

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Puget Sound Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect 1 of 1 sampled resident (Resident 1) reviewed for abuse and the right to be free from physical abuse by (Resident 2). The facility failed to assess, monitor and implement safety interventions to protect residents from residents with known behaviors. These failures placed residents at risk of physical and psychosocial harm, mental anguish, and a diminished quality of life. Findings included. Review of the facility's policy titled Freedom from Abuse, Neglect and Exploitation, revised 04/2025, documented each resident had the right to be free from abuse, and mistreatment. The policy documented the facility would identify, assess, and implement a care plan for appropriate interventions, and monitor residents with behaviors that might lead to conflict.<Resident 1>Review of the annual Minimum Data Set Assessment (MDS-an assessment tool) dated 03/22/2026, showed Resident 1 had Dementia (memory impairment), depression, pain and used a wheelchair for mobility. Review of Resident 1's At Risk for Depression related to Dementia Care Plan (CP) dated 05/03/2025, documented staff were to monitor Resident 1 for being at risk for increased anger, or agitation and feelings of being threatened by others.<Resident 2>Review of Resident 2's admission MDS dated [DATE], documented the resident admitted to the facility on [DATE]. The MDS showed Resident 2 had post-traumatic stress disorder (PTSD), psychoactive substance abuse and major depression.Review of Resident 2's Behavior CP, dated 04/20/2026, documented the resident had the potential to demonstrate physical behaviors, physical and verbal aggression towards others related to anger, poor impulse control, history of PTSD and drug abuse. The CP showed staff interventions were to monitor Resident 2 for signs and symptoms of psychological harm.Review of facility's Investigation Report dated 04/20/2026, documented staff heard residents yelling in a room shared by Resident 1 and 2. Staff observed Resident 1 was on the floor on their back with their wheelchair tipped over backwards. Resident 2 was sitting on the side of their bed yelling at Resident 1. The facility investigation showed Resident 1 stated Resident 2 started screaming at them and grabbed their neck and tipped them over backwards. Upon assessment staff observed Resident 1 had redness and scratches on their neck. The investigation report showed Resident 2 was removed by law enforcement from the facility.In an interview on 04/30/2026 at 1:45 PM, Staff B, Director of Nursing (DNS) stated the facility usually did not admit potential residents if they had uncontrolled behaviors. Staff B stated they were not aware Resident 2 had behaviors prior to being admitted to the facility and did not provide one on one monitoring until after the incident occurred on 4/20/2026. Staff B stated if there were behaviors after admission, the facility should have documented and monitored the residents for safety.In an interview on 04/30/2026 at 1:50 PM, Staff A, Administrator, stated the facility was not aware Resident 2 had behavior issues. Staff A stated the facility does not have a way to screen residents for behaviors if it was not listed on the discharging hospital paperwork prior to admission. Staff A stated they were not aware of the reason why Resident 2 had PTSD and what triggers were to be monitored. Reference WAC 388-97-0640(1)</p>

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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