out. Review of Resident 45's second physical abuse investigation of 09/10/2025 showed purple bruise on right knee measuring four and a half inches and purple bruise on the right inner thigh measuring two inches by four inches, and root cause of the injuries were from Resident 45 throwing themselves onto the bed on the right side and abuse and neglect was ruled out. The investigation did not have witness statements of any staff member observing Resident 45 throwing themselves to the bed or chair. During an interview on 09/15/2025 at 08:54 AM, Resident 45 stated they were still afraid of the staff because they could come back and hurt them again. During an interview on 09/15/2025 at 10:01 AM, Staff J, Nurse Manager /Patient Care Coordinator, stated after reviewing facility policy that law enforcement should have been notified. During an interview on 09/15/2025 at 11:26 AM, Staff B, Director of Nursing Services, stated Resident 45 had allegations and was placed on care in pairs (2 staff members with all interactions) for staff protection, and law enforcement was to be notified only when abuse was confirmed per facility policy. Staff B stated there were no environmental interventions put in place despite the claims that Resident 45 was throwing himself onto the bed or chair. Reference WAC 388-97-0640(6)(a)(b)</p> | | |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 4 of 4 sampled residents (Residents 1, 11, 39 and 52) when reviewed for hospitalization. This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Resident 1 Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses that included dementia (a decline in mental ability that interferes with daily life) and diabetes (too much sugar in the blood). Resident 1 was unable to make needs known. Review of Resident 1's EHR showed hospitalization on 08/31/2025, with no documentation that the resident or resident representative were provided with written copies of the bed hold notice or transfer form. Resident 11 Review of the EHR showed Resident 11 admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis (disease that primarily affects the joints, causing inflammation, pain, stiffness, and damage) and chronic obstructive pulmonary disease (COPD, a condition caused by damage to the lungs). Resident 11 was able to make needs known. Review of Resident 11's EHR showed hospitalization on 08/29/2025, with no documentation that the resident or resident representative were provided with written copies of the bed hold notice or transfer form. Resident 39 Review of the EHR showed Resident 39 admitted to the facility on [DATE] with diagnoses that included COPD and diabetes. Resident 39 was able to make needs known. Review of Resident 39's EHR showed hospitalization on 02/22/2025, with no documentation that the resident or resident representative were provided with written copies of the bed hold notice or transfer form. Resident 52 Review of the EHR showed Resident 52 admitted to the facility on [DATE] with diagnoses that included hip pain, depression and degenerative disc disease (condition that effects discs in the spine). Resident 52 was able make needs known. Review of Resident 52's EHR showed hospitalization on 08/10/2025, with no documentation that the resident or resident representative were provided with written copies of the bed hold notice or transfer form. During an interview on 09/11/2025 at 2:50 PM, Staff A, Administrator, stated the expectation was for bed hold and transfer forms to be provided to residents when transferred to the hospital. Reference WAC 388-91-0120(4)</p> | | |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly screen residents for additional mental health supports through the Preadmission and Resident Review (PASARR, a mental health screening tool) for 4 of 7 sampled residents (Residents 2, 5, 3, and 9) when reviewed for PASARR. This failure placed residents at risk of lack of mental health support, increasing behaviors, decrease in mental health, and a diminished quality of life. Findings included. Resident 2</p> <p>Review of the electronic health record (EHR) showed Resident 2 admitted to the facility on [DATE] with diagnoses to include dementia (a group of conditions that cause a decline in cognitive abilities, memory, and thinking skills that interfere with daily life) and depression. Resident 2 was able to make needs known.</p> <p>Review of the level 1 PASARR showed it was completed on 08/28/2025, 15 days after admission.</p> <p>Resident 5</p> <p>Review of the EHR showed Resident 5 admitted to the facility on [DATE] with diagnoses to include depression, hemiplegia (difficulty moving one side of the body), and diabetes (too much sugar in the blood). Resident 2 was able to make needs known.</p> <p>Review of the level 1 PASARR showed it was completed on 07/23/2025, 1 month and 29 days after admission.</p> <p>Resident 3</p> <p>Review of the EHR showed Resident 3 admitted to the facility on [DATE] with diagnoses to include psychotic disorder and hemiplegia. Resident 2 was able to make needs known.</p> <p>Review of the level 1 PASARR showed it was completed on 07/09/2025, 4 months and 8 days after admission.</p> <p>During an interview on 09/12/2025 at 1:56 PM, Staff N, Social Services Director, stated the facility would receive the PASARR from the hospital and re-complete it in the first few days of admit if inaccurate.</p> <p>During an interview on 09/15/2025 at 12:05 PM, Staff N, Social Services Director, stated Resident 2, Resident 5, and Resident 3's PASARR were not completed timely, and this did not meet expectation.</p> <p>During an interview on 09/15/2025 at 2:10 PM, Staff A, Administrator, stated the facility would receive the PASARR from the hospital on admitting to the facility and correct it, if inaccurate, within the first seven days.</p> <p>Resident 9</p> <p>(continued on next page)</p> |

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| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the EHR showed Resident 9 was admitted to the facility on [DATE] with diagnoses to include arthritis (joint pain and inflammation), depression, bipolar disorder (disorder with episodes of mood swings ranging from depressive lows to manic highs) and heart failure. Resident 9 was able to communicate needs.</p> <p>Review of a PASRR level one, dated 08/08/2023 showed no level two evaluation indicated.</p> <p>During an interview on 09/15/2025 at 11:18 AM, Staff B, Director of Nursing Services, stated Resident 9 not having a level two evaluation referral required for mental illness did not meet expectations.</p> <p>Reference WAC 388-97-1915(1)(2)(a-c)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide quality of care related to the following: medication parameters, non-pressure skin management, bowel management and anticoagulation management for 5 of 22 sampled residents (Residents 30,3, 9, 45 and 5) when reviewed for quality of care. These failures placed the residents at risk for poor clinical outcomes and a decreased quality of life. Findings included .Resident 5</p> <p>Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnosis of stroke. The resident was unable to make their needs known.</p> <p>Review of the EHR showed an order for coumadin (a blood thinning medication) for blood clot prevention daily.</p> <p>Review of the plan of care on 09/10/2025 showed no active care plan for anticoagulant therapy.</p> <p>During an interview on 09/12/2025 at 9:20 AM, Staff E, Licensed Practical Nurse/Resident Care Manager (LPN/RCM) stated Resident 5 should have had a care plan for anticoagulation therapy but did not.</p> <p>During an interview on 09/12/2025 at 9:34 AM, Staff B, Director of Nursing Services (DNS) stated Resident 5 should have had a care plan in place for anticoagulant therapy but did not and this did not meet expectations.</p> <p>Resident 30</p> <p>Review of the EHR showed Resident 30 admitted to the facility on [DATE] with diagnoses to include fracture of the right leg, hypertension (high blood pressure), anxiety, and depression. Resident 30 was able to make needs known.</p> <p>Review of the provider's orders showed Resident 30 received metoprolol tartrate (blood pressure medication) with instructions to hold if the systolic blood pressure (SBP, top blood pressure reading) was less than 105, dated 08/04/2025, and furosemide (a water removing medication) with instructions to hold if the SBP was less than 100, dated 08/12/2025.</p> <p>Review of the August 2025 medication administration record (MAR) showed Resident 30 received metoprolol tartrate with an SBP less than 105 on 6 of 51 opportunities and furosemide with an SBP less than 100 on 2 of 20 opportunities.</p> <p>Review of the September 2025 MAR showed Resident 30 received metoprolol tartrate with an SBP less than 105 on 4 of 21 opportunities and furosemide with an SBP less than 100 on 2 of 11 opportunities.</p> <p>During an interview on 09/15/2025 at 1:14 PM, Staff E, LPN/RCM, stated nursing staff should review and follow parameters associated with medications. Staff E stated Resident 30 received metoprolol tartrate and furosemide outside of parameters.</p> <p>(continued on next page)</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 09/15/2025 at 2:05 PM, Staff B, Director of Nursing Services, stated nursing staff should review and follow parameters associated with medications. Staff B stated Resident 30 receiving blood pressure medications outside of parameters did not meet expectation.</p> <p>Resident 3</p> <p>Review of the EH) showed Resident 3 was admitted to the facility on [DATE] with diagnoses to include hemiplegia following stroke (condition that causes paralysis or severe weakness on one side of the body), end stage renal disease with dialysis (treatment that removes waste products and excess fluid from blood when kidneys are not functioning) and depression. Resident 3 was able to communicate needs.</p> <p>During an interview on 09/11/2025 at 12:08 PM, Resident 3 stated they have chronic constipation (when a person passes less than three bowel movements a week or has difficult bowel movements), and they require assistance to use the bathroom.</p> <p>Review of the bowel documentation from 08/12/2025 through 09/12/2025 showed, Resident 3 did not have bowel movements on the dates 08/12/2025, 08/13/2025, 08/14/2025 and 08/15/2025 for a total of four days and 08/29/2025, 08/30/2025, 08/31/2025, 09/01/2025 and 09/02/2025 for a total of five days.</p> <p>Review of the MAR for August and September 2025, showed no documented laxatives (medications that promote bowel movements) were administered.</p> <p>During an interview on 09/11/2025 at 12:40PM, Staff K, Licensed Practical Nurse, stated the facility has a bowel protocol that is initiated after 72 hours of no bowel movements, and the night shift usually initiates the protocol, and next shift is to follow up on it.</p> <p>During an interview on 09/15/2025 at 11:22 AM, Staff B, Director of Nursing Services, stated the bowel management for Resident 3 did not meet expectations.</p> <p>Resident 9</p> <p>Review of the EHR showed Resident 9 was admitted to the facility on [DATE] with diagnoses to include arthritis (joint pain and inflammation), depression, bipolar disorder (disorder with episodes of mood swings ranging from depressive lows to manic highs) and heart failure. Resident 9 was able to communicate needs.</p> <p>During an observation and interview on 09/10/2025 at 10:44 AM, Resident 9 stated their band aid keeps falling out, and Resident 9 was pointing towards skin- tear with a bruise on left hand.</p> <p>Review of weekly skin check dated 09/03/2025 showed Resident 9 had their right hand with scattered bruising and the back of left hand with scattered bruising.</p> <p>Review of a weekly skin check dated 09/10/2025 showed Resident 9 had a red area on their coccyx (tail bone) from shearing, left hand scratch, left forearm scattered bruising and right forearm scattered bruising. There was no clear description of the skin injuries.</p> <p>(continued on next page)</p> | | |

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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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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 09/12/2025 at 10:30 AM, Staff K, LPN, stated the bruises are usually monitored daily with orders, and the sizes and description should be documented in the record.</p> <p>Resident 45</p> <p>Review of the EHR showed Resident 45 was readmitted to the facility on [DATE] with diagnoses to include acute respiratory failure, malnutrition (lack of sufficient nutrients in the body), depression, anxiety and seizure disorder (uncontrolled jerking, loss of consciousness, and other symptoms caused by abnormal electrical activities in the brain). Resident 45 was able to communicate needs.</p> <p>Observation and interview on 09/11/2025 at 9:49 AM showed Resident 45 with a large purple bruise on their right knee.</p> <p>Review of weekly skin check dated 07/21/2025 showed Resident 45 had no skin issue present.</p> <p>Review of weekly skin check dated 08/28/2025 showed Resident 45 had an old bruise on the front of the left thigh and scattered bruises to the back of their right hand, there was no color description or sizes/measurements included.</p> <p>Review of weekly skin checks dated 08/29/2025 showed Resident 45 had a red/purple bruise on the right forearm, a purple bruise on the right elbow, four small yellow bruises on the left antecubital (inner surface of elbow), scabs on the right ear next to their face, a bruise on the right ankle and scattered yellow bruising on the right front thigh. There were no documented sizes for any of the bruises.</p> <p>Review of weekly skin check dated 09/05/2025 and locked date 09/11/2025, showed Resident 45 had scattered bruising up and down the right leg, with a bruise on the front of left knee, a bruise on the front of the right knee and a bruise on the back of the right thigh. There was no description or sizing of the skin injuries.</p> <p>During an interview on 09/12/2025 at 12:24 PM, Staff K, Licensed Practical Nurse, stated the bruises are usually monitored daily with orders, and the sizes and description should be documented in the record.</p> <p>During an interview on 09/12/2025 at 12:27 PM, Staff H, Registered Nurse, stated the bruises are to have description and sizing documented at the weekly skin checks.</p> <p>During an interview on 09/15/2025 at 11:19 AM, Staff B, Director of Nursing Services, stated the skin checks documentation for Residents 45 and 9 did not meet expectations.</p> <p>Reference WAC 388-97-1060 (1)</p> |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen services per provider's orders for 1 of 3 sampled residents (Resident 48) when reviewed for respiratory services. This failure placed residents at risk of oxygen poisoning, decline in condition, and a diminished quality of life. Findings included. Review of the electronic health record (EHR) showed Resident 48 admitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), and diabetes (too much sugar in the blood). Resident 48 was able to make needs known.</p> <p>Review of the provider's orders showed Resident 48 received oxygen at 2 liters per minute (L/m), dated 08/25/2025, and nursing staff was to verify the flow rate three times a day, dated 08/25/2025.</p> <p>Observation on 09/09/2025 at 12:43 PM, 09/11/2025 at 9:45 AM, and 09/15/2025 at 9:20 AM showed Resident 48 was receiving oxygen at 5 L/m.</p> <p>Review of the medication administration record for 09/09/2025 through 09/15/2025 showed the facility's nursing staff had marked Resident 48 was receiving oxygen at 2 L/m.</p> <p>During an interview on 09/15/2025 at 1:41 PM, Staff L, Licensed Practical Nurse/Resident Care Manager, stated the facility ensured oxygen was provided per provider's order by reviewing the order and the expectation was it would be followed. Staff L observed Resident 48's oxygen and stated it was being provided at 5L/m, which did not meet expectations. Staff L stated facility nursing staff had marked Resident 48 was receiving oxygen at 2L/m on multiple occasions.</p> <p>During an interview on 09/15/2025 at 2:05 PM, Staff B, Director of Nursing Services, stated the expectation was for residents to receive oxygen per provider's orders and Resident 48 receiving oxygen at 5 L/m did not meet expectations.</p> <p>Resident 81</p> <p>Review of EHR showed Resident 81 was readmitted to the facility on [DATE] with diagnoses to include respiratory failure, COPD, and asthma (when airways are inflamed and makes it difficult to breathe). Resident 81 was able to communicate their needs.</p> <p>During an observation and interview on 09/09/2025 at 2:54 PM, Resident 81 was in bed receiving oxygen via nasal cannula (thin tubing in nose) at two liters per minute. Resident 81 stated they have been using oxygen since coming back from the hospital and they need it.</p> <p>Review of the providers orders for September 2025 showed no order for the use of Oxygen.</p> <p>During an interview on 09/15/2025 at 10:01 AM, Staff J, Nurse Manager/Patient Care Coordinator, stated the expectation was for oxygen to be administered with a provider order and descriptions of the rate and to document oxygen saturation levels.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 09/15/2025 at 11:16 AM, Staff B, Director of Nursing Services, stated documentation for Resident 81's oxygen administration did not meet expectations.</p> <p>Reference WAC 388-97-1060(3)(j)(vi)</p> |

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| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement non-pharmacological interventions (NPI) prior to providing as needed (PRN) pain medications for 4 of 5 residents (Residents 5, 39, 30 and 3) and failed to implement parameters for use of pain medications for 1 of 5 residents (Resident 30) when reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary pain medications, and a decreased quality of life. Findings included .Resident 5</p> <p>Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnosis of stroke (when blood supply to part of the brain is blocked or reduced. causing loss of function), and diabetes (too much sugar in the blood). The resident was unable to make their needs known.</p> <p>Review of the provider orders showed Resident 5 received a PRN narcotic pain medication on 08/06/2025 and 09/10/2025.</p> <p>Review showed a provider order for nursing staff to attempt nonpharmacological interventions (NPI) such as repositioning prior to administering as needed pain medications.</p> <p>Review of the medications administration record (MAR) showed no NPI were attempted prior to administering the as needed pain medications.</p> <p>Resident 39</p> <p>Review of the EHR showed Resident 39 admitted to the facility on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD, a lung disease). The resident was able to make needs known.</p> <p>Review of the provider orders showed an order for a narcotic pain medication as needed (PRN).</p> <p>Review of the EHR showed the resident received a narcotic pain medication PRN on 09/08/2025, 09/09/2025 and 09/10/2025. There was no documentation found that NPI were offered/attempted prior to the as needed pain medications.</p> <p>During an interview on 09/11/2025 at 3:17 PM, Staff E, Licensed Practical Nurse (LPN/RCM) stated staff should have documented NPI attempted prior to administering as needed pain medications in the EHR for Residents 5 and 39 but did not.</p> <p>During an interview on 09/12/2025 at 9:31 AM, Staff B, Director of Nursing Services (DNS) stated it was their expectation staff attempt NPI prior to administering as needed pain medications and document them in the EHR.</p> <p>Resident 30</p> <p>Review of the EHR showed Resident 30 admitted to the facility on [DATE] with diagnoses to include fracture of the right leg, hypertension (high blood pressure), anxiety, and depression. Resident 30 was able to make needs known.</p> <p>(continued on next page)</p> | | |

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| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of provider's orders showed Resident 30 received acetaminophen (an over-the-counter pain medication) PRN, dated 08/04/2025, lidocaine external patch (a topical pain medication) PRN, dated 08/04/2025, and received oxycodone (a narcotic pain medication) PRN from 08/04/2025 to 08/08/2025. Review showed none of these orders for PRN pain medications included instructions to nurses on which medication to use for what level of pain. Review showed an order for staff to provide NPI prior to the use of PRN pain medications.</p> <p>Review of the August 2025 MAR showed Resident 30 received acetaminophen without NPI on three occasions, received oxycodone without NPI on 3 occasions, and never received the lidocaine patch.</p> <p>During an interview on 09/15/2025 at 1:14 PM, Staff E, LPN/RCM, stated the facility ensured PRN pain medications were needed by monitoring the pain scale (a scale of 1-10) and providing NPI prior to their use. Staff E stated Resident 30 had orders for NPI to be used but had received PRN pain medications without NPI. Staff E stated the facility's nursing staff would know which PRN pain medications to provide by using a pain scale. Staff E stated Resident 30's PRN medication did not include a pain scale for facility nursing staff to use to determine which PRN pain medication to use. Staff E stated the expectation was Resident 30 would have NPI prior to PRN pain medications and PRN medications would include pain scale for use.</p> <p>During an interview on 09/15/2025 at 2:05 PM, Staff B, DNS, stated NPI should be provided prior to the use of PRN pain medications and PRN pain medications should include a pain scale of when to use. Staff B stated Resident 30's lack of NPI prior to PRN pain medication use and lack of pain scale for PRN medications did not meet expectations.</p> <p>Resident 3</p> <p>Reviews of the EHR showed Resident 3 was admitted to the facility on [DATE] with diagnoses to include hemiplegia following stroke (conditions that cause paralysis or severe weakness on one side of the body) end stage renal disease with dialysis (treatment that removes waste products and excess fluid from blood when kidneys are not functioning) and depression. Resident 3 was able to communicate needs.</p> <p>Review of Resident 3's MAR for August 2025 showed an order for Oxycodone (narcotic pain medicine) to be given every eight hours PRN for severe pain, and for nurses to document NPI prior to the use of the medicine. Records showed Resident 3 had oxycodone medication on 08/10/2025,08/11/2025, 08/12/2025,08/18/2025,08/20/2025,08/22/2025, 08/23/2025 and 08/25/2025 without documentation of any NPI attempted prior to the use of the medication.</p> <p>Review of the September 2025 MAR showed Resident 3 had been administered oxycodone on 09/03/2025, 09/07/2025 and 09/08/2025 without documentation of NPI's attempts.</p> <p>During an interview on 09/15/2025 at 10:16 AM, Staff J, Nurse Manager/Patient Care Coordinator, stated the process is for NPI's to be tried and documented prior use of PRN pain medications.</p> <p>During an interview on 09/15/2025 at 11:18 AM, Staff B, Director of Nursing Services, stated documentation for Resident 3's pain medication administration did not meet expectations.</p> <p>Reference WAC 388-97-1060(3)(k)(i)</p> | | |

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| <p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide dental services to increase residents' ability to eat for 1 of 3 sampled residents (Resident 4) when reviewed for dental services. This failure placed the resident at risk of decreased nutritional intake, oral discomfort, and a diminished quality of life. Findings included. Review of the electronic health record showed Resident 4 admitted to the facility on [DATE] with diagnoses to include enterocolitis (inflammation of the intestines), malnutrition (insufficient nutritional intake), and adult failure to thrive. Resident 4 was able to make needs known. Observation and interview on 09/09/2025 at 10:24 AM showed Resident 4 had 2 teeth. Resident 4 stated the facility did not offer any dental services to them. Review of Resident 4's care plan, initiated 08/19/2025, showed no focus area related to dental. Review showed a focus area related to Resident 4 being at risk for nutritional problems, had a mechanically altered diet (a dietary modification designed for individuals with difficulty chewing or swallowing), and was at risk for inadequate oral intake. Review of a Dietitian Consulting Services - Nutrition Assessment, dated 08/29/2025, showed Resident 4 had a Dysphagia texture - Moist and Minced (modifications in food and liquid consistency to make them easier and safer to swallow for individuals with swallowing difficulties). Review showed the question Resident has dental or mouth problems that make it hard to chew or swallow was answered None noted. During an interview on 09/15/2025 at 1:41 PM, Staff L, Licensed Practical Nurse/Resident Care Manager, stated the facility conducted an oral exam on admission to determine which residents required dental services. Staff L stated residents missing teeth would be referred to a dentist or dentist. Staff E stated Resident 4 had one tooth and would like to have an upgraded diet. Staff E stated Resident 4 had not been referred to dental services and this did not meet expectations. During an interview on 09/15/2025 at 2:05 PM, Staff B, Director of Nursing Services, stated residents would have an oral assessment on admission and be referred to dental services if they had broken or missing teeth. Staff B stated Resident 4 should have been referred to dental services. Reference WAC 388-97-1060 (3)(j)(vii)</p> | | |