

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

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Form Approved OMB
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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 07/30/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review the facility failed to initiate and investigate an allegation of resident-to-resident abuse for 2 of 4 (Resident 1 & 2) residents reviewed for resident-to-resident incidents. The failure to initiate an investigation, document the incident and thoroughly investigate put all residents at risk for unidentified abuse or neglect, lack of protection, continued abuse, and decreased quality of life. Findings included. <Facility Policy>Review of the facility's revised 04/2025 Abuse Prevention of and Prohibition Against policy, showed the facility would protect and prevent abuse from occurring in the facility by identifying, correcting and intervening in situations where abuse is more likely to occur. The policy showed for resident-to-resident allegations the facility would assess, monitor and intervene as necessary to maximize resident health and safety. According to the policy, the facility would investigate and conduct interviews with the residents involved, witnesses, staff members and other residents, and a licensed nurse would immediately examine the resident upon receiving reports of alleged physical abuse and record the examination in the resident's medical record.<Resident 1>According to the 04/21/2026 annual Minimum Data Set (MDS- an assessment tool), Resident 1 had depression (sadness), pain, anxiety, and used a wheelchair. The MDS showed Resident 1 had no memory issues and communication could be understood and was understood by others. According to the revised 03/06/2026 Depression care plan, staff were to monitor, document and report to the provider signs of sadness, negative mood comments and fear of others. Review of the care plan did not show updated documentation of a resident-to-resident incident occurring. In an observation and interview on 07/30/2026 at 2:09 PM, Resident 1 was observed sitting in their wheelchair and stated, approximately two weeks ago Resident 2 intentionally bumped into their wheelchair with their wheelchair while they were near the activity room. Resident 1 stated Resident 2 would get mad at times when they saw Resident 1 talking to another resident or staff member. Resident 1 believed the intentional wheelchair bumping was because of this. Resident 1 stated they told Staff C (Resident Care Manager) about the incident after the event occurred and reported the incident to both Staff A (Administrator) and Staff B (Director of Nursing). Resident 1 stated they had heard back from the facility about interventions the facility had done to prevent this type of event from happening again and was not aware if the facility was monitoring their condition. Resident 1 stated after the bumping event happened, they called their surgeon and case manager to notify them of the bumping incident because they noticed their neck was stiffer after the incident and the additional neck stiffness could delay their upcoming neck surgery. Resident 1 stated after talking with surgeon, there was no delay in surgery plans because of the neck being stiffer. Review of Resident 1's medical record showed no indication that staff documented the resident-to-resident incident, did not monitor Resident 1's condition after the incident, and did not show interventions were put into place to address Resident 1's concerns. The facility was unable to provide documentation to show staff documented and investigated the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505513	Facility ID: 505513 If continuation sheet Page 1 of 2

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-to-resident incident into Resident 1's medical records. Review of the facility's July 2026 incident and grievance logs showed no resident-to-resident incident documented for Resident 1 and Resident 2.<Resident 2>According to the 06/09/2026 quarterly MDS, Resident 2 had memory impairment, altered mental status, a mood disorder, and used a wheelchair for mobility. According to the 11/11/2024 Potential for Psychosocial Wellbeing care plan, staff were to observe Resident 2 for mood changes, and aggressive or impulsive behaviors. Review of Resident 2's medical records showed no documentation of the resident-to-resident incident that occurred between Resident 2 and Resident 1. In an interview on 07/30/2026 at 3:40 PM, Resident 2 stated they sometimes had issues with others but did not have any issues right now and did not recall the event of bumping another resident. In an interview on 07/30/2026 at 2:41 PM Staff C (Resident Care Manager) stated they were made aware of the resident-to-resident incident by Resident 1, however Resident 1 did not appear distressed and Staff C stated they appeared jolly about the event. Staff C stated they reported the incident to the Interdisciplinary Team (IDT) but did not investigate the incident further and did not document the event in the resident's record. Staff C stated if there were incidents of potential abuse, the facility staff should investigate, report, document and notify the Director of Nursing right away for resident safety but did not for the resident-to-resident incident involving Resident 1 and Resident 2.In an interview on 07/30/2026 at 3:30 PM Staff D (Licensed Practical Nurse) stated Resident 2 could become aggressive at times towards others if they were angry. Staff D was not made aware of a resident-to-resident incident between Resident 1 and Resident 2. In an interview on 07/30/2026 at 4:22 PM Staff A stated they were aware of the resident-to-resident incident and thought the incident was accidental and not intentional. Staff A stated no further interventions were put into place to monitor both Resident 1 and Resident 2 for aggressiveness because the residents remained in contact with one another. Staff A stated they kept a file of the occurrence but did not document the conversation with Resident 1 in the medical record and did not conduct a full investigation because they believed the incident to be an accident. Staff A stated all incidents of potential abuse should be investigated and documented in the medical record and updates should have been made to the care plan but were not. REFERENCE: WAC 399-97-0640(6)(a)		