STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505513	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puget Sound Transitional Care	2800 South 224th Street, Des Moines, WA 98198

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure residents with a Percutaneous Endoscopic Gastrostomy (PEG) tube (a soft, flexible plastic feeding tube inserted directly into the stomach through the abdominal wall) received the appropriate treatment and services according to professional standards of practice for 2 of 3 residents (Residents 1 & 2) reviewed for tube feeding management. The facility failed to follow and implement the physician's orders pertaining to tube feeding volume delivery to meet the resident's assessed nutritional requirements (Resident 1) and failed to ensure ongoing review and evaluation regarding the discontinuation of the PEG site after adequate oral nutrition was established and achieved by the resident (Resident 2). These failures placed residents at risk for inadequate nutrition/hydration, PEG site complications including infection, unnecessary pain/discomfort, and a decreased quality of life. Findings included. <Facility Policy>The facility policy titled, Gastrostomy Tube Care and Management, revised 04/2025, showed the facility must follow physician orders and provide proper care and maintenance of gastrostomy tubes. The policy showed the facility should determine if the resident felt any pain or discomfort around the tube insertion site by questioning the resident and evaluating any changes in the resident's gastrointestinal system. The undated facility policy for nursing clinical procedures titled, Physician Order- Transcribing, showed all treatment orders were to be transcribed into the electronic health record and all new orders, including family/representative notification, were to be documented in the nursing notes.<Resident 1>According to the 11/03/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 had impaired memory, did not have the ability to communicate verbally, and had medical conditions including a brain injury with resulting swallowing difficulty. The MDS showed Resident 1 had a PEG tube in place and was administered tube feeding during the assessment period. Review of Resident 1's revised 09/28/2025 nutrition Care Plan (CP) showed the resident had a nutritional problem due to their medical condition and required tube feeding via their PEG tube to meet their nutritional requirements. A 09/28/2025 CP intervention instructed the nursing staff to administer tube feeding as ordered by the physician. Review of Resident 1's January 2026 Medication Administration Record (MAR) showed a 11/02/2025 physician's order to administer a total of 1700 milliliters (ml) of tube feeding to the resident over a span of 20 hours during the day. The MAR showed on 28 out of 30 days, Resident 1 was administered less than what was prescribed: 1660ml on 01/14/2026; 1640ml on 01/29/2026-01/30/2026; 1637ml on 01/27/2026; 1630ml on 01/22/2026-01/26/2026; 1600ml on 01/08/2026-01/12/2026 and 01/20/2026-01/21/2026; 1560ml on 01/15/2026-01/19/2026; 1558ml on 01/01/2026-01/03/2026; 1550ml on 01/13/2026 and 01/28/2026; 1300ml on 01/04/2026; and 450ml on 01/07/2026. In a joint interview with Staff A (Administrator) and Staff E (Infection Preventionist/Staff Development) on 03/05/2026 at 12:13 PM, Staff E stated it was important to ensure residents received the prescribed tube feeding volume for nutritional health and safety. Staff E reviewed Resident 1's MAR and stated the resident should have but was not administered the tube feeding amount the resident was assessed to require as ordered. In a phone interview on 03/09/2026 at 2:34 PM, Staff B (Director of Nursing) stated they expected the nursing staff to follow and implement physician's orders for tube feeding as indicated in the MAR. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 2> According to the 11/07/2025 Quarterly MDS, Resident 2 had clear speech, memory deficits, and had medical conditions including cardiac arrest (a sudden cessation of heart function), respiratory failure, and swallowing difficulty. The MDS showed Resident 2 was provided a mechanically altered texture diet and did not receive any tube feeding during the assessment period. Review of Resident 2's revised 11/01/2025 nutrition CP showed the resident had a PEG tube in place and was able to take food by mouth. A 07/10/2025 nutritional evaluation showed Resident 2's tube feeding was discontinued because the resident established good appetite and oral intake of food. A 11/25/2025 nursing note showed Resident 2's representative notified the facility of the need for a referral from the physician to coordinate the resident's PEG tube removal. A 01/10/2026 progress note by the Physician's Assistant (PA) showed Resident 2 alerted them about the status of their PEG tube removal and expressed discomfort from it. The note showed an order to have the PEG tube removed was pending per the nursing staff. In an observation and interview on 02/11/2026 at 1:56 PM, Resident 2 was observed sitting up in bed; their PEG site had a dressing on. Resident 2 stated they could now manage their nutrition needs by eating and no longer needed tube feeding. Resident 2 stated they did not understand why the facility did not order their PEG tube be removed and wanted their PEG site closed, .I want this [PEG tube] thing out of me. Review of Resident 2's medical records and progress notes from 01/11/2026 until 03/05/2026 did not show the facility followed up regarding the status of Resident 2's PEG tube removal. Documentation was requested from the facility but no additional information regarding a follow-up was provided. In a joint interview with Staff A and Staff E on 03/05/2026 at 12:13 PM, Staff E stated it was important to ensure a PEG tube was removed if it was no longer needed for nutritional support because it was considered a foreign object in the body and could cause infections. Staff E added there was a risk of accidentally pulling the PEG tube out if left in place unnecessarily. Staff E reviewed Resident 2's medical records and stated there was no documentation in the resident's medical records to show follow-up was made by the facility to have Resident 2's PEG tube removed after the PA's visit on 01/10/2026. In a phone interview on 03/09/2026 at 2:34 PM, Staff B stated care coordination regarding the removal of Resident 2's PEG tube was overlooked, .unfortunately, the communication fell through the cracks. REFERENCE: WAC 388-97-1060(3)(f)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure the resident's medical records were complete, accurate, and reflected the actual care provided for 1 of 7 sample residents (Resident 7) reviewed for resident records. The failure to ensure wound care completion was documented accurately in the Treatment Administration Record (TAR) placed residents at risk for inaccurate representation of wound condition and care, unnecessary repetition of dressing changes, and a decreased quality of life. Findings included. <Facility Policy>The facility policy titled, Skin and Wound Monitoring and Management, revised 04/2025, showed the facility would implement wound care approaches that were consistent with the resident's Care Plan (CP) including monitoring the impact of interventions and modifying them as appropriate based on any identified wound change(s) via documentation in the TAR. The policy showed the facility would confirm all treatment orders were implemented as ordered.<Resident 7>According to the 11/25/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 7 was cognitively intact and had medical conditions including heart and respiratory failure, unstable blood sugar levels, and needed assistance with daily cares. The MDS showed Resident 7 had a venous ulcer (a slow-healing, chronic, open wound usually occurring on the lower leg near the ankle due to poor circulation) to their right lower leg and was provided skin/wound treatment during the assessment period. Review of Resident 7's revised 06/03/2025 skin CP showed the resident had altered skin integrity from the venous ulcer in their right leg. A 08/23/2024 CP intervention instructed the nursing staff to perform treatments as ordered and to assess, record, and monitor wound healing. Observation on 02/25/2026 at 1:04 PM showed Resident 7 was lying in bed with their right leg elevated on a pillow; a white, mesh dressing was wrapped around their lower leg that extended up to the ankle and was secured with silk tape. The dressing had scant drainage along the side of their leg and was observed unlabeled (no date/staff initial). In an observation and interview on 03/05/2026 at 11:04 AM, Resident 7's right leg dressing was observed in place and was unlabeled. Resident 7 stated they could not recall exactly when the dressing change was done, .for sure not today. In an interview on 03/05/2026 at 11:43 AM, Staff F (Registered Nurse) stated they changed Resident 7's right leg dressing every other day as ordered. Staff F stated they did not put a date or initial on the dressing after changing it. Review of Resident 7's February 2025 TAR showed, on 02/02/2026, 02/06/2026, and 02/16/2026, the treatment order for Resident 7's right leg wound dressing change was not signed off as completed by the nursing staff and was left blank. In a joint interview with Staff A (Administrator) and Staff E (Infection Preventionist/Staff Development) on 03/05/2026 at 12:13 PM, Staff E stated they expected the nurses to put the date and their initial on the dressing after changing it because it was important for auditing purposes. Staff A reviewed Resident 7's February 2026 TAR and stated they expected the nursing staff to follow wound treatments as ordered by the physician and to document the care that was provided in the resident's medical records. REFERENCE: WAC 388-97-1720(1)(a)(i)-(iv)(b)