STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505324	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Puyallup	511 10th 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to create a comprehensive care plan for 2 of 3 residents (Residents 1 and 2) reviewed for urinary incontinence. This failure placed the residents at risk for unmet needs, skin impairments, feelings of discomfort and a decreased quality of life.Findings included.Resident 1Review of the admission minimum data set (MDS, a required assessment tool), dated 06/18/2025, showed Resident 1 admitted on [DATE] with diagnoses to include hip fracture with surgical repair, weakness, difficulty walking, and need for assistance with personal care. The MDS showed Resident 1 was always incontinent (had lack of voluntary control) of bowel and bladder.Review of the comprehensive care plan, last reviewed 07/09/2025, showed incontinence was not listed, nor were goals or interventions in the care plan to address Resident 1's incontinence. Resident 2Review of the admission MDS, dated [DATE], showed Resident 2 admitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), overactive bladder, and need for assistance with personal care. The MDS showed Resident 2 was frequently incontinent of bladder.Review of a facility document titled, Admission/readmission Collection Tool - V 6, dated 05/20/2025, showed Resident 2 was incontinent of bladder.Review of the discharge MDS, dated [DATE], showed Resident 2 discharged from the facility on 06/02/2025.Review of the comprehensive care plan, last reviewed 07/09/2025, showed that Resident 2's incontinence was not included in their care plan until 06/02/2025, the date that Resident 2 discharged . During interview on 07/09/2025 at 3:36 PM, Staff A, Director of Nursing Services (DNS), stated that Residents 1 and 2 should have had care plans in place for incontinence as soon as the need for care in that area was identified - via the admission nursing assessment and/or the MDS.Reference WAC 388-97-1020(1), (2)(a)(b).

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505324	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to routinely monitor and assess the status of skin impairments for 2 of 3 residents (Residents 1 and 2) reviewed for pressure injuries. This failure placed the residents at risk for worsening of pressure wounds, lack of appropriate treatment, medical complications and a decreased quality of life.Findings included.Resident 1Review of the admission minimum data set (MDS, a required assessment tool), dated 06/18/2025, showed that Resident 1 admitted on [DATE] with diagnoses to include hip fracture with surgical repair, weakness, difficulty walking, and need for assistance with personal care. The MDS further showed that Resident 1 had a stage 1 pressure injury (the initial stage of a pressure ulcer, characterized by non-blanchable [does not fade or turn white when pressure is applied] redness of intact skin, usually over a bony prominence) over the sacrum (large triangular bone at the bottom of the spine). Review of the care plan, dated 06/16/2025, showed that Resident 1 was at risk for pressure related skin injury related to impaired mobility and incontinence (poor bladder and bowel control).Review of the facility document titled, Admission/readmission Collection Tool - V 6, dated 06/16/2025, showed that Resident 1 had non-blanchable redness to sacrum. There were no measurements documented.Review of the active and discontinued physician orders, on 07/09/2025, showed Resident 1 did not have a treatment or monitoring order for the stage 1 pressure injury over the sacrum.Review of the medical record showed no additional documentation, after Resident 1's admission date, to show that the stage 1 pressure injury had been monitored, and no documentation of it's worsening or improvement.Resident 2Review of the admission minimum data set (MDS, a required assessment tool), dated 05/23/2025, showed that Resident 2 was admitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized muscle weakness, and need for assistance with personal care. The MDS further showed that Resident 2 had moisture-associated skin damage (MASD, skin inflammation and erosion caused by prolonged exposure to moisture such as urine) to the gluteal folds (the crease that separates the buttocks from the thighs).Review of the care plan, dated 05/20/2025, showed that Resident 2 was at risk for pressure related skin injury related to impaired mobility and incontinence.Review of a facility document titled, Admission/readmission Collection Tool - V 6, dated 05/20/2025, showed Resident 2 also had a small open area to their gluteal cleft (the deep [NAME] located between the buttocks).Review of a facility document titled, Wound Observation Tool - V 4, dated 05/21/2025, showed Resident 2's gluteal cleft open area measured 1.5 centimeters (cm) long by 1 cm wide.Review of the facility document titled, Weekly Skin Integrity Data Collection - V 2, dated 05/23/2025, showed Resident 2 had a Small size opening on the left gluteal cleft. There were no measurements documented.Review of the medical record showed no additional documentation, after 05/23/2025, to show that Resident 2's gluteal cleft open area had been monitored, and no documentation of it's worsening or improvement.During interview on 07/09/2025 at 3:36 PM, Staff A, Director of Nursing Services (DNS), stated there should have been orders for monitoring Resident 1 and 2's skin impairments, and there should have been assessments completed weekly, to include documentation of measurements and description of wound appearance. Staff A, DNS, further stated that it was their expectation that weekly assessments be completed until open areas heal, at which point there should be documentation that the areas were resolved. Reference WAC 388-97-1060 (3)(b).