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	07/01/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure freedom from abuse, during resident-to-resident altercations, for 3 of 3 residents (Residents 2, 3, and 4) reviewed for resident abuse. Three physical altercations occurred between 1 aggressor (Resident 1) and 3 victimized residents (Residents 2, 3 and 4) within 24 hours. This failure placed the residents at risk for injury, psychological harm, diminished feelings of safety and security, and a decreased quality of life. Findings included.Resident 1Review of the electronic health record (EHR) on 07/01/2026 showed that Resident 1 was admitted to the facility on [DATE] and had diagnoses to include vascular dementia with mood disturbance.Review of the Annual Minimum Data Set (MDS, a required assessment tool), dated 04/08/2026, showed that Resident 1 used a manual wheelchair and was able to wheel at least 150 feet, on their own, once set up in their wheelchair. The MDS further showed that Resident 1 had severe cognitive impairment (trouble thinking, learning, remembering, and making decisions), but was able to communicate and make their needs known.Review of the care plan focus, dated 05/18/2023 and revised on 04/22/2026, showed that Resident 1 had potential to be verbally or physically aggressive, had poor impulse control, and had a history of altercations with other residents. Interventions to address the concerns included redirection, activities (including 1-to-1 monitoring by staff) when agitated, and attempting to calmly intervene before agitation escalated.Review of the care plan focus, dated 06/30/2026, showed that Resident 1's discharge plan was to transition to a higher level of care that could safely accommodate their increasing cognitive and behavioral needs.During interview on 07/01/2026 at 9:43 AM, Staff C, Licensed Practical Nurse (LPN), stated that they were very familiar with Resident 1. Staff C, LPN, stated that there was no way to predict Resident 1's behaviors, and that they could be in a good mood, but suddenly a switch would flip, and if Resident 1 were to see something they didn't like, Resident 1 would react.Observations on 07/08/2026, between 9:15 AM and 12:15 PM, showed Resident 1 independently mobile in their wheelchair, wheeling throughout the hallways and common areas of the facility. Resident 1 and Resident 2 Physical AltercationReview of the EHR showed that Resident 2 was admitted to the facility on [DATE] and was able to independently walk through the facility using a walker. The EHR further showed that Resident 2 was alert and oriented and able to make their needs known.Review of a facility incident investigation, dated 06/21/2026 at 4:00 PM, showed that Resident 1 cornered Resident 2 in a room with a vending machine. Resident 1 proceeded to knock snacks out of Resident 2's hands and kicked Resident 2. Resident 2 stated, stop, and reached to the floor to pick up the snacks, then Resident 1 hit Resident 2 on the left chest with pointed straight fingers. Resident 2 called for help, and staff responded and separated Residents 1 and 2. Documented actions taken to prevent recurrence showed, Care plan reflects impulsive aggressive behavior. Redirection.During interview on 07/01/2026 at 9:50 AM, Resident 2 recalled the events consistent with the facility incident report, and stated that Resident 1 scared them, and that they moved to a different room to be far away from Resident 1. Resident 2 further stated that the staff were keeping an eye out for Resident 1, on behalf of Resident 2, and would warn them when Resident 1 was around so that they (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505324	A. Building B. Wing	07/01/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could go somewhere else to avoid being near them. Resident 1 and Resident 4 Physical AltercationReview of the EHR showed that Resident 4 was admitted to the facility on [DATE], had severe cognitive impairment, would sometimes understand people and be able to make themselves understood, used a wheelchair, and was dependent on staff for mobility in their wheelchair and for all daily care needs.Review of a facility incident investigation, dated 06/22/2026 at 1:50 PM, showed that Resident 4 was near a nurses' station, in their wheelchair, when Resident 1 passed by and became agitated that Resident 4 was too close, kicked Resident 4's leg out of the way and started speaking profanities. Staff separated Residents 1 and 4. Documented actions taken to prevent recurrence showed, Increased supervision in common areas.During observations and attempted interview on 07/01/2026 at 9:37 AM, Resident 4 was dressed and lying in bed on top of the covers. Resident 4 stated they did not feel well and did not engage in further conversation. Resident 1 and Resident 3 Physical AltercationReview of the EHR showed that Resident 3 was admitted to the facility on [DATE], had memory problems, was able to recall location of their room and recognize staff names and faces. Resident 4 could not clearly communicate verbally. Resident 4 used a wheelchair and was dependent on staff for mobility in their wheelchair and for all daily care needs.Review of a facility incident investigation, dated 06/22/2026 at 2:30 PM, showed that Resident 1 was leaving their room, agitated because staff were attempting to collect a urine sample. Resident 1 was being verbally abusive toward staff, cursing at them and threatening to cut them. Resident 1 proceeded to self-propel down the hall in their wheelchair, approached Resident 3, who was sitting in their wheelchair, and hit them in their right leg/ankle. Staff immediately separated Residents 1 and 3 and provided ice for Resident 3's leg. Documented actions taken to prevent recurrence showed that Resident 1 was placed on 1-to-1 supervision with a staff member and then transferred to the emergency department for evaluation and treatment due to increasing behaviors and aggression.During observation and interview on 07/01/2026 at 9:49 AM, Resident 3 was non-verbal but understood questions and was able to communicate using yes and no head movements, facial expressions, and arm movements. Resident 3 indicated that Resident 1 had hit them in the right leg, made a facial grimace, and shook their head no when asked if they felt safe around Resident 1. Observation of Resident 3's right leg showed no skin impairments or discolorations.During interview on 07/01/2026 at 12:01 PM, Staff B, Director of Nursing Services (DNS), stated that they had not yet started in their position with the facility when the resident-to-resident altercations had taken place between Residents 1, 2, 3 and 4, but upon review of the incidents, they advocated for staff refresher training on assessments and dementia/behavior training. Staff B, DNS, stated that the physical altercations between Residents 1 and Residents 2, 3 and 4 did constitute abuse. WAC reference 388-97-0640(1).