STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505246	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pullman Care	Northwest 1310 Deane Pullman, WA 99163

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on observation, record review and interviews, the facility failed to ensure sufficient nursing staff were available to respond to call lights timely and to meet the care needs of 8 of 15 residents (Residents 3,1,4,5,6, 2,7,8) reviewed for sufficient nursing staff. This failure resulted in feeling of frustration and vulnerability, diminished quality of life and unmet care needs of the residents. Findings included . <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses which included diabetes and cellulitis (bacterial skin infection that caused redness, swelling and pain in the affected area). Review of Resident 3's comprehensive assessment, dated 02/16/2024, showed they had no cognitive deficits. Review of Resident 3's plan of care, dated 11/15/2023, showed they required extensive assistance by staff for transfers, turning from side to side and bathing. Review of physician's orders, dated 04/19/2024, showed showers were to be given to Resident 3 every Tuesday, Wednesday, Friday, and Saturday. Review of Progress Notes, dated 04/26/2024 at 8:08 PM, showed Resident 3 returned from the wound clinic. The resident's representative stated antibiotic therapy was ordered for 10 days to treat an infection to the right foot. Review of bathing records between 04/01/2024 to 05/01 2024, showed Resident 3 was showered on 04/02/2024, 04/05/2024, 04/09/2024, 04/12/2024, 04/16/2024, 04/23/2024, 04/28/2024 and 05/01/2024. Despite the physician ordered showers of four times weekly on 04/19/2024 the resident only received three showers during that 12 day period of time. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2024 at 3:25 PM, Resident 3's representative (RR), stated during a telephone interview that the resident had many concerns. Recently Resident 3 was only getting one shower per week. On 04/29/2024 the resident was left sitting in urine for over an hour during dinner due to the facility being short staffed. Thirty to 45 minutes was the average time for the resident's call light to be answered by staff. There would be only one Nursing Assistant (NA) for 28 or more residents on the evening shift. Staff D, Licensed Practical Nurse, came out of their office but really did not help on the floor as observed by the RR. The RR stated they changed Resident 3's brief frequently when they visited. The RR stated, the entire place has gone downhill. On 05/01/2024 at 10:20 AM, Resident 3 was observed seated in a recliner in their room. They kept a note pad of events occurring during the day. Resident 3, stated not enough staff, not doing what they told me they would do. It gets worse as the time goes on. According to the physician and wound clinic Resident 3 was supposed to get showers every other day. The resident stated they had never refused a shower, they [staff] tell me they'll do it and then it doesn't get done. The resident stated they had gone five to seven days without a shower. Call lights had been an issue as sometimes the resident had not had their call light answered by staff for 1.5 hours, which caused them to urinate in their brief. The resident stated, can take awhile to get care .sometimes they say I got a shower when I didn't. The resident stated, after obtaining information from their note pad, that they had received showers in April 2024 on 04/12/2024 at 10:05 AM, 04/16/2024 at 3:15 PM, 04/21/2024 at 4:05 PM, 04/28/2024 at 10:00 AM and 04/30/2024 at 3:25 PM. On 05/01/2024 at 10:40 AM, Anonymous Staff E (ASE), stated it had been really difficult and they never took breaks. Anonymous Staff E stated NA staff just learned that week Resident 3 was supposed to get showers ever other day. Resident 3 took 45 minutes to complete a shower. Many times the evening shift did not get their showers completed. When one NA was at lunch and the other two NAs were in a resident's room it took quite awhile for call lights to be answered. On 04/22/2024 there were no NAs scheduled for the evening shift. Anonymous Staff E stated they felt like they were being forced to work that evening shift (04/22/2024) after working all day. They had no options as they would have been abandoning residents had they not worked. Additionally, ASE stated there were too many residents that required two staff to assist with transfers. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included a serious illness that attacked the resident's nervous system, causing weakness and muscle paralysis. Review of the resident's comprehensive assessment, dated 03/09/2024, showed they had no cognitive deficits and required staff assistance with activities of daily living, including eating. Review of Resident 1's April 2024 bathing records showed they were showered on 04/04/2024, 04/10/2024, 04/11/2024, 04/18/2024, 04/25/2024, and 04/29/2024. On 04/24/2024 at 5:30 PM, Resident 1's family member, stated during a telephone interview that the resident had not gotten a shower for eight days. They stated the service provided by staff at the facility was better two months ago than it was currently. Staff was not answering the resident's call light timely and sometimes it took 1.5 hours to get staff assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/2024 at 6:58 PM, Resident 1, stated it generally took over 30 minutes for staff to respond to their call lights. On the weekends it could take two hours and the worst time was between 5:00 to 9:00 PM. Resident 1 stated prior to that week they had only received showers once weekly instead of twice weekly. Often on the evening shift there were only two NAs and they were feeding residents so no staff were on the floor assisting residents. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses which included depression and bone disease. Review of Resident 4's comprehensive assessment, dated 02/01/2024, showed they had no cognitive deficits. Review of Resident 4's plan of care, dated 04/14/2022, showed they required limited assistance by one staff for bathing, turning in bed, dressing, personal hygiene and transfers; and extensive assistance by one staff for toileting. On 04/26/2024 at 10:05 AM, Resident 4, stated sometimes there was only one NA on the floor on the evening shift. The call light response time used to be five to 10 minutes, now it could be 20 to 25 minutes. Resident 4 stated they often had to wait for staff to be changed following a urinary incontinency episode. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility with diagnoses which included Parkinson's disease (progressive disorder that affected the nervous system and the parts of the body controlled by the nerves). Review of Resident 5's comprehensive assessment, dated 02/05/2024, showed they had no cognitive impairments. Review of Resident 5's plan of care, dated 03/17/2023, showed they required extensive assistance by one staff for bathing and personal hygiene; extensive assistance by two staff for turning in bed, toileting, dressing; and was dependent on two staff for transfers using a mechanical lift (device used for residents who were unable to assist with transferring in and out of a bed, wheelchair or shower chair). Review of Resident 5's April 2024 bathing records showed they were showered by staff on 04/08/2024, and had received bed baths on 04/15/2024 and 04/29/2024. On 05/01/2024 at 3:00 PM, Resident 5, stated that staff used the excuse they were too busy to be bothered by me. Resident 5 stated sometimes their call light did not get answered for 1.5 hours. They stated it had been several hours since they had their disposable brief changed that day. They stated they were incontinent of urine and stool. On 05/01/2024 at 3:10 PM two caregivers were observed changing the resident's disposable brief which was wet with urine and had stool. <Resident 6> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses which included stroke with left sided weakness. Review of Resident 6's comprehensive assessment, dated 02/25/2024 showed the resident had no cognitive impairments. Review of Resident 6's plan of care, dated 10/12/2023, showed the resident required total staff assistance with bathing, turning in bed, personal hygiene, dressing, toilet use; and a mechanical lift was utilized by two staff for transfers. On 04/26/2024 at 10:15 AM, Resident 6, stated it took over 30 minutes to get their call light answered by staff and they usually needed to have their disposable brief changed. The resident kept track of the time by looking at the clock on the wall across from their bed. <Resident 2> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses which included a respiratory disease which required the use of oxygen therapy. Review of Resident 7's comprehensive assessment, dated 03/05/2024, showed they had moderate cognitive impairment. Review of a Progress Note by the interdisciplinary team, dated 04/24/2024, showed Resident 2 required stand by assistance by staff with turning in bed, transfers, walking using a walker; and staff supervision with toileting, and dressing. Resident 2 was alert and oriented and able to make their needs known. On 04/26/2024 at 10:25 AM, Resident 2, stated the facility needed more help. The resident's call light was not answered for one hour that week which caused them to wet their bed. Resident 2 stated that had happened more than once. They stated that either on 04/25/2024 or 04/24/2024 they put their call light on at 4:00 PM and staff did not respond until 5:45 PM. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility on [DATE] with diagnoses which included stroke. Review of Resident 7's comprehensive assessment, dated 02/27/2024, showed severe cognitive impairment. Review of Resident 7's plan of care, dated 02/27/2024, showed they required total staff assistance with bathing, personal hygiene, dressing; and extensive staff assistance with turning in bed, eating, transfers and toileting. Review of Resident 7's April 2024 bathing records showed they received showers on 04/03/2024, 04/06/2024, 04/14/2024 and 04/25/2024. <Resident 8> Review of the medical record showed Resident 8 was admitted to the facility on [DATE] with diagnoses which included diabetes. Review of Resident 8's comprehensive assessment, dated 04/16/2024, showed they had severe cognitive deficits. Review of Resident 8's plan of care, dated 04/05/2024, showed they required extensive staff assistance with all activities of daily living. Review of the April 2024 bathing records showed Resident 8 received showers on 04/04/2024, 04/25/2024, 04/29/2024 and one bed bath on 04/05/2024. <Staff Interviews> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Anonymous Staff F (ASF) On 04/26/2024 at 8:30 AM, ASF, stated the facility was short handed 90 percent of the time. On 04/22/2024 two NAs, that had worked the dayshift, had to stay over on the evening shift as there were no scheduled NAs assigned to work. The facility was chronically understaffed. Resident 1 only got a shower once weekly despite the resident's request to have two showers weekly. Additionally, ASF stated, call lights were on forever. Anonymous Staff G (ASG) On 04/29/2024 at 12:14 PM, ASG, stated during a telephone interview that they were unable to take any breaks if there were only two NAs assigned to care for residents, which occurred twice last week. They stated that staffing had not been very good. Anonymous Staff G stated Staff D never got on the floor to assist with resident care. They stated they try to give showers but residents end up getting bed baths instead due to staffing issues. Anonymous Staff H (ASH) On 04/30/2024 at 3:55 PM, ASH, stated during a telephone interview that staffing was the worst. They stated Staff I, Administrator, was aware there was only one Licensed Nurse (LN) and one NA on the evening shift. The evening shift was not getting their showers done, they had several assigned showers per evening. Instead of a shower the resident might only get a bed bath due to staffing issues. Anonymous Staff H stated, we are not fulfilling our jobs .call lights were on forever. One resident was dying that week and there was not enough staff to spend any time with them. Residents had eaten in their beds due to low staffing. Administrative staff knew there was inadequate numbers of staff and they did nothing about it. Anonymous Staff H stated they had requested additional help several times. They had asked for help from Staff D when a new resident was admitted to the facility and Staff D had never been out helping. Additionally, ASH stated they rarely got a lunch break. Anonymous Staff J (ASJ) On 04/30/2024 at 4:08 AM, ASJ, stated during a telephone interview that on the evening shift of 04/29/2024 (a Monday) they had approached administrative staff and informed them they would not accept the medication cart until another NA was assigned to work (at that time there was only one LN and one NA). The daily assignment sheet had been out for staff to view all weekend. Anonymous Staff J stated Staff I knew about the staffing since 04/26/2024 but could not get to it. They stated they had worked an additional three hours the previous Sunday to get the work done. Anonymous Staff J stated Staff D stated they would help on the floor, but more often that not their office door was closed. Staff D would state they were too busy doing their own work. Call lights were not being answered timely and showers were not getting done. There were not enough staff with two NAs scheduled to work. Anonymous Staff K (ASK) On 05/01/2024 at 8:15 AM, ASK, stated most of last week there were only two NAs working and one LN. Some night shifts there was only one NA. Anonymous Staff K stated, pretty short handed this past month, There was not enough staff on the evening shift to do showers and frequently bed baths were given instead. Call lights could be on for an hour. Staff D was asked on one occasion to help on the floor but they stated they were on their lunch break and slammed the door. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/26/2024 at 9:15 AM, Staff I, stated they had previously identified issues with staffing and call lights especially on the evening shift. Staff I stated they were aware on 04/18/2024 they had no NA staff scheduled for the evening shift of 04/22/2024, as staff was on vacation and college students could not work due to final exams. They stated two NAs who had worked the dayshift on 04/22/2024 also worked the evening shift along with the Director of Nursing. Review of the Resident Council Minutes, dated 03/24/2024, showed residents had complained of long call light wait times over 20 minutes, not enough NAs and over working the NA staff. Review of the Resident Council Minutes, dated 04/10/2024, showed several residents complained about long call light wait times over 20 minutes. Review of facility records between 04/12/2024 to 04/26/2024 showed there was an average of 26.43 residents in the facility. Additionally, there were seven residents who required a mechanical lift for transfers using two staff and five residents who required two staff to assist with transfers. Review of the facility Admission/Discharge form for April 2024 showed there were seven residents admitted to the facility and five discharges. On 05/01/2024 at 3:30 PM Staff I verified there was a new admission that day and three additional admissions coming during the remainder of the week. Reference (WAC) 388-97-1080(1),1090(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on observation, interviews and record review the facility failed to serve meals that were at a safe temperature for 2 of 7 residents (Residents 1 and 2) reviewed for food temperatures. This failed practice placed residents at risk for decreased nutritional intake and food borne illness. Findings included . Review of the facility policy titled, Preventing Foodborne Illness - Food Handling, revised in July 2014, showed food temperatures would be monitored at designated intervals throughout the day and documented according to state-specific requirements. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included a serious illness that attacked the resident's nervous system, causing weakness and muscle paralysis. Review of the resident's comprehensive assessment, dated 03/09/2024, showed they had no cognitive deficits and required staff assistance with activities of daily living, including eating. On 04/26/2024 at 10:30 AM, Resident 1, stated that the food served to them in their room was cold and they had complained of cold food several times. On 04/26/2024 Resident 1's food tray was brought to their room at 12:50 PM by Staff A, Nursing Assistant. It was the last tray to be taken off the food cart (unheated) in the south hallway. The food cart had arrived to the hallway from the kitchen at 12:35 PM. The noon meal consisted of two fish fillets, mixed vegetables, and a lettuce salad. Staff A proceeded to assist Resident 1 with the meal. Upon questioning by the investigator Resident 1 stated the food items were cold. There was no attempt by Staff A to return the tray to the kitchen for reheating or offer an alternative menu. The investigator, with Resident 1's permission, took the plate of food to the kitchen and requested Staff B, Cook, to check the food temperatures. The temperature of the fish was 88 degrees Farenheit (F) and the mixed vegetables were 80 degrees F. Staff B stated the temperature of the fish had been 168 degrees F and the vegetables had been 158 degrees F at the steam table prior to serving. The plate of food was reheated in the microwave to appropriate temperatures and returned to Resident 1. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses which included respiratory disease. Review of Resident 2's comprehensive assessment, dated 03/05/2024, showed they had moderate cognitive deficits. On 04/26/2024 at 10:25 AM, Resident 2, stated their food was always cold. They ate in their room for all meals, and resided on the south hallway. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility food temperature monitoring forms between 04/01/2024 to 04/25/2024, showed they were documented on two different forms, Cooling Temperature Log (form designated for recording temperatures every two hours during the cooling cycle), and Food Substitution Log (form designated for recording substiuted food items). Despite food temperatures to be taken at every meal the first documented temperature was on 04/22/2024 and only certain food items had documented temperatures. The two forms utilized by staff were incomplete and there were no documented food temperatures between 04/01/2024 to 04/21/2024 taken by kitchen staff. On 05/01/2024 at 10:20 AM, Staff C, Food Service Manager, stated the facility had not been using the correct form regarding monitoring food temperatures since 03/01/2024, when the facility kitchen transitioned to the existing corporation. Reference (WAC) 388-97-1100(2)