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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Creeks Post Acute	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) remained free from abuse. This failure placed residents at risk for abuse and diminished quality of life.Findings included.Review of Resident 1's medical record showed that they had been admitted to the facility on [DATE], with diagnoses of diabetes (a chronic condition characterized by persistently high levels of sugar in the blood, often treated with a medication, called insulin, used to help the body absorb excess sugar), enterocolitis due to Clostridium Difficile (swelling of the large intestine caused by a bacteria, with symptoms including fever, abdominal cramps, weakness and diarrhea), malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) and adult failure to thrive (gradual decline in health and functional abilities in older adults, characterized by weight loss, decreased appetite and fatigue). The resident's medical record further showed that they had experienced a reoccurrence of the bacterial infection in their large intestine and had started another round of antibiotics to try and treat the infection on 09/21/2025 through 10/04/2025, and again on 10/27/2025 with an end date of 11/10/2025. Their medical record showed that they were cognitively intact. Review of Resident 1's care plan, dated 05/01/2025, showed the resident required staff assistance with hygiene after episodes of bowel incontinence, needed assistance with transfers and needed setup assistance to dress and perform personal hygiene (brush hair, brush teeth, wash face) related to their diagnosis of failure to thrive and weakness. During a phone interview with Resident 1's family member, Collateral Contact 1 (CC1), on 11/05/2025 at 8:42 AM, they stated that they had requested a care conference to occur on 11/03/2025 at 1:00 PM related to concerns for the care of Resident 1 they had identified over the prior weekend. During the care conference CC1 stated that the Director of Nursing, Staff B, had humiliated Resident 1, by making statements about their bowel incontinence, had told them they did not belong at the facility and had then called the resident a nasty little man before leaving the care conference. CC1 further stated that they had shared their concern for the language used by Staff B toward Resident 1 with Staff A, Administrator, immediately after the care conference on 11/03/2025 and that Staff A had not addressed the concern. During this conversation CC1 named the other people present in the room for the care conference. During a phone interview on 11/06/2025 at 9:04 AM, a state worker from another agency, Collateral Contact 2 (CC2), stated that they had been present for the care conference with Resident 1 on 11/03/2025 at 1:00 PM. They stated that Staff B had called Resident 1 a nasty little man, that [Resident 1] was nasty to the staff, so they are nasty to you. They further stated that Staff B did not attempt to address the stated concerns and just said that Resident 1 did not belong in the facility, that [they] would just sit in [their] poop. CC2 further stated that after Staff B left the room, they tried to reassure the family and the resident that their nursing home stay was appropriate. They further stated that they had never experienced a similar interaction and did not report the situation to the required State Agency as they were sure the facility would follow up on the situation. During an interview with Resident 1 on 11/06/2025 at 11:14 AM, with another family member present, Collateral Contact 3 (CC3), Resident 1 stated that they had been at the facility for about 11 months and that they had been fighting a bacterial infection in their bowels and were on their third round of antibiotics. They stated that they needed assistance to use the bathroom and get cleaned up afterwards as they were weak and that was the main reason they were at the facility. CC3 then stated that on 11/02/2025 that Resident 1 had been weak, shaky and cold and they had asked the nursing staff to check on them, when it took awhile for them to come check they had gone out to where the nurses were exchanging report and asked for one of them to come and check on Resident 1 and that the on coming nurse had yelled at me. CC3 then stated that Staff B had stepped out of their office, CC3 had asked them to have the nurses check on Resident 1 and Staff B had turned their back and walked away. CC3 further stated that the nurses had come and checked on Resident 1 but that they were concerned about this interaction and asked for a care conference the next day. Resident 1 then stated that during the care conference on 11/03/2025 that Staff B had told them that you don't belong here, you are capable of taking care of yourself. Resident 1 then stated that he was hard of hearing but that they thought Staff B had called them a dirty little man, before leaving the room. CC3 then stated that Staff B had called Resident 1 a nasty little man. Resident 1 said that they were upset about the situation and felt like Staff B did not want them at the facility and didn't like them. They further stated that they wanted to stay at the facility and just wanted Staff B to stay away from them. During a phone interview on 11/06/2025 at 1:17 PM, Staff C, Social Services Director, stated that

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were given their medications as ordered for 2 of 3 sampled residents (Resident's 2 and 3) reviewed for medication management. This failure placed residents at risk of exacerbations of their chronic health conditions, and unintended consequences when doses of their medications were omitted.Findings included . <Resident 2>The 09/11/2025 admission assessment documented Resident 2 had diagnoses which included osteomyelitis (a bone infection that spreads through the bloodstream) and sepsis (a life-threatening medical emergency that happens when your body's response to an infection triggers a chain reaction throughout your body, causing widespread inflammation and damage to organs). The resident was cognitively intact and able to make their needs known.The 09/06/2025 wound infection care plan documented Resident 2 would be free of an acute infection. Nursing staff were instructed to give medications as ordered.A 09/05/2025 hospital discharge order documented Resident 2 was supposed to have Vancomycin (an antibiotic used to treat infections) for six weeks and the treatment was to end on 10/13/2025.A review of the October 2025 Medication Administration Record (MAR) documented the following order: -Vancomycin 1000 grams, give 1 gram every 12 hours for osteomyelitis until 10/03/2025. The medication was discontinued after the 10/03/2025 doses were administered.On 11/10/2025 at 12:22 PM, the pharmacy the facility used was contacted. A pharmacist stated the original order for the Vancomycin was through 10/13/2025 and they had received an updated order on 09/14/2025 to give the Vancomycin until 10/03/2025.In an interview on 11/10/2025 at 1:03 PM, Staff D, Resident Care Manager, stated the original stop date for the Vancomycin was 10/13/2025. Staff D said the last order received to change the dose of the medication was on 09/14/2025 and they thought the Director of Nursing meant to put the stop date for 10/13/2025 on the order but instead put 10/03/2025.In an interview on 11/10/2025 at 2:18 PM, Staff F, Medical Director, stated she spoke to the physician who gave the order, and they made an error when they had typed the order. Staff F stated the Vancomycin should have been given through 10/13/2025.<Resident 3>The 11/03/2025 care plan documented Resident 3 had diagnoses including diabetes, high blood pressure and an amputation. The resident was cognitively intact and able to make their needs known.A review of the November 2025 MAR documented the following orders:-Doxycycline (antibiotic) 100 milligrams was ordered twice daily on 11/02/2025 for an infection times seven days. The medication was to be discontinued after the 11/05/2025 doses.-Doxycycline 100 milligrams was ordered twice daily on 11/05/2025 to continue indefinitely. The MAR was blank on the evening of 11/05/2025.In an interview on 11/10/2025 at 2:43 PM, Staff D stated Resident 3 should have received their Doxycycline and it was a medication error that they did not. Staff D stated it was important for the residents to receive their full doses of antibiotics, so they were effective.In an interview on 11/10/2025 at 2:50 PM, Staff E, Licensed Practical Nurse, stated they gave Resident 3 their antibiotic. Resident 3 stated after they administered medication to a resident, they would click that it was given in the MAR. Staff E pulled up the administration record for the Doxycycline on 11/05/2025 and it was red. Staff E stated that if it was red on the MAR it meant the medication was late and if it stayed red it was not administered.Reference: WAC 388-97-1060(3)(k)(iii)