STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505485	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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 interview and record review the facility failed to protect resident's right to be free from physical abuse for 3 of 4 sample residents (Residents 1, 3, and 4) reviewed for resident-to-resident altercations. This failure placed residents at risk for abuse, psychosocial harm, and a diminished quality of life.Findings included.Based on interview and record review the facility failed to protect resident's right to be free from physical abuse for 3 of 4 sample residents (Residents 1, 3, and 4) reviewed for resident-to-resident altercations. This failure placed residents at risk for abuse, psychosocial harm, and a diminished quality of life.Findings included.Review of the facility policy titled, Coordinating/Implementing Abuse, Neglect and Exploitation Policies and Procedures, dated April 2021, documents 1. Policies are in place that: a. prohibit and prevent resident abuse, neglect, exploitation and misappropriation of resident property. The policy further documents 2. Policies address the following as part of abuse, neglect, misappropriation prevention: c. Prevention.Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a progressive mental deterioration of the brain) late onset. The Quarterly Minimum Data Set, (MDS-an assessment tool), dated 03/19/2026, documented Resident 1 as moderately cognitively impaired.Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including unspecified Dementia (a condition characterized by progressive or persistent loss of intellectual functioning) without behavioral disturbance. The admission MDS, dated [DATE], documented Resident 2 as cognitively intact.Review of the Alleged Resident to Resident Altercation packet number 2385 dated 03/28/2026 at 04:30 PM documents, Resident 1 was involved in a resident-to-resident altercation in which an alternate resident (Resident 2) grabbed his (Resident 1's) wrist and Resident 1 hit the alternate resident (Resident 2) in the face. The immediate intervention was to separate the residents and place Resident 1 on 1 to 1 supervision with a staff member.On 04/02/2026 at 12:52 PM, Resident 2 stated, about a week ago he was in the main dining room, and the meal was almost over, and trays were being picked up when Resident 1 came in and took a piece of cornbread off a used tray. Resident 2 said, he told Resident 1 You can't take food off of trays. Resident 2 said Resident 1 clocked him in the face and he fell to the ground. On 04/02/2026 at 02:00 PM, Resident 1 said he took a piece of cornbread off a tray that had been picked up already. Resident 1 said the guy (Resident 2) that lived down the hall was in the dining room and was telling me to put it back. Resident 1 said tempers flared, he hit Resident 2 in the face, and Resident 2 fell to the ground. Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease. The Quarterly MDS, dated [DATE], documented Resident 3 as severely cognitively impaired.Resident 4 was admitted to the facility on [DATE] with multiple diagnoses including unspecified Dementia with other behavioral disturbances. The admission MDS, dated [DATE], documented Resident 4 as severely cognitively impaired.Review of the Alleged Resident to Resident Altercation packet number 2376 dated 03/23/2026 at 11:00 AM, documents Resident 3 was trying to get a wheelchair away from Resident 4. Resident 3 and Resident 4 pushed each other. Resident 3 fell to the ground. The immediate intervention was to separate the residents by offering a room move. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 accepted the room move and is now in a private room. On 04/02/2026 at 01:01 PM, an interview was conducted with Resident 3. Resident 3 did not remember the incident.Record review of progress note, dated 03/23/2026 at 11:45 AM, for Resident 3 documented, RN received report that resident was involved in altercation. Resident reported that her roommate pushed her down causing her to hit her head and back. Resident unable to remember what occurred during incident.On 04/02/2026 at 01:14 PM, an interview was conducted with Resident 4. Resident 4 did not remember the incident.Record review of progress note dated 03/23/2026 at 11:41 AM, for Resident 4 documented, Resident reported that her roommate was attempting to touch her wheelchair and pushed roommate away from the wheelchair. Resident reports she pushed her roommate back which caused her to fall. Resident reports she didn't mean to push her down, that she accidentally pushed too hard. Residents separated and Resident was assisted to activities.During an interview on 04/14/2026 at 01:30 PM, Staff A, Executive Director, stated Residents 1 and 2 were involved in a Resident-to-Resident altercation which involved Resident 1 hitting Resident 2. Staff were able to intervene and separate the residents. Resident 1 was placed on a 1 to 1 monitoring. Staff A stated Residents 3 and 4 were also involved in a Resident-to-Resident altercation which involved Resident 4 pushing Resident 3, causing her to fall. Staff A said it was determined that Resident 4 thought all belongings in her room belonged to her, therefore she was moved to a private room to minimize any further occurrences. Staff A said he was the facility abuse coordinator and after any type of abuse allegation there was a risk call. Staff A said this was a TEAMS meeting that included the Executive Director, Director of Nursing Services, Corporate Compliance, Corporate Social Services, Corporate Human Resources, Regional Consultant, and legal if necessary. Reference WAC: 388-97-0640 (1)