

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Linden Grove Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 1 of 4 sample residents (Resident 1) 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 originally admitted to the facility on [DATE] with multiple diagnoses including Parkinson's Disease with dyskinesia with fluctuations (a condition where a person has uncontrolled, involuntary, movements, which are side effects of long-term dopamine [a chemical that helps nerve cells in the brain send signals] replacement therapy rather than symptoms of the disease itself). The Quarterly Minimum Data Set, (MDS-an assessment tool), dated 07/16/2026, documented Resident 1 as moderately cognitively impaired. Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including chronic kidney disease stage 3 unspecified (moderate kidney damage and working at 30 percent to 59 percent capacity). The Quarterly MDS, dated [DATE], documented Resident 2 as cognitively intact. Review of the Alleged Resident to Resident Altercation packet number 2558, dated 07/17/2026 at 04:10 PM, documents, A female resident came up behind male resident and punched him on the right side of his face several times. The immediate intervention was to separate the residents and place Resident 2 on 1 to 1 supervision with a staff member. Resident 1 was offered to be transported to the hospital for evaluation and treatment (Resident 1 declined); Resident 2 sent to hospital for evaluation and treatment. In-house provider ordered x-ray of skull for Resident 1 and placed on alert status to monitor for any changes in mentation. Resident 2 was moved to a room on the opposite hall, and Resident 2 was offered to be seen by the Behavioral Health Services but declined. On 07/29/2026 at 11:30 AM, Resident 1 said He was in the main dining room enjoying a planned activity with a live band when he caught out of the corner of his eye someone slightly behind him. Resident 1 said he turned to that person and before he knew what was happening a female resident began hitting him several times on the side of his face/head and neck. Resident 1 said he is unsure how many times he was hit. Resident said this really caught him off guard because he was just minding his own business listening to the music. On 07/29/2026 at 12:00 PM, Resident 2 said she entered the main dining room after being outside and heard Resident 1 making racial slurs towards her and she snapped. Resident 2 said she knew it was wrong to hit Resident 1 but her body just did it. Resident 2 said Resident 1 made several comments using the 'N' word and using profanity. Record review of progress note, dated (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/17/2026 at 17:37 PM, for Resident 1 documented during a scheduled activity in dining room Resident 2 became verbally agitated and yelled at Resident 1. Resident 2 then struck Resident 1 multiple times in the facial area. Staff immediately intervened, separated the residents, and ensured their safety. The Resident Care Manager, Director of Nursing and Executive Director were notified of incident. Skin assessments were completed. Resident and staff interviews completed. Resident 1 expressed desire to press charges; law enforcement notified. Vulnerable Adult abuse reports were filed online. During an interview on 07/29/2026 at 01:30 PM, Staff A, Executive Director, said Residents 1 and 2 were involved in a Resident-to-Resident altercation which involved Resident 2 hitting Resident 1 while in the main dining room during an activity. Staff were able to intervene and separate the residents immediately. Resident 2 was placed on a 1 to 1 monitoring and moved to a window bed on the other hallway for separation. Staff A said he was the facility abuse coordinator and after any type of abuse incident there was a risk call held. Staff A said this was a TEAMS meeting that included the Executive Director, Director of Nursing Services, Social Services Director, Corporate Compliance, Corporate Social Services, Corporate Human Resources, Regional Consultant, and legal if necessary. Staff A said Resident 2 had not been identified as a behavior risk prior to the incident. Staff A said all admissions were screened at the facility and corporate level to identify any potential behaviors prior to admission. Staff A said new admits were also reviewed during the clinical meeting to ensure staff are aware of any potential behaviors towards others, history of behaviors, and to review the residents' room to ensure a good fit. Reference WAC: 388-97-0640 (1)		