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	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Puyallup	511 10th Avenue Southeast Puyallup, WA 98372

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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 - 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 observations, interviews, and record review, the facility failed to provide the necessary treatment and services consistent with professional standards of practice to prevent the development and/or promote healing of PU/PI (Pressure Ulcers/Pressure Injuries) for 4 of 5 Residents (Residents 11, 128, 13, and 134) reviewed for PU/PIs. Resident 11, who was identified to be at risk for developing PU/PI, experienced harm when they developed an avoidable right heel Stage II (partial-thickness skin injury that breaks through the epidermis and exposes the dermis) that worsened to an unstageable (a full-thickness wound whose depth cannot be determined because it is covered by obstructive material) PU/PI and pain after admission to the facility, when the facility failed to develop/implement/update a resident-centered care plan (CP) for the prevention of PU/PIs that included timely pressure offloading interventions for PU/PI prevention, accurately follow physician orders (PO) for wound care, and consistently implement CP interventions after the PU/PI developed to promote healing. These failures placed residents at risk for the development of new PU/PIs, delayed healing, unnecessary discomfort, infection, and diminished quality of life/quality of care. Findings included.<POLICY>Review of the facility's Pressure Injury Prevention and Unavoidable Pressure Ulcer/Injury policy, revised 06/12/2025, showed the facility utilized the professional standards of the National Pressure Injury Advisory Panel (NPIAP) and the Wound, Ostomy, Continent Nurses Society (WOCN) for PU/PI prevention and care. The facility's process included evaluation of the resident's clinical condition and risk factors, define and implement interventions that were consistent with the resident's needs, goals, and professional standard of practice, monitor/evaluate the impact of the interventions, and revise the CP as needed.Review of the facility's Pressure Ulcer Prevention policy, reviewed 06/11/2025, showed all residents upon admission were at risk to develop PU/PIs due to medical issues that required nursing care, disease process, illness, or need for rehabilitation services. The facility would routinely use the Braden Risk Assessment (Braden Scale - a standardized assessment tool used to estimate risk of developing PU/PIs by evaluating six key criteria: sensory perception, moisture, mobility, nutrition, and friction/shear to help prioritize preventative measures for CP development) to evaluate the resident's risk of developing PU/PIs. After a comprehensive assessment, a resident-centered care plan would be developed. Measures to protect the resident against the adverse effects of external mechanical forces such as pressure, friction, and shear were implemented in the plan of care, including: repositioning at least every two-four hours, utilizing positioning devices to keep boney prominences from direct contact, ensuring proper body alignment when side-lying, heel protection/offloading, maintaining head-of-bed at the lowest degree of elevation consistent with medical conditions, use of lift devices to move the resident in bed, pressure redistribution mattress, and a pressure reduction surface for the wheelchair.According to the NPIAP Pressure Injury Prevention Points: Risk Assessment, updated 2016, use of a structured risk assessment at routine intervals (such as the Braden Risk Assessment) to identify individuals at risk for PU/PIs should be used to develop a CP based on the areas of risk, rather than on the total risk assessment score and provided potential interventions to consider based on each risk category. <RESIDENT 11>Review of the 03/11/2026 admission Minimum Data Set (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
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F 0686 Level of Harm - Actual harm Residents Affected - Few	(MDS-assessment tool) showed Resident 11 admitted to the facility on [DATE] and had no problems with cognition. Resident 11 had limited range of motion of one side of their lower extremity, was dependent on staff for assistance with toileting, bed mobility, transfers, and was incontinent of bladder. Resident 11 diagnoses included a right hip fracture, diabetes, and respiratory failure. Resident 11 had pain rated 8/10 and received both scheduled and as needed pain medication. Resident 11 had no unhealed PU/PIs and their formal risk assessment determined they were at risk for the development of PU/PIs.Review of the 03/09/2026 Braden Scale assessment showed Resident 11 had problems related exposure to moisture, they were confined to the bed, had very limited mobility, and problems with friction/shearing. Resident 11's identified risk factors for clinically unavoidable PU/PIs included bowel/bladder incontinence, pain that effects movement, chronic kidney/liver/heart disease, a hip fracture, diabetes, and use of anticoagulants. Review of the 03/09/2026 Skin Integrity care plan (CP) showed their skin was at risk due to diabetes, incontinence, fragile skin, anemia, and limited mobility. Interventions to maintain skin integrity were to clean and dry the skin after each incontinent episode and monitor for signs of infection or breakdown. The CP did not include resident-centered interventions to address the pressure related identified risk factors in the Bradens or clinical assessments for the prevention of PU/PIs.Review of the Kardex (an abbreviated CP tool for the Certified Nursing Assistants [CNAs] to identify/implement immediate care needs and special alerts), dated 03/23/2026, did not show Resident 11 was at risk for PU/PI and did not include resident-centered CP interventions for direct care staff to implement for the prevention of PU/PIs. <DEVELOPED PU/PI>Review of the facility's Wound Observation Tool (WOT), dated 03/24/2026, showed Resident 11 developed a right heel Stage II PU/PI (partial-thickness skin loss that does not extend to the underlying fat tissue) that measured 5.5 centimeters (cm) x 0.1 cm. Resident 11's pain related to the wound was 8/10(pain scale where 0=no pain and 10= extreme pain). Interventions implemented were wound treatment and cushion boots to wear when in bed.Review of the 03/24/2026 right heel PU/PI CP showed the goal was to show signs of healing and remain free of infection by implementing the following interventions: administering treatments as ordered, education to the resident/family/caregivers of the cause of skin breakdown, placement of cushion boots to both feet while in bed, and to follow policies and protocols for the prevention/treatment of skin breakdown.Review of the Wound Care Consultant (WCC) progress note, dated 03/30/2026, showed Resident 11 had a right heel unstageable PU/PI (a full-thickness tissue injury where the base of the wound is completely covered by dead tissue making it impossible to determine the true depth of tissue damage) that measured 3.0 cm x 4.2 cm x unknown depth. The wound bed contained dead tissue that needed to be removed to determine the extent of tissue damage. The WCC recommended a wound care treatment: cleanse with wound cleanser, apply skin prep around the wound, apply medical honey to the wound bed, cover with a bordered dressing, change daily (and as needed), and float heels with pillows or wedge heel lift device.Review of the facility's WOT, dated 04/06/2026, showed Resident 11's right heel wound remained an unstageable PU/PI. The documentation did not show wound measurements or wound characteristics and referred to the WCC progress notes.Review of the clinical record on 04/07/2026 did not show the WCC progress notes for 04/06/2026.In an interview on 04/07/2026 at 8:50 AM, Staff Q, Registered Nurse-RN, stated they were not aware of any residents that had PU/PIs on their hall but the facility had a wound treatment nurse who would know.In an interview on 04/07/2026 at 9:06 AM, Staff J, Licensed Practical Nurse-LPN/Treatment Nurse, stated they performed the wound care on all PU/PIs, diabetic foot ulcers, and vascular ulcers on the days they worked, and the medication nurses were responsible to perform the dressing changes on their days off. Staff J stated Resident 11 developed an unstageable PU/PI after admission to the facility. Staff J stated they had a wound care consultant who saw patients on Mondays, but they had not received the most recent wound care progress notes. Staff J stated they also completed WOTs of the wounds they monitored weekly. Staff J stated the CNAs and nurses knew who had PU/PIs and the care residents required for PU/PI prevention by reading the CP and/or Kardex.During an observation (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	on 04/07/2026 at 11:37 AM, Resident 11 was observed sitting up in their wheelchair with slip socks on, no shoes or heel protection boots on, and feet were resting on hard metal wheelchair foot pedals. At the bottom of Resident 11's right closet were two blue and grey soft heel lift boots (the only two items on that side of the closet). In an interview on 04/07/2026 at 11:38 AM, Resident 11 stated they had a bad wound on their right heel that was not there when they admitted to the facility. Resident 11 stated they could not move their right leg independently due to increased pain in their hip, they did not get repositioned frequently by staff and did not get their heels lifted off the bed but thought it would help their wound. Resident 11 was not aware of any special heel boots they were supposed to have on when they were in bed to keep the heels off the bed. During subsequent observations on 04/07/2026 (at 2:45 PM, 3:30 PM, and 4:20 PM) and 04/08/2026 (at 7:50 AM and 2:36 PM) Resident 11 was observed lying in bed with their heels lying directly on the mattress, and no heel lift boots were in place or pillows to elevate the heels off the mattress.During an observation and interview on 04/09/2026 at 8:04 AM, Resident 11 was observed lying in bed, their heels were directly on the mattress with no pillow or heel lift boots in place. Resident 11 stated their right heel hurt awfully bad, rated their pain a 10/10 and they were trying to move their heel off the bed. Resident 11 stated their heels had been on the mattress throughout the night and they asked a CNA to bring them a pillow they could use to place under their leg to help relieve their pain. Resident 11 stated the CNA said they needed to find a pillowcase and left the room but never returned with a pillow. Resident 11 stated they did not wear any special heel lift boots during the night. <WRONG WOUND CARE TREATMENT>Review of the April 2026 Treatment Administration Record (TAR) showed a physician order for wound care dated 04/06/2026 to cleanse the right heel wound with wound cleanser (or saline), pat dry, apply skin prep around the wound, place an iodine based ointment into the wound bed, cover with a clean dry dressing, and change daily (or as needed).During an observation on 04/09/2026 at 9:39 AM, Staff J, Licensed Practical Nurse-LPN/Treatment Nurse, performed Resident 11's wound care of the right heel PU/PI. Staff J removed Resident 11's right heel dressing and an unstageable PU/PI was observed; the wound bed covered greater than 75 percent of the wound with adherent moist black eschar (dead tissue). When Staff J cleaned the wound with saline, Resident 11 winced in pain. Resident 11 stated their pain was 10/10 coming from the center of the right heel wound. Staff J then began to apply the new dressing; they applied medical honey to dressing and then placed the dressing on the wound and secured it in place with kerlix. The observation showed Staff J did not follow the 04/06/2026 wound care treatment order as directed by the physician. After completing the wound care, Staff J stated to Resident 11, Where is your cushion boots? and Resident 11 Stated I have no idea. Staff J began to place a thin pillow under Resident 11's right calf to elevate the right heel, then looked in the closet and found the heel lift boots. As Staff J placed the soft blue/grey heel lift boots on Resident 11, Staff J stated, They [the CNAs] are not putting the boots on you like they are supposed to.During an interview on 04/09/2026 at 10:15 AM, Staff J stated [they] realized they placed the incorrect treatment on Resident 11's wound so they redressed Resident 11's right heel wound with the correct wound treatment. Staff J stated they should have reviewed the order prior to performing the dressing change but did not.In an interview on 04/09/2026 at 5:16 PM, with Staff J and Staff P, LPN/Unit Care Coordinator, Staff P stated their expectation was the staff follow the facility's policy and procedures for PU/PI prevention and care. Staff P stated the residents should be assessed timely for their risk of developing PU/PIs and have a care plan developed and implemented timely as soon as the risks were identified. Staff J stated the interventions that were in Resident 11's CP were not resident-centered and did not provide interventions to manage the problems that were identified in the Bradens and clinical assessments, but should have. In an interview on 04/10/2026 at 1:03 PM, Staff G, LPN/Unit Care Coordinator, stated it was their expectation that when a new resident was admitted to the facility, their skin was assessed as soon as possible after they arrived, and then assessed timely for their risk of developing PU/PIs. Staff G stated they would expect to see person-centered interventions in the baseline CP to help prevent new wounds from (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	developing starting the day of admission. Staff G stated resident education, keeping skin clean and dry, and doing weekly skin checks were not person-centered PU/PI prevention interventions and did not meet professional standards of care for prevention of PU/PIs. <RESIDENT 134>Review of the 04/06/2026 admission MDS showed Resident 134 admitted to the facility on [DATE], had some problems with cognition, and required staff assistance for bed mobility, toileting, and transfers. Resident 134 was incontinent of bowel/bladder, and their diagnoses included heart disease, diabetes, and peripheral vascular disease (PVD-a circulatory condition that causes narrowing of the blood vessels/arteries restricting blood flow to the extremities and/or back to the heart from the extremities). Resident 134 had no unhealed PU/PIs and was assessed to be at risk for the development of PU/PIs.Review of the 04/02/2026 Braden Scale assessment showed Resident 134 had problems with activity and friction/shear, pain that affected movement or mood, acute illness, PVD, and diabetes.Review of the baseline CP, dated 04/02/2026, showed Resident 134 was at risk for skin alterations due to fragile skin, diabetes, and PVD. The CP interventions directed staff to clean and dry skin after each incontinent episode and perform weekly skin checks. The CP did not provide person-centered interventions to prevent PU/PIs or address the risk areas identified in the Bradens and clinical assessment.In an observation on 04/08/2026 at 10:41 AM, Resident 134 was lying in bed with nonskid socks on their feet, and their heels were lying directly on the mattress. Resident 134 stated their heels hurt a lot and an unidentified CNA assisted Resident 134 to sit up, then removed their socks. Resident 134's right heel was red in the area where they stated the heel hurt.During an interview on 04/09/2026 at 8:16 AM, Resident 134 stated their heels continued to hurt and they reported their pain to staff. Resident 134 stated they had not received any treatment or interventions to relieve their heel pain.During subsequent observations on 04/09/2026 (at 8:16AM, 11:52 AM, and 3:40 PM) and 04/10/2026 (at 8:03 AM and 8:29 AM) Resident 134 was observed with their heels lying directly on the bed and not elevated with pillows or other heel lifting devices. Review of Resident 134's Kardex, dated 04/09/2026, did not show any interventions consistent with professional standards of care for the prevention of PU/PIs.During an observation and interview on 04/10/2026 at 8:29 AM, Staff P, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), removed Resident 134's socks. Both heels were observed to be red. Staff P measured the left heel redness (2.0 cm x 3.0 cm) and the right heel redness (3.0 cm x 2.5 cm and boggy [a soft, spongy texture of the heel tissue, often indicating the early stages of a pressure injury or deep tissue injury]). <RESIDENT 128>Review of the 04/03/2026 Entry MDS showed Resident 128 admitted on [DATE] from an acute care hospital.Review of Resident 128's Braden Scale Assessment, dated 04/03/2026, showed they had problems related to excessive moisture, chairfast (unable to walk), very limited mobility, and problems with friction and shear. Resident 128's clinical risk factors for an unavoidable PU/PI included the presence of an existing PU/PI, bowel incontinence, edema, acute illness, diabetes, and chronic kidney/liver/heart disease.Review of the admission Skin Assessment, dated 04/03/2026, showed Resident 128 admitted with a Stage I (an area of intact skin with localized non-blanchable redness) on the sacrum (just above the tailbone area) that extended down to the buttocks and measured 15.0 cm x 7.0 cm.Review of the wound care physician order, dated 04/03/2026, directed staff to cleanse the sacrum/buttocks with soap and water, pat dry, and apply a zinc-based ointment every shift and as needed.Review of Resident 128's baseline CP, dated 04/03/2026, showed they were at risk for a break in skin integrity with actual impairment to the skin. The CP interventions were to ensure the skin was clean and dry after each incontinent episode, educate the resident/family on causative factors and measure to prevent skin injury, encourage/assist with turning and repositioning, and perform weekly skin checks. The baseline CP did not indicate Resident 128 admitted with a Stage I PU/PI on the buttocks/sacrum and the CP interventions were not person-centered to address their assessed risks identified in the Braden Scale and Clinical Assessment.Review of a facility WOT, dated 04/06/2026, showed Resident 128 had a Stage I on their right lower back that measured 0.5 cm x 0.5 cm. The wound was not documented on the admission (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin Assessment. The documentation showed the treatment plan was repositioning but did not indicate how often.Review of Resident 128's Kardex, dated 04/07/2026, did not show they had two Stage I PU/PIs or direct the care staff on how to remove the pressure from the affected areas (and prevent new PU/PIs). The CP directed staff to encourage/assist to turn and reposition (but did not state how often), to clean and dry the skin after each incontinent episode, and to perform weekly skin inspections. Review of Resident 128's clinical record on 04/06/2026, did not show a wound care treatment physician order for the Stage I.During an observation and interview on 04/07/2026 at 11:12 AM, Resident 128 was observed lying in bed, flat on their back, with their feet almost touching the footboard of the bed, and their heels were flat on the bed without offloading. Resident 128 stated they had a wound on their butt that was very sore and treated with a cream the staff put on it. Resident 128 stated the staff did not turn/reposition them frequently and could not recall a time staff put pillows behind their back to get the pressure off their butt. Resident 128 stated the staff did not get them up for meals and they ate in bed with their head of the bed elevated.During subsequent periodic observations on 04/07/2026 (a 2:40 PM, 3:38 PM, 4:10 PM), 04/08/2026 (at 8:01 AM, 11:22 AM, and 1:00 PM), and 04/09/2026 (at 8:50 AM, 10:36 AM, 12:15 PM, and 3:25 PM) Resident 128 was observed lying in bed, flat on their back, without side-lying support to relieve pressure to their buttocks, and their heels were flat on the bed.In an interview on 04/09/2026 at 10:15 AM, Staff J stated Resident 128 admitted with a Stage I on their sacrum/buttocks and it was treated with zinc/barrier ointment every shift, and they were looking at getting them an air mattress.During an observation and interview on 04/10/2026 at 7:52 AM, Resident 128 was sitting up in a wheelchair in their room. Resident 128 stated they asked to get up out of bed in the middle of the night because they had been in bed so long. Resident 128 stated that since they got up out of bed, their butt felt better and they had no pain in their back. The mattress on Resident 128's bed was not an air mattress.In an interview on 04/10/2026 at 8:05 AM, Staff V, CNA, stated they were unsure if the facility had a standard of care protocol for PU/PI prevention but stated some of the residents had air beds, [they] used pillows to position residents on their sides and to place under their legs to keep the heels off the bed, and they were repositioned every two hours. Staff V stated they looked at the Kardex, or the nurse would notify them, if a resident required PU/PI prevention care. <RESIDENT 13>Review of the 01/08/2026 Medicare 5-Day Assessment showed Resident 13 admitted to the facility on [DATE], had some problems with cognition, and required staff assistance for eating, bed mobility, toileting, and transfers. Resident 13 was incontinent of bowel/bladder and diagnoses included pneumonia, anemia, heart failure, diabetes, vascular disease, malnutrition, and required a feeding tube to receive adequate nutrition. Resident 13 was assessed to be at risk of developing PU/PIs and admitted to the facility with two-unstageable PU/PIs and two-DTIs for a total of four PU/PIs.Review of the hospital Post Acute and Transition of Care orders, dated 01/06/2026, showed pictures and measurements of Resident 13's four PU/PIs prior to discharge from the hospital: one Stage I PU/PI (Wound #1) on the top of the right foot and three deep tissue injuries (DTI -) on the back of their right heel (Wound #2), left inner ankle (Wound #3), and top of the left foot (Wound #4). Review of the facility's nursing admission Assessment, dated 01/06/2026, showed Resident 13 had the same four PU/PIs and measurements identified on the Post Acute Transition of Care Orders, plus one left heel DTI (Wound #5). The documentation did not provide measurements for Wound #5. Review of the 01/06/2026 Bradens Scale assessment showed Resident 13 had problems related to sensory perception, mobility, activity, and friction/shear. Other risk factors included existing PU/PIs, medical devices, peg tube, head of bed elevated majority of the time. The documentation showed the remainder of the assessment was incomplete.Review of the comprehensive CP showed two skin focus problems. The At-Risk Skin integrity CP, dated 01/06/2026, directed staff to clean and dry the skin after each incontinent episode. The Actual Impairment to Skin Integrity CP, dated 01/06/2026, showed Resident 13 had four PU/PIs and listed Wounds #2, # 3, #4, and #5. Wound #1 was not indicated on the CP. The interventions directed the nurses to educate the resident, perform treatments as ordered, and perform (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	weekly skin checks. The interventions directed the CNAs to encourage/assist with turning and repositioning. The CP did not show person-centered interventions consistent with Resident 13's identified risks/care needs or professional standards of practice for prevention/promoting healing of PU/PIs.Review of the 01/15/2026 Kardex did not show Resident 13 had multiple PU/PIs on their lower extremities and did not provide the care staff with directives consistent with professional standards of care to promote healing of PU/PIs. During an interview and record review of Resident 13's 04/09/2026 Kardex and CP on 04/10/2026 at 9:58 AM, Staff U, CNA, stated PU/PIs were caused by sitting too long in one place (or prolonged pressure), excessive skin moisture, and shearing. Staff U stated the professional standards of care for the prevention of PU/PIs depended on each residents care needs but could include: turn/reposition every two hours, pressure relieving air mattress and/or wheelchair cushion, getting up for meals to sit in a chair (not in bed with the head of the bed elevated so they slide down in bed), turning side to side (or side lying to keep them off their tailbone) with the use of pillows, keeping their skin clean and dry, applying barrier ointment to protect their skin, using pillows or a wedge device/heel lift boots to keep their heels off the bed, keeping pressure off their boney prominences (defined as back of the ears if wearing oxygen, spine, elbows, tailbone, sides of the hip, sides of the ankle bone, back of the heel, top of the toes) using pillows to elevate the body part, and using a draw sheet to lift them in bed (not drag them in bed). Staff U stated they would read their Kardex to find out what each resident needed for care. Staff U stated the information should be simple and to the point so they could quickly get the information they needed to provide the care. Staff U stated Resident 13's Kardex and CP did not provide sufficient information or interventions related to the care they required. REFERENCE WAC: 388-97-1060 (1), (3)(b).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an infection control program to track all infectious organisms present in the facility for 2 of 3 months (January and February 2026) and failed to implement transmission-based precautions for 1 of 4 halls (400 hall) reviewed for infection control. The facility also failed to follow infection control practices during wound care for 1 of 2 residents (Resident 11) when reviewed for wound care. These failures placed the residents at risk for poor clinical outcomes, and a decreased quality of life. Findings included.TrackingReview of the infection control line listings for January, February and March 2026 showed no documentation that the organisms present for residents with a diagnosis of urinary tract infection (UTI) were identified and tracked for the months of January and February 2026. During an interview on 04/10/2026 at 12:40 PM, Staff C, Registered Nurse/Infection Preventionist (RN/IP), stated they were aware of the missing organisms on the monthly tracking for January and February 2026 and stated the laboratory results should have been reviewed for all infections but were not. Transmission Based Precautions (TBP)Review of the posted contact precautions signs on 04/09/2026 showed staff were to perform hand hygiene and put on a gown and gloves when entering the room. Observation on 04/07/2026 at 9:35 AM showed room [ROOM NUMBER] with contact precautions sign posted at the door. An unidentified staff member was observed entering the room without performing hand hygiene or putting on a gown or gloves and failed to perform hand hygiene when exiting the room. Observation and interview on 04/10/2026 at 1:24 PM showed room [ROOM NUMBER] with a contact precautions sign posted at the door. Staff H, Licensed Practical Nurse, was observed standing in room [ROOM NUMBER] next to the resident and did not have on a gown or gloves. Staff H stated they should have followed the posted sign. Wound CareObservation on 04/09/2026 at 9:39 AM showed Staff J, Licensed Practical Nurse/Treatment Nurse, provided wound care for Resident 11. Staff J removed the soiled bandage and with the same gloves cleansed the wound and applied a new bandage. No hand hygiene or glove changes were performed during the bandage change. During an interview on 04/10/2026 at 12:40 PM, Staff C, RN/IP, stated it was their expectation staff followed the posted precautions signs. Staff C stated when changing a bandage staff should perform hand hygiene after removing the soiled bandage before cleansing and applying a new one. During an interview on 04/10/2026 at 1:38 PM, Staff E, Regional Registered Nurse, stated it was their expectation for the infection preventionist to review lab results and track the identified organisms, and staff should have followed the posted precautions signs. Staff E stated wound care should have been performed following proper infection control procedures. Reference WAC 388-97-1320(2)(b)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Puyallup	511 10th Avenue Southeast Puyallup, WA 98372

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use, and decrease the development of adverse side effects and antibiotic resistance for 2 of 2 sampled residents (Residents 80 and 52) reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included.Review of the facility policy titled Antibiotic Stewardship revised 07/22/2025 showed the facility would implement Antibiotic Reassessment at two to three days after empiric antibiotic initiation [the immediate prescribing of antibiotics based on clinical suspicion, patient symptoms, and risk factors before specific laboratory culture or susceptibility results are known] or first dose in the facility, each resident should be reassessed for consideration of antibiotic need. At this time, laboratory testing results, response to therapy and resident condition will be considered. Resident 80Review of the electronic health record (EHR) showed Resident 80 admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (a movement disorder of the nervous system). The resident was able to make needs known. Review of a provider's order, dated 01/27/2026, showed Resident 80 received Macrobid (an antibiotic) for a UTI for five days. Review of a provider's order, dated 02/10/2026, showed Resident 80 received Cephalexin (an antibiotic) for a skin infection for five days. Review of Resident 80's provider note dated 03/08/2026 showed, Treat with Keflex [an antibiotic] (Cephalexin) per susceptibility for E Coli [a bacteria] UTI. Review of Resident 80's provider orders showed Cephalexin with a start date of 03/08/2026 for a urinary tract infection (UTI) for seven days. Review of the progress notes dated between 01/22/2026 and 03/12/2026 showed no documented signs and symptoms of a UTI for Resident 80. During an interview on 04/09/2026 at 11:27 AM, Staff C, Registered Nurse/Infection Preventionist (RN/IP), stated the provider was responding to a laboratory report that was collected on 01/27/2026 but they had not received the results until 03/07/2026. Staff C stated Resident 80 should have been assessed using the McGeers criteria (an infection assessment) and an Antibiotic Reassessment should have been done but was not. Resident 52Review of the EHR showed Resident 52 admitted to the facility on [DATE] with a diagnosis of broken leg. The resident was able to make needs known. Review of Resident 52's EHR showed an order for Macrobid for a UTI for four days with a start date of 03/18/2026. Review of Resident 52's EHR showed no laboratory results were received or reviewed, and no antibiotic reassessment was completed. Review of the progress notes dated between 03/18/2026 and 03/22/2026 showed no reports of symptoms of a UTI for Resident 52. During an interview on 04/09/2026 at 11:27 AM, Staff C, RN/IP, stated they should have requested and reviewed the lab results and completed an antibiotic reassessment but had not. During an interview on 04/10/2026 at 1:38 PM, Staff E, Regional Registered Nurse, stated it was their expectation that the Infection Preventionist review all infection associated lab results and follow up with antibiotic reassessments to ensure appropriate treatment and this did not happen for Residents 80 and 52 but should have. Reference WAC 388-97-1620(2)(b)(i)(ii)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed accurately complete a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN, a form which explains costs of facility services and allows residents to make an informed decision regarding care) for 1 of 3 sampled residents (Resident 136) reviewed for beneficiary notices. This failure placed the residents at risk of denying Medicare/Medicaid appeals rights, being uninformed of costs for facility services and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 136 was admitted to the facility on [DATE], and on 11/01/2025 switched their insurance to Medicare A.Review of the EHR showed Resident 136's Medicare coverage ended on 11/13/2025 and was not issued a SNFABN form. During an interview on 04/09/2026 at 3:07 PM, Staff K, Business Office Manager (BOM), stated that Resident 136 discharged from the facility on 11/14/2025 and the previous BOM discharged Resident 136 as private pay. Staff K, BOM, stated that a SNFABN form should have been completed. Reference WAC 388-97-0300(1)(e),(5),(6)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review the facility failed to ensure residents were free from chemical restraints for 1 of 5 sampled residents (Resident 125) reviewed for unnecessary medications. The failure to evaluate and document a clinical rational for continued use of a psychotropic medication and ensure adequate indications for the use of the medications placed residents at risk for decline in activities of daily living, potential adverse consequences, and diminished quality of life. Findings included.Review of the facility's Unnecessary Medications policy, dated 08/09/2023, showed each resident's drug regimen would be free from unnecessary drugs, including antipsychotic drugs without adequate indications for its use. The resident's medical record should show documentation of adequate/appropriate indications for the medication's use, the diagnosed condition for which a medication was prescribed, and in accordance with clinical practice guidelines and standards of practice. Review of the 03/25/2026 admission minimum data set (MDS, a required assessment tool) showed Resident 125 admitted to the facility 03/23/2026 and had some problems with cognition but was able to understand and be understood. Resident 125 had no behaviors, symptoms of delirium, or rejection of care. Resident 125's diagnoses included an infection, depression, and non-Alzheimer's dementia (diminished cognition skills). Resident 125 received an antipsychotic medication (medication affecting the brain). Review of the 03/23/2026 antipsychotic (AP) medication care plan (CP) showed the medication was administered due to behavior management and dementia with behavior and psychosis. The interventions directed staff to administer the AP medications as ordered by the physician, observe for adverse effects, and effectiveness every shift. The non-person-centered target behaviors for the AP medication use were agitation, anxiety, delusions, hitting/kicking and the non-medication interventions included redirection, providing reassurance, talking with the resident to problem-solve, encourage activities, and return the resident to their room. Review of the March and April 2026 Medication Administration Records (MAR) showed a physician order (PO) dated 03/23/2026 to administer Seroquel (an antipsychotic medication) 12.5 milligram (mg, unit of weight) every night at bedtime. The indication for use showed unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. The documentation showed the medication was administered every night. Review of the target behavior documentation showed Resident 125 had no behaviors. During an interview on 04/09/2026 at 4:19 PM, Staff D, Social Services Director, stated dementia was never an appropriate indication for use of antipsychotic medication and Resident 125 should have been evaluated for the use of the medication and/or it should have been discontinued, but was not. Reference WAC 388-97-1060 (1)(3)(e)(k)(i)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to offer bed holds and provide notice of transfer to the resident or Ombudsman (advocacy program to assist residents living in nursing homes) in writing at the time of transfer for 3 of 4 sampled residents (Residents 20, 12, and 3) reviewed for hospitalization. These failures placed the residents at risk for lack of knowledge of their rights and a decreased quality of life. Findings included.Resident 20 Review of the electronic health record (EHR) showed Resident 20 was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, lung disease that makes breathing difficult due to damaged or inflamed airways), diabetes (high blood sugar), and hypothyroidism (condition where an underactive thyroid [endocrine gland that regulates metabolism] fails to produce enough hormones). Resident 20 was able to communicate their needs During an interview on 04/08/2026 at 9:29 AM, Resident 20 stated they were sent to the hospital and had to wait three days before they could come back to their room. Review of the EHR showed Resident 20 was transferred to the hospital on [DATE] with new onset of weakness on one side, and there was no written nursing home transfer/discharge form or bed hold. During an interview on 04/09/2026 at 8:24 AM, Staff B, Director of Nursing Services (DNS), reviewed Resident 20's EHR and could not locate any information related to the 02/09/2026 discharge. During an interview on 04/10/2026 at 12:36 PM, Staff A, Administrator, stated they would look for Resident 20's discharge documentation, but none was provided. Resident 12 Review of the EHR showed Resident 12 admitted to the facility on [DATE] with diagnoses of diabetes, kidney disease and heart disease. The resident was able to make needs known. During an interview on 04/07/2026 at 12:31 PM, Resident 12 stated they had gone to the hospital two to three months ago. Review of the EHR showed Resident 12 had been sent to the emergency room on [DATE] and returned to the facility on [DATE]. Review of the EHR on 04/09/2026 showed no documentation that a bed hold was offered for Resident 12 at the time of transfer and no record that a notice of transfer was completed and provided to the resident, their representative, or the ombudsman. Resident 3 Review of the EHR showed Resident 3 admitted to the facility on [DATE] with diagnoses of congestive heart failure (CHF, when the heart cannot pump blood effectively), COPD and diabetes. The resident was able to make needs known. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed Resident 3 was transferred to the emergency room (ER) from a doctor's appointment on 01/26/2026 and returned to the facility on [DATE] and was also sent to the ER from a doctor's appointment on 02/23/2026 and returned to the facility on [DATE]. Review of the EHR showed no documentation that a bed hold was offered or a notice of transfer was provided to the ombudsman for the discharges on 01/26/2026 or 02/23/2026. During an interview on 04/09/2026 at 11:10 AM, Staff D, Social Services Director (SSD), stated it was their expectation that the nursing staff offer the bed hold and complete the transfer form to provide to the resident and ombudsman when a resident was sent to the hospital but this did not happen for Resident 12 or Resident 3. During an interview on 04/09/2026 at 2:17 PM, Staff E, Regional Registered Nurse, stated it was their expectation that bed holds would be offered when residents were transferred to the hospital and a notice should have been provided to the Resident, 3, Resident 12, and the ombudsman. Reference WAC 388-97- 0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080 -0140(1)(a)-(c)(i)-(iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of assessments for 3 of 4 residents (Residents 56, 62, and 11) reviewed for accuracy of assessments. These failures placed the residents at risk for unmet care needs, diminished quality of care/quality of life. Findings included . <RESIDENT 56> Review of the electronic health record (EHR) showed Resident 56 readmitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (high blood sugar), and respiratory failure. Resident 56 was able to make needs known. Review of the significant change minimum data set assessment (MDS) dated [DATE] showed Resident 56 was coded No for Hospice care. Review of the EHR showed Resident 56 had an order dated 11/22/2025 to admit to Hospice services and documentation showed Resident 56 was visited by Hospice care staff from 11/22/2025 – 03/19/2026. During an interview on 04/10/2026 at 11:04 PM, Staff L, Registered Nurse/Minimum Data Set Coordinator (RN/MDSC), stated Resident 56's significant change MDS dated [DATE] was coded No for Hospice care and should have been coded Yes. During an interview on 04/10/2026 at 11:10 AM, Staff A, Administrator, stated Resident 56's 12/04/2025 significant change MDS was coded No and was supposed to be coded Yes for Hospice care, and the MDS needed to be modified. <RESIDENT 62> Review of the 03/19/2026 admission Minimum Data Set (MDS) showed Resident 62 admitted to the facility on [DATE] with diagnoses that included a urinary tract infection and cancer. Resident 62 had an indwelling urine catheter. The MDS did not show a corresponding diagnosis or indication for use of the catheter. Review of the 03/16/2026 Post Acute and Transition of Care Orders showed Resident 62 had a standard urinary catheter due to urinary retention (inability to urinate). Review of the March 2026 Medication Administration Record (MAR) showed a physician order (PO) dated 03/17/2026 for the urinary catheter. The indication for use showed it was related to a tear in the aorta (the main artery that supplies blood to the body) and cancer. In an interview on 04/10/2026 at 1:25 PM, Staff Z, Registered Nurse-RN/MDS Coordinator, stated the indication for the use of the urinary catheter should have been clarified and assessed accurately on the MDS but was not. <RESIDENT 11> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/11/2026 Admission/5-Day MDS showed Resident 11 was edentulous (had no natural teeth). Review of the 03/09/2026 nursing admission Assessment showed Resident 11 had no oral problems and was missing natural teeth (but not edentulous). During an observation and interview on 04/07/2026 at 11:28 AM, Resident 11 was observed to have some natural teeth present, but not all. During an interview on 04/10/2026 at 4:10 PM, Staff P, Licensed Practical Nurse-LPN/Unit Care Coordinator, stated the assessment should accurately reflect the resident's current status but did not. Reference WAC 388-97-1000(1)(a)(b)(4)(a).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to initiate new intervention and update the care plan for 1 of 3 sampled residents (Resident 20) reviewed for accidents. This failure placed the resident at risk of preventable falls, injuries, and a diminished quality of life Findings included .Review of the electronic health record (EHR) showed Resident 20 was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, lung disease that makes breathing difficult due to damaged or inflamed airways), diabetes (high blood sugar), and hypothyroidism (condition where an underactive thyroid [endocrine gland that regulates metabolism] fails to produce enough hormones). Resident 20 was able to communicate their needs. Observation on 04/08/2026 at 9:32 AM showed Resident 20 sat in their bed with commode next to the bed. Resident 20 stated they had two falls because they slipped on the floor during transfers. Review of the second fall investigation dated 01/01/2026 showed Resident 20 had a fall due to self-transferring from commode to the bed. Investigation showed Resident 20 needed extensive assistance with transferring and Resident 20 had forgotten to put their nonskid socks on. Review of the investigation showed Resident 20 had previously used interventions in the summary of the fall. Review of care plan with focus area of fall, initiated 10/30/2025, revised on 12/26/2025 and 12/30/2025, showed Resident 20 did not have any new interventions initiated after the fall on 01/01/2026. During an interview on 04/10/2026 at 1:07 PM, Staff E, Regional Registered Nurse, stated the care plan for Resident 20 should have been updated and that did not meet expectations. Reference WAC 388-97-1020(2)(c)(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oral care was provided for 1 of 3 sampled residents (Resident 91) reviewed for activities of daily living. This failure placed the resident at risk for decreased self-worth, oral infection, and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 91 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, pneumonia (infection of the lungs), asthma, and chronic obstructive pulmonary disease (COPD, lung disease that makes breathing difficult due to damaged or inflamed airways). Resident 91 was able to communicate their needs and required assistance with activities of daily living (ADL). Observation and interview on 04/07/2026 at 1:34 PM showed Resident 91 laid in bed. Resident 91 stated they had not brushed their teeth in the facility, and they did not have any oral care supplies. During an interview and observation on 04/08/2026 at 12:57 PM Resident 91 stated they still did not have any oral supplies. Observation of the sink area showed no oral care supplies. During an interview and observation on 04/09/2026 at 8:05 AM, Resident 91 stated that they could not brush their teeth. Observation showed a gray box on a nightstand out of reach of Resident 91 that had a new, unopened toothbrush and travel sized toothpaste that was not opened. During an interview on 04/09/2026 at 8:09 AM, Staff M, Certified Nursing Assistant (CNA), stated the process for oral care was to assist residents that could not perform the task, and set up and remind the ones that could perform oral care them self. Staff M stated they did not know about oral care of Resident 91 as they were not assigned to them. During an interview won 04/09/2026 at 8:12 AM, Staff O, Licensed Practical Nurse, stated the oral care supplies should be easily available and the staff were expected to assist residents with oral care. During an interview on 04/09/2026 at 8:13 AM, Staff N, CNA, stated they were assigned to the care of Resident 91 but did not remember if they had assisted with oral care. During an interview on 04/09/2026 at 8:34 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was for staff to assist with oral care. Observation on 04/09/2026 at 8:39 AM, showed Staff B in Resident 91's room telling them they have seen them brush their teeth and Resident 91 stating No, you did not. During an interview on 04/09/2026 at 9:33 AM, Staff A, Administrator, stated the expectation was for oral care to be done every day per residents' preferences. Reference WAC 388-97-1060 (2) (b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 3 sampled residents (Resident 91) reviewed for respiratory care. Failure to follow provider's order placed residents at risk of complications, potential negative outcomes and diminished quality of life Findings included .Review of the electronic health record (EHR) showed Resident 91 was admitted to the facility on [DATE] with diagnoses to include respiratory failure, pneumonia (lung infection), asthma, and chronic obstructive pulmonary disease (COPD, lung disease that makes breathing difficult due to damaged or inflamed airways). Resident 91 was able to communicate their needs. Observation and interview on 04/07/2026 at 1:01 PM and 1:34 PM showed Resident 91 laid in bed receiving oxygen (O2) set to 4 liters (L) per minute via a nasal canula (devise to deliver O2 through a tube into the nose) that was connected to an O2 concentrator (a device used to deliver O2 therapy). Observation on 04/09/2025 at 1:23 PM showed Resident 91 was receiving O2 at 3L via nasal cannula. Resident 91 stated they were unable to reach and adjust the liters of the O2 delivery. Review of the providers' orders dated 03/27/2026 showed Resident 91 had an order for Oxygen at 2L/minute via nasal cannula. During an interview on 04/09/2026 at 3:03 PM, Staff T, Registered Nurse, verified the O2 delivery rate was at 3L/min and stated the nursing report two days prior discussed how Resident 91 was desaturating (oxygen level below normal of 90%) and the O2 rate was increased. Staff T stated that the expectation was for the nurses to notify provider and obtain new orders. During a joint interview on 04/10/2026 at 12:21 PM, Staff A, Administrator, and Staff E, Regional Registered Nurse, stated the expectation was to follow oxygen orders. Reference WAC 388-97 -1060(3)(j)(iv)-(vi)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act on and/or follow the consultant pharmacist's medication regimen review (MRR) recommendations in a timely manner for 1 of 5 sampled residents (Resident 15) reviewed for unnecessary medication use. This failure placed the resident at risk for receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 15 admitted to the facility on [DATE] with diagnoses to include high blood pressure, diabetes (high blood sugar), and arthritis (conditions that cause pain, swelling, stiffness, and reduced movement in one or more joints). Resident 15 was able to make needs known. Review of the pharmacist consultation report recommendation, dated 03/23/2026, showed Resident 15 received as needed oxycodone (narcotic medication used to treat moderate to severe pain) one to three times a day; however, nonpharmacological interventions (NPI, health interventions/approaches used instead of medication) were not linked to the as needed oxycodone order. It showed, Please ensure nonpharmacological therapies are attempted prior to prn [as needed] oxycodone administration. Review of Resident 15's April 2026 medication administration records (MAR) from 04/01/2026 - 04/09/2026 showed an order dated 01/08/2026 to monitor and document pain level every shift and to attempt non-medication interventions prior to administering as needed pain medication with NPI interventions listed. Documentation showed Resident 15's pain level was documented; however, NPI was not. Review showed an order with a start date of 03/27/2026 for oxycodone one tablet every eight hours as needed for moderate to severe pain. Review showed Resident 15's pain levels documented and oxycodone was provided; however, there was no NPI linked to the order to ensure NPI was provided prior to being given the oxycodone per pharmacy recommendation. During an interview on 04/09/2026 at 4:57 PM, Staff E, Regional Registered Nurse, stated Resident 15's pharmacy recommendation on 03/23/2026 was not followed up on. Staff E stated that Resident 15 should have had specific NPIs linked to the oxycodone order and needed to be addressed per pharmacy recommendation. During an interview on 04/09/2026 at 5:02 PM, Staff A, Administrator, stated Resident 15's pharmacist consultation report dated 03/23/2026 was noted on 03/27/2026 by the nurse, and should have been linked per pharmacy recommendation, and this did not meet their expectations. Reference WAC 388-97-1300 (1)(c)(iv)

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Life Care Center of Puyallup	511 10th Avenue Southeast Puyallup, WA 98372

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure their facility medication error rate was less than 5%. The facility's medication error rate was 12% for 2 of 5 residents (Resident 43 and 98) reviewed for medication error rate. These failures placed residents at risk for potentially significant medication errors, dehydration, inadequate pain management, and diminished quality of care/quality of life. Findings included. <RESIDENT 43>Review of the 02/18/2026 Significant Change minimum data set (MDS-assessment tool) showed Resident 43 admitted to the facility on [DATE] and had some problems with cognition. Resident 43 was hard of hearing and used hearing aids, vision impaired with the use of glasses, and was able understand others and was understood. Resident 43 was incontinent of bowel and bladder and required maximum assistance for toileting, bed mobility, and transfers.<Physician Order vs Medication Card Prescription label)During a medication administration observation on 04/10/2026 at 8:57 AM, Staff AA, Licensed Practical Nurse-LPN, showed the physicians order (PO) on the April 2026 medication administration record (MAR) for gabapentin 100mg, 1 capsule by mouth three times a day for nerve pain. The medication card prescription label showed ?gabapentin 100mg, 1 capsule by mouth one time a day'. The medication card did not match the order on the MAR and the card did not show the discrepancy in orders had been clarified. Staff AA placed one capsule in Resident 43's medication cup and administered the medication. In an interview on 04/10/2026 at 9:40 AM, Staff AA stated the medication card did not show the prescription order had been previously clarified by any of the nurses and they should have clarified the order prior to administration. Staff AA stated they were expected to note on the side of the card the date and time with their initial to show they verified which order to follow but that was not done.<Lidocaine patch removal>During a medication administration observation on 04/10/2026 at 9:15 AM, Staff AA lifted Resident 43's back of their shirt and observed a large white patch on Resident 43's lower back. Staff AA removed the patch, then placed a new lidocaine 4% patch on the same area of skin as the patch they removed. Staff AA stated the patch they removed was their lidocaine 4% patch that was placed yesterday morning. Review of the April 2026 MAR showed transcription of a PO dated 12/18/2025 for a lidocaine external patch 4%-apply to the back in the morning for pain, remove the patch at night. The transcribed hour for application of the lidocaine patch was scheduled for every morning at 9:00 AM. The transcribed hour for removal of the lidocaine patch was scheduled for every morning at 7:59 AM. The documentation showed that between 04/01/2026 and 04/10/2026, the same morning nurse documented both the removal of the old patch and placement of the new patch. In an interview on 04/10/2026 at 9:40 AM, Staff AA stated the lidocaine order directed the nurses to remove the patch in the evening, but the MAR transcription schedules showed to remove the patch in the morning an hour prior to application of the new patch. Staff AA stated this was an error and the patch should be removed in the evening, but it was not. <Failure to hold stool softener for loose stools>On 04/10/2026 at 9:10 AM, Staff AA showed the MAR PO for polyethylene glycole 3350 powder (stool softener) 17 grams mixed in eight ounces of water, by mouth twice a day for constipation and hold for loose stools. Staff AA took the cup of stool softener and the medications to Resident 43 and explained each of the medications. Staff AA asked Resident 43 Did you poop today? and Resident 43 stated yes. Staff AA administered both the stool softener and the gabapentin pill. Staff AA was not observed to have asked Resident 43 if they had any loose stool or diarrhea today. Staff AA left Resident 43's room.On 04/10/2026 at 9:23 AM, Resident 43 was asked if they had loose stool or diarrhea today and Resident 43 stated they did not know.In an interview on 4/10/2026 at 9:24 AM, Staff AA stated they determined if a resident had loose stools by asking the CNA's, asking the resident, and/or review of the ?alerts' list every morning on the Point Click Care (PCC-electronic health record system) dashboard. Staff AA stated they had not asked the CNAs about Resident 43's bowel consistency but asked Resident 43 if they had pooped. Staff AA stated they (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have asked Resident 43 if they had loose stools/diarrhea but did not.On 04/10/2026 at 9:26 AM, Staff AA pulled up the alert list dashboard for 04/10/2026. Review of the list showed Resident 43 was not on the list for loose stool. A joint review of Resident 43's bowel record under the TASK tab in PCC showed they had a loose stool on 04/10/2026 at 5:18 AM. Staff AA stated they did not know they could pull up the bowel and bladder TASK responses in PCC. Staff AA acknowledged they did not look at the bowel record, identify Resident 43 had loose stool that morning, and should have held the stool softener, but did not.In an interview on 04/10/2026 at 1:10 PM, Staff G, LPN/Unit Care Coordinator, stated stool softener medications should be held after any episode of loose stool and monitored on alert for loose stool until resolved. To evaluate loose stools, the nurses are expected to include a review of the resident's bowel record daily under the TASK tab in PCC; Question 3, which shows the consistency of bowel movements. Staff G stated medication prescription labels should match the current medication orders and when they don't, the orders should be clarified and notated on the card (to the side of the prescription label) that the order was clarified and which order is correct until the card with the current order on the prescription label has arrived. <RESIDENT 98>Review of the 01/28/2026 Annual Comprehensive MDS showed Resident 98 admitted to the facility on [DATE], had short-term and long-term memory problems, was dependent on staff for assistance with toileting, bed mobility, and transfers. Diagnoses included cerebral palsy (a condition that affects a person's ability to move and control their muscles due to changes or damage in the brain during development before, during, and/or shortly after birth) and was incontinent of bowel and bladder.During a medication administration observation on 04/10/2026 at 10:29 AM, Staff H, LPN, showed a PO from the April 2026 MAR for Senna-Docusate sodium oral tablet 8.6mg - 50mg, one tabled two times a day for constipation. Staff H removed a bottle from the top drawer of the medication cart, placed a tablet in the medication cup, and the bottle read ?Senna 8.6mg'. The senna 8.6 mg was administered to Resident 98.In an interview on 04/10/2026 at 10:40 AM, Staff H provided the bottle they removed the senna 8.6 mg from and administered to Resident 98. Staff H re-read the PO listed in the MAR and realized they administered the wrong medication. Staff H stated they should have administered the senna with docusate sodium 8.6mg-50mg tablet but did not.Reference WAC: 388-97-1060 (3)(k)(ii).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review the facility failed to ensure intravenous (IV-administered into the veins) medications were properly labeled during administration for 3 of 3 residents (Residents 14, 104, and 125) reviewed for medication labeling and storage. The failure to ensure the medication bag was labeled with the date, time, and nurse initials at the time of administration placed residents at risk for significant medication errors, adverse effects, and diminished quality of care/quality of life.Findings included. <RESIDENT 104>Review of Resident 104's April 2026 Medication Administration Record (MAR) showed: A physician order (PO) dated 03/19/2026 for Cefepime 2Gm Intravenously every eight hours for infection. The transcription schedule showed the medication was to be administered at 6:00 AM, 2:00 PM, and 10:00 PM.A PO dated 03/27/2026 for Daptomycin 825 mg intravenously every 24 hours for infection. The transcribed schedule time on the MAR showed 24h. Review of the nurse's documentation showed the antibiotic medication was administered between 10:00 AM and 1:00 PM daily.A PO dated 03/22/2026 showed to hang a 250 ml bag of normal saline to use for priming the IV line and to flush 25ml of saline before and after the IV antibiotic medication administration and change the IV set daily. The MAR transcription schedule showed the 25 ml flush was to be administered four times a day, at 6:00 AM, 11:00 AM, 2:00 PM, and 10:00 PM.During observations on 04/07/2026 at 3:45 PM and, Resident 104's IV pole and IV solutions showed an empty 100ml bag of saline with a prescription label for Cefepime 2 Gm (an intravenous antibiotic medication) in 100ml solution, every eight hours. The second bag that was hanging was a 250ml bag of normal saline with no name on the bag, rate/time to infuse, date and time it was hung, when to discard unused amounts, and the nurse who hung the bag.During an observation on 04/10/2026 at 12:06 PM, Staff Q, Registered Nurse-RN, administered Resident 104's daily daptomycin antibiotic. Observation of the IV bag after administration began showed the bag did not indicate the date/time of the dose hung, the rate it should be hung, or the nurse who hung the dose.During an interview on 04/10/2026 at 12:10 PM, Staff Q was unsure what the facility's policy was regarding labeling of IV medications but felt that since they were the nurse that hung the medication, labeling the IV bag with the date/time/rate and nurse initials was not necessary. Similar findings for. <RESIDENT 14>During an observation on 04/07/2026 at 2:38 PM of Resident 14's IV pole and IV solutions showed an empty 100 milliliter (ml) bag of normal saline solution with a pharmacy prescription label that indicated the bag contained cefazolin 2 grams (GM)(an intravenous antibiotic medication) in the 100ml of saline to be administered IV over 60 minutes every eight hours. The empty bag did not include the date and time the dose was hung, or which nurse hung the medication. Additionally, a separate 250 ml IV solution of normal saline hung but did not indicate the name of the resident, the amount to infuse, the rate, when the bag was hung, and by which nurse, and when to discard the bag if not all the fluid was used. This IV bag had approximately 125 ml of solution remaining in the bag.During an observation on 04/10/2026 at 3:00 PM of Resident 14's IV pole and IV solutions showed the 100ml bag of saline that contained the cefazolin was empty. The IV bag did not indicate the date/time of the dose hung, or the nurse who administered the IV. Similarly, a second 250 ml bag of saline was hung but without the name of the resident, infusion rate, when to infuse, when the bag was hung, when to discard, and the nurse that hung the bag.Review of the April 2026 MAR showed the IV antibiotic medication was administered at 2:00 PM by Staff Q. <RESIDENT 125>Review of Resident 125's April 2026 MAR showed:A PO dated 03/23/2026 for cefazolin 2 Gm (IV antibiotic medication) intravenously every eight hours. The transcribed dose schedule was for 6:00 AM, 2:00 PM, and 10:00 PM.A PO dated 03/28/2026 showed to hang a 250 ml bag of normal saline to use for priming the IV line and to flush 25ml of saline before and after the IV antibiotic medication administration and change the IV set daily. The MAR transcription schedule showed the 25 ml flush (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to be administered three times a day, at 6:00 AM, 2:00 PM, and 10:00 PM. During observations on 04/07/2026 at 9:50 AM and 04/08/2026 at 1:35 PM of Resident 125's IV Pole and IV solutions, the medication bag and the 250 ml saline solution were not dated/timed or initialed by the nurse that hung them. The Saline bag did not include the name of the resident, the rate of infusion, time of infusion, or when to discard if not used.An observation on 04/10/2026 at 2:25 PM of Resident 125's IV Pole and IV solutions showed an empty bag of the IV antibiotic and a bag of 250 ml normal saline with approximately 100 ml used. Both IV bags did not show the date/time of the dose administered, the nurse initials who hung the bag, and the Saline did not include the Resident's name.Review of Resident 125's April 2026 MAR showed the last IV antibiotic dose was administered by Staff Q at 2:00 PM.In an interview on 04/10/2026 at 4:00 PM, Staff P, LPN/Unit Care Coordinator, stated the professional standards for IV administration should be followed and all intravenous fluids/medications administered must be properly labeled with the Resident's name, the name of the medication if there was one added, the rate of infusion, the date and time of the dose that was hung, and initialed by the nurse that hung the dose. If the antibiotic IV medications did not indicate the date/time of the dose and the nurses' initials, then professional standards were not followed. Reference WAC: 388-97-1060 (3)(k); -1300(2).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide needed dental services for 1 of 3 sampled residents (Resident 17) when reviewed for dental services. This failure placed residents at risk for unmet needs, poor nutritional intake, and a decreased quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 17 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, difficulty breathing) and diabetes (high blood sugar). The resident was able to make needs known. During an interview on 04/07/2026 at 10:06 AM, Resident 17 stated their dentures did not fit and they had seen a dentist three months ago for new dentures but had not heard anything further. Review of the EHR showed a form titled Dental Progress Note dated 02/05/2026 which recommended new upper and lower dentures and extractions for Resident 17. Review of a progress note dated 02/12/2026 showed Resident was seen by [outside dental provider]. Will need a referral out for x-rays, ex [extractions] FOR ALL LOWER TEETH. Referral and Transportation specialist is aware and working on it. During an interview on 04/09/2026 at 1:24 PM, Staff F, Central Supply/Transportation Specialist, stated they had not seen the recommendation for new dentures and Resident 17 was scheduled for a recall exam in one year. During an interview on 04/09/2026 at 1:27 PM, Staff G, Unit Care Coordinator, stated it was their expectation that transportation schedule the follow up and send them notice when it was done, but they had not received notice yet for Resident 17. During an interview on 04/09/2026 at 2:21 PM, Staff E, Regional Registered Nurse, stated it was their expectation Resident 17 be referred for dentures timely. Reference WAC 388-97 -1060(1)(3)(j)(vii)