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	05/24/2024

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review the facility failed to notify the resident's representative of changes in condition in a timely manner for 1 of 3 residents (Resident 1) reviewed for notification of changes. The failure to notify the representative placed the resident at risk of not having them involved in the health care decision making process for timely care and services. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] from the hospital with diagnoses which included right hip fracture with surgical repair and dementia. Review of Resident 1's comprehensive assessment, dated 04/24/2024, showed they were rarely/never understood and had short and long term memory issues. Review of Resident 1's plan of care, revised on 04/23/2024, showed they required extensive staff assistance with turning in bed, personal hygiene, dressing, transfers; and was totally dependent on staff for eating and toilet use. In addition, the plan of care showed Resident 1 was at risk for falls. On 05/24/2024 at 1:15 PM Staff B, Administrator, stated on 05/01/2024 they witnessed Resident 1 stand up from their wheelchair and got their left leg caught on the footrest, causing them to fall to the floor hitting their head. Staff B stated the resident's skin tear to the left lower leg truly happened at that time. On 05/30/2024 at 9:20 AM, Resident 1's representative stated they were notified by facility staff on 05/06/2024 (five days later) of the resident's fall and subsequent injury to their left lower leg. The representative stated they were concerned they were not being told by staff of the severity of the resident's injury. On 05/29/2024 at 8:30 AM Staff D, Registered Nurse (RN), stated they had not called Resident 1's representative following the resident's fall with injury on 05/01/2024. Staff D had assisted Resident 1 following the fall on 05/01/2024. On 05/29/2024 at 8:48 AM Staff C, RN, stated they had not called Resident 1's representative following the resident's fall with injury on 05/01/2024. Staff C was the charge nurse at the time of the fall. (continued on next page)

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

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	05/24/2024

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference (WAC)388-97-0320(1)(a)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review the facility failed to ensure an incident of neglect was reported to the State Survey Agency, as required, for 1 of 1 resident (Resident 1) reviewed for neglect. Failure to report a worsening wound on Resident 1's left lower leg due to a lack of timely staff assessments and delay in receiving medical treatment placed all residents at risk for continued neglect and poor quality of care. Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, undated, showed neglect was the failure of the facility to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Staff were to report the incident immediately any allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property to applicable state and other agencies, including State Survey Agencies. Review of the medical record showed Resident 1 was admitted to the facility on [DATE] from the hospital with diagnoses which included right hip fracture with surgical repair and dementia. Review of Resident 1's comprehensive assessment, dated 04/24/2024, showed they were rarely/never understood and had short and long term memory issues. Review of Resident 1's plan of care, revised on 04/23/2024, showed they required extensive staff assistance with turning in bed, personal hygiene, dressing, transfers; and was totally dependent on staff for eating and toilet use. In addition, the plan of care showed Resident 1 was at risk for falls. Progress Notes (PNs), dated 05/06/2024, showed Staff F, Director of Nursing, was first made aware on 05/06/2024 (five days later) that Resident 1 had a fall on 05/01/2024 after getting out of their wheelchair (w/c) hitting the outside of their left lower leg on the footrest of the w/c potentially causing a skin tear. Review of Progress Notes showed there was no documentation Resident 1 had fallen in the facility with injury prior to 05/06/2024 and no assessment of the skin tear to the left lower leg. The skin tear on 05/06/2024 measured 1. 0 by 0.5 by 0.2 inches with the deepest open area on the top, then proceeded to get shallower on the bottom of the skin tear. Progress Notes, dated 05/10/2024 at 5:57 PM, showed the left lower leg skin tear had increased redness, pain, swelling with slough (dead cells that accumulated in the wound which contributed to a delay in wound healing and prevented an accurate assessment) in 100% of the wound bed. The wound had increased in size to 2.0 by 1.0 by 0.5 inches. The on-call provider was notified and gave orders to culture the wound, antibiotic therapy every eight hours for five days, and begin treatment using Aquacel (wound dressing). Later at 6:23 PM on 05/10/2024 showed there was wound drainage. Progress Notes, dated 05/13/2024 at 10:37 AM, showed the culture obtained from the resident's wound showed a contagious, bacterial infection resistant to many antibiotics. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2024 at 2:44 PM, Staff A, Licensed Practical Nurse/Infection Control Preventionist, stated that despite staff being aware of the resident's fall on 05/01/2024 and subsequent injury there was no documentation/assessments in the resident's medical record until 05/06/2024. At that time Staff E, Nursing Assistant, brought Resident 1 to Staff A's office so the left lower leg wound could be assessed. Staff A stated when they first saw Resident 1's open wound on 05/06/2024 there was redness and swelling from the left outer ankle to the left outer knee. Despite the failure of staff to assess Resident 1's skin tear at the time of the fall on 05/01/2024 until 05/06/2024, and no prescribed treatment orders being obtained until 05/10/2024, review of the facility State Reporting Log showed no reporting of staff neglect as required. Refer to F684 for further information. Reference (WAC) 388-97-0640(6)(c)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review the facility failed to conduct a thorough investigation in a timely manner for 1 of 3 residents (Resident 1) reviewed for falls. Failure to conduct a thorough investigation to identify the root cause and all contributing factors related to Resident 1's fall placed residents at risk for ineffective care planning interventions to prevent further falls with injury. Findings included . Review of the facility policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, undated, showed staff was to review and investigate all allegations of abuse, neglect, exploitation, injuries of unknown source and misappropriation of resident property. Staff were to complete investigation summaries and final outcome summaries. Staff was to analyze the occurrences to determine what changes were needed to prevent further occurrences. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] from the hospital with diagnoses which included right hip fracture with surgical repair and dementia. Review of Resident 1's comprehensive assessment, dated 04/24/2024, showed they were rarely/never understood and had short and long term memory issues. Review of Resident 1's plan of care, revised on 04/23/2024, showed they required extensive staff assistance with turning in bed, personal hygiene, dressing, transfers; and was totally dependent on staff for eating and toilet use. In addition, the plan of care showed Resident 1 was at risk for falls. Progress Notes (PNs), dated 05/06/2024, showed Staff F, Director of Nursing, was first made aware on 05/06/2024 (five days later) that Resident 1 had a fall on 05/01/2024 after getting out of their wheelchair (w/c) hitting the outside of their left lower leg on the footrest of the w/c potentially causing a skin tear. Review of Progress Notes showed there was no documentation Resident 1 had fallen in the facility with injury prior to 05/06/2024. The skin tear on 05/06/2024 measured 1.0 by 0.5 by 0.2 inches with the deepest open area on the top, then proceeded to get shallower on the bottom of the skin tear. Review of the facility investigation report, dated 05/06/2024 at 3:58 PM (five days following the resident's fall), showed Resident 1 had gotten up from their wheelchair unassisted in the hallway near the kitchen door and was walking when they fell on the floor hitting their head. Resident 1 sustained a skin tear to their left lower leg measuring 1.0 by 0.5 by 0.2 inches. The resident hit their left lower leg on the footrest. They were given a new wheelchair and new footrests with no sharp edges. The resident was unable to state the reason why they fell due to severe cognitive impairments. Staff B, Administrator, stated at the exit conference on 05/24/2024 at 1:15 PM, that they had witnessed Resident 1's fall on 05/01/2024. Staff B stated Resident 1 sustained the skin tear injury to their outer, left, lower leg at the time of that fall when their leg got caught on the footrest of their wheelchair. The resident was wearing sweat pants at the time of the fall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite Resident 1 sustaining an injury following their fall on 05/01/2024 a facility investigation and preventative interventions were not initiated by staff until 05/06/2024. Refer to F684 for further information. Reference (WAC) 388-97-0640(6)(a)(b) This is a repeat deficiency from the Statement of Deficiencies dated 12/05/2023.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on observation, interviews and record review, the facility failed to perform a thorough and timely assessment of a lower leg injury at the time a fall occurred, and evaluate for changes in condition for 1 of 3 residents (Resident 1) reviewed for assessments. Resident 1 experienced harm when they developed a necrotic (death of cells or tissue), contagious (spreads from one person to another), wound infection which extended their stay in the facility, and a delay in treatment. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] from the hospital with diagnoses which included right hip fracture with surgical repair and dementia. Review of Resident 1's comprehensive assessment, dated 04/24/2024, showed they were rarely/never understood and had short and long term memory issues. Review of Resident 1's plan of care, revised on 04/23/2024, showed they required extensive staff assistance with turning in bed, personal hygiene, dressing, transfers; and was totally dependent on staff for eating and toilet use. In addition, the plan of care showed Resident 1 was at risk for falls. Nursing Progress Note (NPN), dated 05/06/2024, showed Staff F, Director of Nursing, was first made aware on 05/06/2024 (five days later) that Resident 1 had a fall on 05/01/2024 after getting out of their wheelchair (w/c) hitting the outside of their left lower leg on the footrest of the w/c potentially causing a skin tear. Review of PNs showed there was no documentation Resident 1 fell in the facility with injury prior to 05/06/2024. The skin tear on 05/06/2024 measured 1.0 by 0.5 by 0.2 inches with the deepest open area on the top, then proceeded to get shallower on the bottom of the skin tear. Review of a NPN, dated 05/10/2024 at 4:27 PM, showed the resident's representative was notified Resident 1 would be discharging back to their Adult Family Home (AFH) on 05/13/2024. An assessment of the wound that day (05/10/2024 at 5:57 PM) showed the left lower leg skin tear had increased redness, pain, swelling with slough (dead cells that accumulated in the wound which contributed to a delay in wound healing and prevented an accurate assessment) in 100% of the wound bed. The wound had increased in size to 2.0 by 1. 0 by 0.5 inches. The on-call provider was notified (four days after the NPN documenting the injury) and gave orders to culture the wound, antibiotic therapy every eight hours for five days, and begin treatment using Aquacel (wound dressing). Later at 6:23 PM on 05/10/2024 showed there was wound drainage. Review of a NPN, dated 05/13/2024 at 10:37 AM, showed staff called Resident 1's AFH stating the culture obtained from the resident's wound showed a contagious, bacterial infection resistant to many antibiotics. The decision was made for Resident 1 to continue residing in the facility until the infection resolved as they shared a room with their spouse at the AFH to avoid spreading the bacteria. Review of a NPN, dated 05/17/2024 at 5:38 PM, showed Resident 1's left leg wound appeared to be still active. The Provider was notified and orders received to start a new antibiotic for seven days. (continued on next page)

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	505246	A. Building B. Wing	05/24/2024

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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 0684 Level of Harm - Actual harm Residents Affected - Few	An observation of Resident 1's left lower leg wound on 05/20/2024 at 2:30 PM with Staff A, Licensed Practical Nurse/Infection Control Preventionist, showed the area surrounding the small open area was bright red in color. The open area had some depth and slough was observed in the wound. On 05/24/2024 at 1:15 PM, Staff B, Administrator, stated at the exit conference, they had witnessed Resident 1's fall on 05/01/2024 in which they hit their head on the floor. Staff B stated Resident 1's skin tear injury to their outer, left, lower leg truly happened at the time of the fall when their left leg got caught on the footrest of their w/c. The resident was wearing sweatpants at the time of the fall. On 05/21/2024 at 4:40 PM, Staff C, Registered Nurse (RN), stated they were not involved with Resident 1 at the time of their fall on 05/01/2024 as they were on the other side of the facility. Staff C stated Staff D, RN, informed them they had taken care of the fall incident so Staff C stated they assumed Staff D had documented the incident in the PNs on 05/01/2024 and initiated an investigation. On 05/22/2024 at 8:20 AM, Staff D, stated the fall on 05/01/2024 occurred between 5:30 PM to 6:00 PM. Staff D stated they were in their office at the time of the fall and immediately went to assess Resident 1. Vital signs were taken and the back of the resident's head was assessed for injuries. Staff C was not present at the time of Resident 1's fall. Staff D stated they did not take over the care of the resident, but rather waited for Staff C to come. On 05/20/2024 at 2:44 PM, Staff A, stated Staff B had witnessed Resident 1's fall on 05/01/2024. Staff A stated that despite staff being aware of the resident's fall on 05/01/2024 and subsequent injury there was no documentation in the resident's medical record until 05/06/2024. At that time Staff E, Nursing Assistant, brought Resident 1 to Staff A's office so the left lower leg wound could be assessed. Staff A stated when they first saw Resident 1's open wound on 05/06/2024 there was redness and swelling from the left outer ankle to the left outer knee. At the time of the exit conference with the facility on 05/24/2024 at 1:15 PM, Resident 1 was observed as a resident in the facility despite initial plans to be discharged on [DATE]. Reference (WAC) 388-97-1060(1) This is a repeat deficiency from the Statement of Deficiencies dated 08/19/2023.