

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER Three Creeks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and record review, the facility failed to provide an environment with a comfortable temperature during an extended power outage, for 33 of 33 residents admitted to the facility on [DATE]. This failure placed Residents at risk for discomfort and a decreased quality of life. Findings included . During an interview with Staff E, Maintenance Director, on 12/18/2025 at 10:40 AM, they stated that the facility had experienced a power outage during a winter storm with high winds on 12/17/2025 from 5:10 AM until 3:30 PM. They stated that during that time period the facility backup generator powered seven lights, three outlets and the facility fire suppression system. They stated that the generator did not cover heat in the building and that toward the end of the power outage the temperature in the building was between 62 to 65 degrees F (Fahrenheit). They stated they knew the temperature because they had measured it to determine the safety of the residents and had told the other staff in the building. During an observation of the facility backup generator system, on 12/18/2025 at 10:40 AM, the system was old and looked to be as old as the 1970's. The actual generator was faded blue metal with rounded corners and was less than two feet wide and two feet tall with old wiring and faded gold sticker indicating the unit was 6 HP (horsepower) on generator front exterior. A newer generator of similar size was observed to be next to the older generator, and per Staff E used gasoline for fuel, and was the back up to the backup. Further interview with Staff E, who had worked at the facility for more than three years as the maintenance director, showed that they were aware of the undersized and outdated generators and that they knew the administrator was also aware of the situation with the backup generators. During an interview on 12/18/2025 at 10:50 AM, Staff G, Registered Nurse, stated they had worked during the power outage on 12/17/2025 and that after lunch the building was cooling off and was down to an inside temperature of 65 degrees F at the nurses' station and about 62 degrees toward the end of the hallways along which the residents resided. They stated that it was noticeably cold and that they went around with the other staff and offered the residents extra blankets. During an interview on 12/18/2025 at 10:53 AM, Staff H, Nursing Assistant, stated that they had worked on 12/17/2025 during the power outage and that the backup generator did not provide heat to the building. They stated that towards the end of their shift it was cold in the building and that maintenance staff had measured the temperature at the main nurses' station and told them it was 65 degrees F. During an interview on 12/18/2025 at 10:55 AM, Staff I, Nursing Assistant, stated that they worked on 12/17/2025 during the power outage. They stated that the temperature in the building was cold and that they had gone around with the other facility staff and offered the residents extra blankets. They stated that all of the residents in the building that day were affected, as all areas of the building were at or below 65 degrees. They stated that maintenance staff were checking temperatures and made the other staff aware of the low temperatures so they could care for the residents. During an interview on 12/18/2025 at 11:45 AM, Staff A, Administrator In Training, stated that the building was purchased by the current corporation in June of 2025 and that since then a new generator had been on the facility wish list. During the interview, Staff A provided a receipt for two 3000W output/6000W battery generators, with a delivery date of December 24, 2025. Staff A stated that the two generators would cover all the requirements for the building, including heat, if another power outage occurred. Reference: WAC 388-97-0880 (3)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Preadmission Screening and Resident Reviews (PASRR, a two-part screening assessment; Level I was determined by the presence of a Severe Mental Illness [SMI] or Developmental Disability. If present, a Level II evaluation by a specialized evaluator would then occur where it would be determined if nursing home placement was the appropriate level of care, and if behavioral health or other community services were recommended for the given resident. A Level I, and if indicated, a Level II PASRR was required to be completed prior to nursing home admission) were completed correctly and PASSR Level II were referred for evaluation prior to admission as required for 1of 6 sample residents (Resident 1). This failure placed residents at risk of behavioral health needs not being met and diminished quality of life. Findings included . A record review showed Resident 1 was admitted to the facility on [DATE] and had diagnoses that included major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities, changes in sleep/appetite, fatigue and difficulty concentrating, significantly impacting daily life) and vascular dementia (a decline in memory thinking and judgement due to reduced blood flow to the brain). Further record review for Resident 1 found A PASRR Level I, dated 06/12/2025, that documented Resident 1 had a mental health diagnosis, did not have a diagnosis of dementia, and indicated the resident needed a Level II evaluation referral required for SMI. A PASRR Level II Initial Psychiatric Evaluation Summary, the detailed findings of the Level II evaluation, was not included in Resident 1's record. Further record review found a SLUMS examination (St. Louis University Mental Status - A set of questions used to assess adults for orientation, memory, attention and executive function), completed after Resident 1 admitted to the facility on [DATE], indicating the resident had severely impaired cognition. No behavioral health provider notes were found in Resident 1's record. During an interview on 12/16/2025 at 12:45 PM, Resident 1 was in their room finishing their lunch. They stated that they believed the year was 1974 and they had just been discharged from the military to the current facility. They further stated that they did take medication for depression daily. During an interview on 12/22/2025 at 1:20 PM, Staff J, Admissions Director, stated that Resident 1 had not been admitted to the facility through the standard process. They stated that the resident had transferred from a sister facility after the directors of the current facility and the former facility had discussed the transfer. They further stated that prior to a resident being admitted they, or social services, would review the resident record to see if a PASRR Level I had been completed and if a Level II was needed. They stated that if a Level II was needed it should occur prior to the resident having admitted to the facility. Staff J further stated that they did not review this resident's records prior to admission and were not aware that the resident had a need for a Level II to be completed, nor that the Level I was filled out incorrectly. During an interview on 12/22/2025 at 2:05 PM, Staff A, Administrator In Training, stated that they had accepted the transfer of Resident 1 from their sister facility. They further stated that they were not aware that prior to their admission to the facility, Resident 1 had a Level I PASRR which indicated they needed a PASRR Level II completed, and they had not reviewed the resident's PASRR prior to admission. Reference: WAC 388-97-1915(4)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review the facility failed to keep Potentially Hazardous Foods (PHFs) within safe temperature guidelines during an extended power outage during which the facility backup generator did not power kitchen appliances, PHFs that were above safe temperatures were not discarded and served above safe temperature PHFs (specifically milk) to residents during two subsequent meal services for 33 of 33 residents. These failures placed residents at risk of serious food borne illness and constituted immediate jeopardy (IJ).The facility failed to consistently monitor refrigerator and food temperatures during a power outage on 12/17/2025 from 5:10 AM until 3:30 PM, with kitchen staff identifying one refrigerator temperature above 45 degrees Fahrenheit (F) after lunch service on 12/17/2025 and then failed to discard PHFs and then served PHFs to residents during dinner service 12/17/2025, and again on 12/18/2025 for breakfast. The Department intervened to prevent service of PHFs to residents for lunch service on 12/18/2025. An IJ was identified on 12/18/2025. The facility was notified of the noncompliance on 12/18/2025 at 2:28 PM, regarding, F812, Food Storage, when the complaint investigator interviewed kitchen staff who reported elevated refrigerator temperatures during an extended power outage (greater than four hours) affecting refrigerators containing PHFs. The IJ was determined to begin on 12/17/2025. The immediate jeopardy was removed on 12/18/2025 at 4:30 PM, as confirmed by an onsite verification by the complaint investigator on 12/22/2025. The Facility removed the IJ by discarding affected PHFs, education to food service staff, implementing safety protocols for food temperature monitoring, and updating policies and procedures. Findings included. Review of the facility policy titled Food receiving and storage revised November 2022, documented PHFs, like milk, are to be stored at or below 41 F, further review showed no documentation for when and how to discard the PHFs, like milk, when out of acceptable storage temperatures. Review of Department of Health Food Safety guidelines, https://www.foodsafety.gov/food-safety-charts/food-safety-during-power-outage, showed that milk held at or above 40 degrees F for more than two hours should be discarded after a power outage. Review of Department of Health power outage guidance for food establishments, https://doh.wa.gov/emergencies/be-prepared-be-safe/power-outages/food-establishment-poweroutage, showed that upon power restoration, cold PHFs should have an internal temperature taken prior to use, with the zone of safety being at or below 45 degrees F as long as the foods were below 41 degrees F when the power went out. Further direction from the same source showed that during a power outage of more than four hours, cold PHFs that were found to be above 46 degrees F should be discarded. In an interview with Staff D, Cook, on 12/18/2025 at 11:20 AM, they stated that they were the primary cook on 12/17/2025 and started work at 5:00 AM that morning and were just beginning daily work when there was a power outage beginning at 5:10 AM during which time the backup generator did not power the kitchen appliances. They stated that they notified their boss, Staff C, Dietary Manager, about the power outage and were told to try and keep the appliance doors closed to keep food cold. They further stated that during breakfast and lunch the kitchen staff had to open the door for one refrigerator which contained milk and juices and that after lunch Staff D noticed the inside thermometer of the refrigerator with the milk and juice was above 45 degrees F. They stated that they then texted Staff C for directions. Document review showed a text sent from Staff D to Staff C on 12/17/2025 that stated the refrigerator temperature was 50 degrees F. They further stated that they ended their shift at 2:00 PM that day and did not take, document or notice any further temperature readings for the kitchen appliances. They further stated that no food was discarded from the refrigerator during or after the outage and that on 12/18/2025 for breakfast the milk that was in the refrigerator during the power outage was served to resident's and was still in the refrigerator during the interview. During an interview with Staff F, Dietary Aide, on 12/18/2025 at 11:35 AM, they stated that they and Staff D worked together on the day shift on 12/17/2025, starting at 5:00 AM. They stated that shortly after they started work there was a power outage. They stated that during the power outage they were told to keep the kitchen appliance doors closed as the backup generator did not power the refrigerators or freezer. They stated that they did not take any temperatures of foods inside the refrigerators or freezer during the power outage and was not sure if temperatures in the refrigerator and freezer stayed within acceptable limits. In an observation of the refrigerator identified by Staff D as being above acceptable temperature limits for PHFs, on 12/18/2025 at 11:22 AM, there was milk present with dates written on the containers showing prior to 12/16/2025. Record Review of the Refrigerator/Freezer Temperature Logs for December 2025 showed the refrigerator</p>		