

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 11/17/2024
NAME OF PROVIDER OR SUPPLIER Pullman Care		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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544</p> <p>Based on interview and record review, the facility failed to ensure there was a completed Physician's Order for Life-Sustaining Treatment [POLST] (a form which instructed medical staff what treatment the resident wished to have done in the event they are seriously ill, or their heart stopped beating for 1 of 2 sampled residents (Resident 6) reviewed for Advance Directives. This failure placed the resident at risk for not having their wishes and choices regarding end-of life care honored.</p> <p>Findings included .</p> <p><Resident 6></p> <p>The [DATE] admission assessment documented Resident 6 admitted to the facility on [DATE] and was cognitively intact to make decisions regarding their care.</p> <p>Review of the [DATE] care plan documented Resident 6 made their own health care decisions and a POLST was in their medical record.</p> <p>Review of Resident 6's medical record found no documentation of a completed POLST form or other documentation that showed education and/or conversation had occurred related to the resident's wishes for cardiopulmonary resuscitation (CPR) in the event their heart stopped beating, or other treatment they wished to have if they became seriously ill. In addition, review of the white facility POLST binder located at the nurse's station found the admission record form documented Resident 6 was a full code (would receive CPR), but no completed POLST form for the resident was in the binder.</p> <p>On [DATE] at 2:44 PM, Resident 6 was observed in their room lying in bed, watching television. When asked if anyone at the facility had discussed what their preference for CPR would be in the event their heart stopped, Resident 6 stated they had never filled out a POLST form, and nobody had discussed that with them since they had been at the facility.</p> <p>In an interview on [DATE] at 4:40 PM, Staff A, Administrator, stated the POLST usually came with resident's paperwork when they admitted to the facility, and it was followed until the facility discussed it with the resident and completed a new one. When informed Resident 6 did not have a completed POLST, Staff A stated they would follow-up and see if any notes had been made or if Medical Records had any other additional documentation.</p> <p>(continued on next page)</p>

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 5:05 PM, Staff B, Director of Nursing, stated they reviewed Resident 6's record and the facility POLST binder and confirmed a POLST had not been done and was being completed now.</p> <p>Reference (WAC): [DATE] (3)(c)(i-ii), 0300 (1)(b)(3)(a-c)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802</p> <p>Based on interview and record review, the facility failed to provide a Notification of Medicare Non-Coverage (NOMNC) two days prior to a planned discharge, as required, for 1 of 3 residents (Resident 136) reviewed for liability notices. This failure prevented the resident from exercising the right to appeal and dispute the termination of Medicare covered services.</p> <p>Findings included .</p> <p>According to their medical record, Resident 136 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Per the admission assessment, dated 10/28/2024, Resident 136 had diagnoses which included Myocardial Infarction (MI, a heart attack) and a recent Coronary Artery Bypass (open heart surgery.) Resident 136 was alert, oriented and able to make their needs known.</p> <p>A progress note, dated 10/28/2024 at 12:54 PM, documented the resident was going to be discharged on [DATE].</p> <p>In a further review of Resident 136's record, no NOMNC form was found.</p> <p>During an interview at 11/15/2024 at 4:40 PM, Staff B, Director of Nursing, verified that the required notice was not given for Resident 136, and it should have been.</p> <p>Reference: WAC 388-97-0300 (1)(e)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>37544</p> <p>Based on interview and record review, the facility failed to ensure a resident's medical record contained documentation of a hospital transfer and/or that the receiving hospital had received information of the resident's condition, for 1 of 2 sampled residents (Resident 31), reviewed for hospitalization . This failure placed the resident at risk for a delay in treatment and unmet care needs.</p> <p>Findings included .</p> <p><Resident 31></p> <p>The 11/04/2024 discharge assessment documented Resident 31 had cognitive impairment and had diagnoses which included malnutrition and a fractured left leg.</p> <p>Review of Resident 31's record showed a transfer form dated 11/04/2024 which documented the resident needed a proxy to make decisions and was being transferred to the hospital to be evaluated for unresponsiveness. Aside from the resident's diagnoses, date of birth, full name, reason for the transfer, and name of the hospital the resident was being sent to, the form was blank and did not include any other additional information, such as the resident's care needs, treatments, or status prior to being sent.</p> <p>A nursing progress note dated 11/04/2024 at 3:19 PM documented the hospital had been called to inquire about the resident's status, and had been told the resident was being admitted and would be placed on comfort care. Additional record review found no documentation that stated the resident was being transferred to the hospital or the reason/events that occurred that necessitated the transfer, or that information had been communicated to the receiving hospital.</p> <p>In an interview on 11/17/2024 at 10:35 AM, Staff C, Registered Nurse, stated when a resident was transferred to the hospital, a transfer form was filled out, the hospital was called to notify them of the resident's status, and a progress note was made in the resident's chart. After review of Resident 31's record, Staff C confirmed no progress note had been made and the transfer form had not been completely filled out.</p> <p>In an interview on 11/17/2024 at 10:55 AM, Staff B, Director of Nursing, confirmed the transfer process and documentation expectations as stated by Staff C. Staff B then reviewed Resident 31's record and confirmed the documentation had not been done and the transfer form was not thoroughly completed.</p> <p>Reference (WAC) 388-97-0120(2)(a)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>37544</p> <p>Based on interview and record review, the facility failed to provide a bed-hold notice, a notice that informed the resident of their right to pay the facility to hold their room/bed while they were hospitalized , to the resident and/or their representative at the time of discharge, or within 24 hours of transfer to the hospital, for 1 of 2 sampled residents (Resident 31), reviewed for hospitalization . This failure placed the resident at risk for a lack of knowledge regarding the right to a bed-hold while they were hospitalized .</p> <p>Findings included</p> <p><Resident 31></p> <p>The 11/04/2024 discharge assessment documented Resident 31 had cognitive impairment and had diagnoses which included malnutrition and a fractured left leg.</p> <p>Review of Resident 31's record showed a transfer form dated 11/04/2024 which documented the resident was being transferred to the hospital to be evaluated for unresponsiveness. Additional record review found no documentation that the resident and/or resident representative had been provided the required bed hold notice.</p> <p>In an interview on 11/17/2024 at 10:42 AM, Staff C, Registered Nurse, stated bed hold notices were done at the time of the resident being transferred to the hospital and if the resident was being transferred emergently, then the notice was done within 24 hours.</p> <p>In an interview on 11/17/2024 at 10:55 AM, Staff B, Director of Nursing, stated bed hold notices were included in the admission packet documentation, but a notice also needed to be completed at the time of transfer to the hospital or as soon as possible if the transfer was of an emergent nature. After review of Resident 31's record, Staff B confirmed a bed hold notice had not been done.</p> <p>Reference (WAC) 388-97-1020 (4)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>50027</p> <p>Based on observation, interview and record review, the facility failed to ensure that 1 of 2 sampled residents (Resident 5) had current and complete oxygen orders for respiratory care. This failure placed the resident at risk for respiratory complications and a diminished quality of life.</p> <p>Findings included .</p> <p><Resident 5></p> <p>Per the 08/08/2024 quarterly assessment, Resident 5 was moderately cognitively impaired, had chronic obstructive pulmonary disease (COPD: a progressive lung disease that blocks air flow and makes it difficult to breathe) and heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen).</p> <p>During an observation on 11/12/2024 at 3:03 PM, Resident 5 was sitting in their room with the oxygen concentrator (a device that converted room air to oxygen) placed next to their bed. The concentrator was on and administering oxygen at 3.5 litres (L) per minute, but the nasal cannula was draped over the top of the concentrator and was not being worn by the resident.</p> <p>During an observation on 11/14/2024 at 3:18 PM, Resident 5 was sitting in their room wearing their nasal cannula with the oxygen concentrator flowing at 2 L per minute.</p> <p>A review of Resident 5's medication administration records (MARS) from 07/01/2024 to 11/14/2024 found no documentation that the physician had ordered oxygen.</p> <p>A review of Resident 5's care plan, dated 04/24/2024, found no respiratory care plan had been implemented nor were there any interventions in place that informed nursing staff what the resident's care needs were related to the COPD.</p> <p>A review of the Physician-Nursing Communication Book from 07/18/2024 to 11/16/2024 found no documentation related to Resident 5's respiratory status/care needs.</p> <p>A review of the progress notes from 10/01/2024 through 11/16/2024 documented on 10/16/2024 at 9:41 AM, Resident 5 complained of being short of breath and oxygen was administered at 2 L per minute via nasal cannula.</p> <p>In an interview on 11/16/2024 at 11:44 AM, when asked if they used oxygen, Resident 5 stated they had difficulty with their breathing at times and used oxygen when that occurred.</p> <p>In an interview on 11/16/2024 at 3:34 PM, Staff D, Nursing Assistant, stated for at least a month, Resident 5 had expressed being short of breath at times, and when that happened, Resident 5 requested their oxygen saturation level to be checked and oxygen administered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/16/2024 at 4:07 PM, Staff C, Registered Nurse, stated that Resident 5 has required supplemental oxygen for approximately one month. Staff C confirmed that Resident 5 did not have physician orders related to oxygen prior to 11/15/2024.</p> <p>Reference (WAC): 388-97-1060(3)(j)(vi)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>50027</p> <p>Based on interview and record review, the facility failed to employ sufficient staff with the appropriate certifications necessary to carry out the functions of nutritional services for 30 residents. Specifically, the facility failed to ensure Staff E, Dietary Manager, had the required certification. This failure placed the residents at risk for unmet nutritional needs and a diminished quality of life.</p> <p>Findings included .</p> <p>A review of staff credentials showed that Staff E, Dietary Manager, did not have the required certification to serve as the dietary manager.</p> <p>In an interview on 11/14/2024 at 9:55 AM, Staff E confirmed that they had not finished completing the required training, and did not have the credentials for their role as a dietary manager.</p> <p>In an interview on 11/17/2024 at 12:20 PM, Staff A, Administrator, stated the facility did not have a full time Registered Dietician. When asked if Staff E had the certification required for a Dietary Manager, Staff A confirmed Staff E had not finished completing the training and did not have the certification.</p> <p>Reference (WAC): 388-97-1160(1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027</p> <p>Based on observation, interview, and record review the facility failed to store, discard and distribute food in accordance with professional standards for food safety for 1 of 1 facility kitchens reviewed. This failure placed residents at risk for food borne illness and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed that food must be labeled with the date the food was prepared, the package opened, and the date the food must be consumed or discarded as directed by the food manufacturer's use-by-date.</p> <p>During a kitchen observation on [DATE] at 10:31 AM, the produce refrigerator contained three extra-large bags of shredded iceberg lettuce that was brownish, wilted and soggy. The bags of lettuce were labeled with the used-by date of [DATE].</p> <p>In an observation of the dry storage room on [DATE] at 10:43 AM, a bag of opened crispy fried onions was undated and a 10-quart sealed container (less than 4 quarts full) of flour was labeled with an expiration date of [DATE].</p> <p>In an observation on [DATE] at 11:00 AM, a second refrigerator in the common area of the kitchen showed the following items were unlabeled and undated: large, sealed container of diced pineapples, a full pitcher of orange juice, and a half a bag of BBQ riblets. There was also a large box of prepackaged boiled eggs in the refrigerator that was labeled with an expiration date of [DATE].</p> <p>In an observation on [DATE] at 11:06 AM, the kitchen freezer contained a half of bag of unlabeled and undated sausage patties.</p> <p>In an observation and interview on [DATE] at 11:15 AM, the nourishment refrigerator contained three cups of milk that had mold on the lids labeled with an expiration date of [DATE] and an opened commercial pumpkin pie with no label or date. Staff E, Dietary Manager, acknowledged that the food and drink items should have been labeled, dated and discarded by the expiration date. Staff E stated that it was important to provide a label, date and to discard expired food items to make sure residents do not become ill.</p> <p>Reference (WAC) [DATE] (2)</p>		