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	12/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of neglect for 1 of 3 sample residents (Resident 6) reviewed for neglect. This failure placed residents at risk for lack of regulatory oversight and on-going abuse and neglect.Findings included .Review of a public complaint sent to the State Agency, dated 12/09/2025, showed allegations of neglect related to Resident 6. The complaint showed allegations that Resident 6 was left in soiled adult diapers for long periods of time, and had developed open sores in their groin area; that staff were using incorrect treatment to treat/prevent Resident 6's skin impairments; and that Resident 6 had complained of left arm numbness and tingling, as well as nausea and vomiting (email noted these were signs of stroke), and symptoms were ignored by facility staff. The complaint showed that the contents of the allegation were copied (cc'd), via email, to Staff A, Administrator. Review of the facility incident report logs dated December 1, 2025, through December 17, 2025, did not show an allegation of neglect for Resident 6 was logged and/or reported to the State Agency. During interview on 12/17/2025 at 2:06 PM, Staff A stated that they had received an email copy of the allegations on 12/08/2025. Staff A stated that they had addressed the concerns with Resident 6 and Resident 6's concerned family members but had not reported the allegations to the State Agency. WAC reference 388-97-0640(5)(a).

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	12/17/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow provider orders for laboratory blood work for 1 of 1 resident (Resident 1) reviewed for laboratory services. This failure placed the resident at risk for unidentified changes in condition and lack of, or delayed, medical intervention.Findings included . Review of the electronic medical record showed Resident 1 was admitted to the facility on [DATE] after surgical amputation of toes. The medical record showed that Resident 1 also had diagnoses to include diabetes and heart disease. Review of a document titled, After Visit Summary, dated 10/31/2025, showed Resident 1 had gone to an outpatient wound care center for follow up, and treatment of a dehiscence (opening/splitting apart) of their surgical foot wound. The After Visit Summary had orders for Resident 1 to have blood work drawn at the facility: c-reactive protein (CRP) and sed rate (ESR) - both laboratory tests are used to evaluate inflammation and infection in the body. Review of a facility physician's order, dated 10/31/2025, showed Resident 1's orders for CRP and ESR were transcribed onto the facility's orders to be completed. Review of Resident 1's laboratory results showed that a CRP and ESR was drawn on 12/10/2025 - 40 days after they were ordered. During interview on 12/17/2025 at 2:10 PM, Staff B, Director of Nursing Services, stated that Resident 1's lab work was not drawn on, or around, 10/31/2025 because the facility did not have a phlebotomist at that time, and the facility only had two nurses who knew how to draw blood. Staff B, DNS, stated that they tried to keep up with the orders for laboratory blood work, but Resident 1 was missed. WAC reference 388-97-1620(2)(b)(i)(ii).

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	12/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate wound monitoring records for 1 of 1 resident (Resident 5) reviewed for medical records. This failure placed residents at risk for incomplete and inaccurate clinical information being presented to the interdisciplinary team, delays in care, prolonged stay, and a decreased quality of life.Findings included . Review of the admission Minimum Data Set assessment, dated 10/09/2025, showed Resident 5 admitted to the facility on [DATE] with a Stage 4 pressure ulcer (a full-thickness wound with extensive tissue loss, exposing muscle, tendons, ligaments or bone). Review of a facility document titled, NRSG: Admission/readmission Collection Tool - V 6, dated 10/07/2025, showed that Resident 5 had a Stage 4 pressure ulcer over their sacrum (a sheild-shaped bony structure located at the base of the spine, and between the two hip bones), with sacral bone exposed, measuring 3 centimeters (cm) by 2.2 cm by 1cm. Review of documents titled, Wound Observation Tool - V 4, on multiple dates, showed notes related to Resident 5's pressure ulcer to include location, stage, type and amount of drainage, wound measurements, condition of the tissue, status of the wound, and current treatment. Further review of the dates of Resident 5's Wound Observation Tools showed that the tool dated 10/14/2025 was entered into the medical record on 11/19/2025; the tools dated 10/21/2025, 10/28/2025, 11/04/2025, 11/11/2025 and 11/18/2025 were entered into the medical record on 11/20/2025. During an interview on 12/17/2025 at 2:10 PM, Staff B, Director of Nursing Services (DNS), stated that Resident 5's weekly wound documentation, via the Wound Observation Tools, were not completed on a weekly basis, as they should have been. Staff B, DNS, stated that they had entered all of the documentation into the electronic medical record, for dates 10/14/2025 through 11/18/2025, on 11/19/2025 and 11/20/205. When asked to produce the source of the data for the wound documentation, Staff B, DNS, was not able to provide documentation that was consistent with what was entered into the electronic medical record. During further interview on 12/17/2025 at 2:10 PM, Staff B, DNS, stated that everyone with a wound should have weekly wound documentation, in the form of a Wound Observation Tool document, and that they should be completed on a weekly basis, at the time of the wound assessment. Staff B, DNS, stated that they were behind in their documentation. WAC reference 388-97-1720(1)(a)(i)-(iv)(b).