STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505304	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rainier Rehabilitation	920 12th Avenue Southeast 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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a written bed hold notice at the time of transfer to the hospital for 2 of 3 sampled residents (Residents 109 and 56) 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 109Review of the electronic health record (EHR) showed Resident 109's current admission to the facility was on 10/03/2024 with diagnoses that included kidney failure, diabetes (too much sugar in the blood) and chronic pain. Resident 109 was hospitalized on [DATE] with readmission to the facility on [DATE]. Resident 109 was hospitalized on [DATE] with readmission to the facility on [DATE]. There was no documentation showing the bed hold notice was provided in writing to the resident/resident representative. Resident 56Review of the EHR showed Resident 56 admitted to the facility on [DATE] with diagnoses that included diabetes and chronic obstructive pulmonary disease (COPD, an ongoing lung condition caused by damage to the lungs. Resident 56 was hospitalized with Return Anticipated on 05/28/2025 and readmitted to the facility on [DATE]. There was no documentation showing the bed hold notice was provided in writing to the resident/resident representative. During an interview on 08/11/2025 at 2:41 PM, Staff B, Director of Nursing Services, stated the facility did not provide residents with a written copy of bed holds at the time of transfer only upon admission. During an interview on 08/11/2025 at 2:43 PM, Staff A, Administrator, stated bed holds were communicated verbally, and the facility did not provide residents with a written copy. Reference WAC 388-91-0120(4).

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a level I Pre-admission Screening and Resident Review (PASRR, a mental health screening tool) assessment was obtained prior to admission and was completed timely for 1 of 6 sample residents (Residents 49) reviewed for PASRRs or unnecessary medication use. This failure placed the resident at risk for unidentified mental health care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, PASRR screening for Mental Disorder/ Intellectual Disability, dated 01/22/2025 showed, The PASRR, process requires all individuals be screened for possible serious mental disorders or intellectual disabilities and related conditions. The initial pre-screening (PASRR level I) should be completed prior to admission to facility. A negative Level I requires no further action. Review showed, A positive Level I Screen (PASRR Indicates that individual requires a PASRR Level II Referral) necessitates an in-depth evaluation of the individual by the state-designated authority (PASRR Level II) which must be conducted prior to admission to a nursing facility OR upon identification that the individual may need a level II PASRR Referral while at the Nursing Facility. Review of the electronic health record (EHR) showed Resident 49 admitted to the facility on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD, a mental health condition caused by an extremely stressful or terrifying event), cognitive (relating to the mental process involved in knowing, learning, and understanding things) communication deficit, and depression. Resident 49 was able to make needs known. Review of the level I PASRR form, dated 07/22/2025, showed Resident 49 was a current nursing facility resident that was admitted on [DATE] and had serious mental illness indicators marked on the form for PTSD and mood disorders. Review showed Resident 49 required a level II evaluation referral for their serious mental illnesses. During an interview on 08/11/2025 at 1:08 PM, Staff G, Social Services Director/Admissions Coordinator (SSD/AC), stated Resident 49 was admitted to the facility on [DATE] and did not admit to the facility with a level I PASRR completed. Staff G stated they completed a level I PASRR for Resident 49 on 07/22/2025 and was completed timely because they had completed it within 24 hours of admission. During an interview on 08/11/2025 at 1:25 PM, Staff A, Administrator, stated PASRRs were to be obtained prior to admission and/or if inaccurate they were to be completed on the date of admission. Staff A stated Resident 49's level I PASRR did not meet expectations because it should have been completed on 07/21/2025 (on admission). Reference WAC 388-97-1915 (1)(2)(a-c)

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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** Based on observation, interview and record review the facility failed to obtain and/or ensure physician orders were followed for 1 of 24 sampled residents (Residents 47) reviewed for vision care related to medication administration. This failure placed the resident at risk for medical complications, substandard quality of care and unmet care needsFindings included .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. The Washington State Nurse Practice Act, WAC 246-840-710(2)(d), states nurses violate standards of practice by, Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards. Review of a document titled, Medication Administration / Standards and Principles - Eye drops, dated 04/2016, showed medications were to be accurately prepared, administered and documented per provider's order. Resident 47Review of Resident 47's quarterly minimum data set (MDS, a required assessment tool), dated 05/17/2025, showed Resident 47 admitted on [DATE] with multiple health conditions to include traumatic brain injury, respiratory failure, malnutrition, and depression. Review of the electronic health record (EHR) showed Resident 47 had visual impairment and was able to make their needs known. Review of Resident 47's current focus care plan, multiple dates, showed the resident was at risk for impaired visual function. Interventions included for licensed nurses (LNs) to administer medication as ordered by the provider. Review of Resident 47's medication administration record (MAR), dated August 2025, showed a provider's order dated 12/17/2024 for LNs to administer multiple ophthalmic (eye) medications to include carboxymethylcellulose sodium ophthalmic solution (an eye drop treatment that acts as a lubricant for dry eyes), two drops in the residents left eye four times a day and wait five minutes before the administration of another eye drop. An additional ophthalmic medication was ordered on 07/01/2025 for the LN to administer erythromycin ophthalmic ointment in the left eye four times a day and not to apply at the same time as the carboxymethylcellulose drops and to separate them (eye drop) administration by 60 minutes. Resident 47's MARs for the ordered eyes drops did not show the eye drops being held as ordered for 60 minutes between each eye drop administration. Observation and interview on 08/11/2025 at 9:18 AM showed Resident 47's left eye with small amount of secretion. Resident 47 stated the LNs administered their eye medications all at once throughout the day. During an interview on 08/11/2025 at 9:18 AM, Staff F, Licensed Practical Nurse/Unit Supervisor (LPN/US) stated the LNs were supposed to space out Resident 47s eye drops as per the providers' orders. During an interview on 08/11/2025 at 9:24 AM, Staff B, Director of Nursing Service, stated Resident 47 was being administered the eye drops by the LNs at the same time despite a provider's order to hold 60 minutes between each of eye drop medication. Staff B stated it was the expectation for the LNs to administer the eye drops as per the providers' orders. 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** Based on observation, interview, and record review the facility failed to consistently implement and provide splints (device used to support, protect and immobilize body parts) for 1 of 4 sampled residents (Resident 2) reviewed for position/mobility. This failure placed the resident at risk for worsening contractures (condition when joint becomes permanently fixed in a bent or short-ended position due to the shortening of muscle, tendon, or skin), increased difficulties with dressing, grooming and decreased quality of life Findings included. Review of the electronic health record (EHR) showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital or before birth disorder of brain with abnormal movement, muscle tone or posture), chronic respiratory failure and quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). Review of the annual minimum data set (MDS, an assessment tool), dated 06/18/2025, showed Resident 2 could not communicate and had severely impaired decision-making skills. The MDS showed Resident 2 was dependent on staff for all the activities of daily living including nutrition and showed Resident 2 was using a splint or brace assistance for seven days of the week. Review of the care plan with focus area Restorative, dated 04/17/2017, showed Resident 2 was to have the following interventions Apply splints to Bilateral hands and elbows, splints alternating days on right and left side, Wear time up to 4 hours. Application time approx. 15 min [minutes] up to 7 days a week as tolerated by resident. Observation on 08/09/2025 at 10:35 AM, showed Resident 2 laid in bed, in a facility gown, with both elbows, wrists and fingers contracted without splints in place. Observation on 08/10/2025 at 10:30 AM, 12:10 PM and 1:44 PM showed Resident 2 in their wheelchair with no splints in place. Observation on 08/11/2025 9:23 AM and 10:30 AM showed Resident 2 in bed in a facility gown and hands folded without splints in place. Review of the EHR showed Resident 2 had documentation that showed splints application applied on 08/09/2025 at 10:14AM, 08/10/2025 at 10:00AM and 08/11/2025 at 9:19AM. During an interview on 08/11/2025 at 10:54 AM, Staff D, Restorative Nursing Assistant, stated they applied the splints and then signed for them. Staff D pulled the splints from the closet and applied them to Resident 2. Staff D stated the splints were to stay on for 6 hours. During an interview on 08/11/2025 at 10:58 AM, Staff C, Assessment MDS Nurse, stated the facility had two restorative nursing assistants. Staff C stated Resident 2 may have had a shower and restorative staff were to apply the splints back on. Staff C provided paper documentation that showed staff were signing for splints, and Resident 2 usually had their splints taken off between 10:20 AM and 12:15 AM from 08/01/2025 through 08/08/2025.Review of the paper splint documentation showed Resident 2 had nursing remove the splints on 08/09/2025 and on 08/10/2025 the time for the splint removal was unclear and the time was scribbled over and showed nursing written next to it. During an interview on 08/11/2025 at 12:51 PM, Staff E, Certified Nursing Assistant, stated they showered Resident 2 before 9:00 AM, and asked restorative staff to place the splints back on. Reference WAC 388-97-1060(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to use proper Personal Protective Equipment (PPE, equipment worn to minimize exposure to infectious diseases/illnesses) and follow hand hygiene practices to transport used gowns from resident rooms with Enhanced Barrier Precautions in 1 of 3 sampled Halls (100 Hall) when reviewed for Infection Control. This failure placed residents at risk for transmission of communicable diseases, hospitalization and diminished quality of life.Findings included. Observation on 08/11/2025 at 10:01 AM showed Staff H, Housekeeping Supervisor, in room [ROOM NUMBER] (a room with an Enhanced Barrier Precaution sign) transferring used gowns from the receptacle in the room to a large plastic bag on the floor. Staff H was not wearing any gloves; they proceeded to tie the plastic bag and threw it in a cart in the hallway. No hand hygiene was observed prior to Staff H pushing the cart to the next room. During an interview on 08/12/2025 at 9:45 AM Staff H, Housekeeping Supervisor, stated when the plastic bag was overfull in the receptacle, they would transfer all the gowns to another bag and refit the current bag in the receptacle. Staff H stated the expectation was to wear gloves; however, they did not have a pair in their pocket at the time. During an interview on 08/12/2025 at 11:45 AM, Staff A, Administrator, stated the expectation was staff would wear gloves when handling dirty gowns or linen. Reference WAC 388-97-1320(1)(a)