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	03/03/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screenings and Resident Reviews (PASRR, a mental disorder and intellectual disabilities screening) were completed prior to admission as required for 3 of 9 sampled residents (Residents 26, 34 and 36) reviewed. Additionally, 1 of 9 sampled residents (Resident 30) reviewed were not referred for an evaluation after a 30-day hospital exemption (when the resident was expected to be at the facility less than 30 days) expired and the resident remained at the facility. These failures placed the residents at risk of not having their behavioral health needs met and possible decline in their mental health.Findings included.<Resident 26>A review of the record showed Resident 26 was admitted on [DATE] and had diagnoses that included depression and anxiety.A PASRR Level I screen (which screens for possible serious mental disorders or intellectual disabilities) dated [DATE], documented Resident 26 had indicators of serious mental illness. A Level II evaluation (an evaluation that is conducted by a state designated authority to determine if the resident meets nursing facility criteria and/or specialized behavioral health or rehabilitative services) was required and was not completed.<Resident 34>A review of the record showed Resident 34 was admitted on [DATE] and had diagnoses that included major depressive disorder.A PASRR Level I Screen dated [DATE] documented Resident 34 had indicators of serious mental illness. A Level II evaluation was required and was not completed.<Resident 36>A review of the record showed Resident 36 was admitted on [DATE] and had diagnoses that included depression and anxiety.Further review of the record showed a PASRR Level I screening was not completed until [DATE], after Resident 36 had been at the facility several weeks.<Resident 30>A review of the record showed Resident 30 was admitted on [DATE] and had a diagnosis of depression.A PASRR Level I screen dated [DATE] showed Resident 30 had indicators of serious mental illness. A Level II evaluation was not indicated. Resident 30 had a 30-day hospital exemption and was expected to be at the facility less than 30 days. Resident 30 remained a resident of the facility as of [DATE], but a new PASRR screening and Level II evaluation had not been completed.During an interview on [DATE] at 1:00 PM, Staff H, Social Services Director, stated they began their employment at the facility in July of 2025. Staff H stated they were not aware the PASRR screens and Level II evaluations were required to be completed before the residents were admitted . Staff H stated it would be important for any recommendations made by the evaluator to be added to a resident's plan of care, and it was important to provide behavioral health services to the residents.Reference: WAC 388-97-1915(1)(2)(a-c)

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

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	03/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safety risk preventative measures were assessed and implemented for 2 of 3 sampled residents (Residents 18 and 19), reviewed for smoking. In addition, the facility failed to monitor 1 of 1 sampled residents (Resident 4) reviewed for falls. This failure resulted in Resident 4 not being monitored for 72 hours after a multiple unwitnessed falls. These failures placed the residents at risk of fires, injury, health complications and a diminished quality of life.Findings included.<Smoking>The undated No smoking policy documented the facility was smoke-free. Smoking was not allowed at any time, inside or outside the building or on the property by residents, staff or visitors. Smoking supplies were to be kept in a locked container.<Resident 19>The 11/14/2025 Smoking Safety Evaluation documented Resident 19 used tobacco and the only concern checked on the form was balance problems while sitting or standing. The boxes that stated they were unable to light tobacco safely, unable to hold tobacco products safely, unable to extinguish tobacco safely and unable to use ashtray to extinguish tobacco were not checked. Resident 19 originally admitted to the facility on [DATE] and discharged on 12/05/2025. The resident readmitted to the facility on [DATE] and there was no updated Smoking Safety Evaluation completed.The 01/08/2026 comprehensive care plan did not address smoking.The 01/13/2026 admission assessment documented Resident 19 had diagnoses including substance abuse disorder and diabetes. Resident 19 was cognitively intact and made their needs known.In an observation and interview on 02/25/2026 at 10:50 AM, Resident 19 was lying in bed and there was a smoke odor in the room. Resident 19 stated they smoked and went off the premises to do so. Resident 19 stated it was a non-smoking facility so they put their cigarette out and then placed it in their pocket and threw it away in the garbage can.In an observation on 02/26/2026 at 9:21 AM, Resident 19 was lying asleep in bed and had a pack of cigarettes lying on their nightstand.In an observation on 02/28/2026 at 3:09 PM, Resident 19 went outside to smoke. Resident 19 put their cigarette on the wheel of their wheelchair and placed it in their pocket, wheeled themselves to their room and threw the unlit remains of the cigarette away in their garbage can. Resident 19 was observed smoking again on 03/01/2026 at 9:05 AM and the same process was followed.<Resident 18>The 02/11/2026 Smoking Safety Evaluation documented Resident 18 used tobacco and was safe to do so when wearing their glasses.The 02/12/2026 admission assessment documented Resident 18 had diagnoses including emphysema (a progressive lung disease that made it hard to breathe), anxiety and chronic pain.In an interview on 02/25/2026 at 1:57 PM, Resident 18 stated they had quit smoking today. Resident 18 stated when they smoked, they went off the property, put their cigarette out and threw it in the trash can by the front door of the facility or in their personal trashcan in their room. Resident 18 stated they put the cigarette butts in a bottle so they did not stink.In an observation on 02/28/2026 at 3:09 PM, Resident 18 went outside to smoke. It was unknown where Resident 18 discarded their cigarette because a staff member approached them outside and they hid the cigarette between their legs and quickly put it out.In an interview on 03/01/2026 at 1:00 PM, Resident 19 stated they put their cigarettes out on their wheelchair or on the ground and put them in their pocket. Resident 19 stated they pinched the end of their cigarette and made sure it was not hot. Resident 19 stated they knew the cigarette was out because it stayed in their pocket and it took them about five minutes to get back into the facility before they threw it away. Resident 19 stated it was just a cigarette butt (cigarette that has been put out) and that there was no tobacco left in the cigarette. Resident 18 was present in the room for the interview and stated an ashtray or container was not provided to dispose of their cigarettes.During an interview on 03/01/2026 at 2:11 PM, Staff P, Registered Nurse (RN), stated the residents who smoked had to go off the property and disposed of their cigarettes somewhere off the property. Staff P stated it was not appropriate for the residents to bring their (continued on next page)

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	03/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cigarettes back into the facility to throw them away because it was against their protocol.In an interview on 03/01/2026 at 2:16 PM, Staff A, Interim Administrator, stated residents who smoked signed a smoking agreement stating the facility was non-smoking. Staff A stated the residents were given a lock box to keep their smoking supplies in and they smoked off the property. Staff A acknowledged there was no receptacle for the residents to dispose of their cigarettes in and no smoking blanket to put out a fire. Staff A stated they were unaware of where the residents were disposing of their cigarettes and stated they should not have put their cigarettes in the garbage can in their rooms and this was important to prevent fires. In an interview on 03/01/2026 at 2:51 PM, Staff N, RN, stated the facility was non-smoking. Staff N stated Resident 19 should have been reassessed for their smoking ability upon their second admission to the facility as they may have had a decline. Staff N acknowledged there were no smoking care plans for the above residents and stated it was important to have a care plan to monitor for possible injury and health complications.<Falls>The 01/12/2026 fall care plan documented Resident 4 was at risk for falls related to poor balance, history of falls and impaired cognition. The fall care plan instructed nursing staff to monitor the resident for 72 hours post falls for pain, bruises, and changes in mental status.The 01/26/2026 annual assessment documented Resident 4 had diagnoses including dementia, anxiety and a stroke. Resident 4 had severe cognitive impairments, required moderate to substantial assistance with activities of daily living and had two or more falls. The facility incident log showed Resident 4 had unwitnessed falls on 08/29/2025, 09/14/2025, 09/26/2025, 12/06/2025, 01/09/2026, and 02/05/2026. An initial neurological assessment was completed after the falls. The neurological assessments sheets showed omissions on 08/29/2025, 09/14/2025, 09/26/2025, 12/06/2025, 01/09/2026 and 02/05/2026. A review of the medical record showed no documentation that Resident 4 had neurological monitoring after the unwitnessed falls occurred. In an interview on 03/02/2026 at 2:39 PM, Staff P, Registered Nurse, stated after an unwitnessed fall occurred, they completed neurological assessments for 72 hours. Staff P stated it was important to do neurological assessments to monitor for a head injury and decrease in level of consciousness.In an interview on 03/03/2026 at 9:22 AM, Staff B, Director of Nursing, stated neurological monitoring was completed after unwitnessed falls and it was important to assess the residents for cognitive changes and potential bleeding in the brain. Staff B acknowledged Resident 4 did not have neurological assessments completed as required. Reference: WAC 388-97-1060(3)(g)

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	03/03/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure medications were given as ordered for 3 of 11 sampled residents (Residents 4, 30, and 48) reviewed for medication administration. This failure resulted in Resident 4 not having their blood pressure medication held when indicated by ordered parameters, and Residents 4, 30, and 48 had doses of medications omitted when medications were unavailable. This failure placed the residents at risk of decline in their medical conditions and decreased quality of life.Findings included. <Resident 30> On 11/26/2025, an order was written for Resident 30 to be given aprimilast, a medication used to treat plaque psoriasis, twice daily. The 12/01/2025 comprehensive admission assessment documented Resident 30 had diagnoses that included paraplegia (paralysis of the lower body) and psoriasis (a rapid build-up of skin cells that caused thick itchy scaly patches on elbows, knees or the trunk). Resident 30 was cognitively intact and was dependent on staff for activities of daily living. The 12/04/2025 skin evaluation documented Resident 30 had two wounds on their right shoulder blade. The type of wound was not documented. The 12/26/2025 skin evaluation documented the resident had a wound on their right upper back that was related to psoriasis. The 01/10/2026 skin evaluation documented the right upper wound was present, and the entire body was flaky and dry. A review of the January 2026 Medication Administration Record (MAR) showed that beginning 01/07/2026 until 01/27/2026, the aprimilast was not administered and a code 6 was entered on the MAR. A key on the MAR identified code 6 to mean the medication was unavailable. On 01/27/2026, and the medication had resumed and Resident 30 began to receive it regularly again as ordered. On 03/02/2026 at 1:19 PM, Resident 30's wound care was observed with Staff D, Infection Prevention Registered Nurse, Staff M, Nursing Assistant (NAC), and Staff F, NAC. When Resident 30 was turned on their left side, they were very vocal regarding how bad their back itched. Their entire back was red and had patches of flaky dried skin throughout. The area was cleansed and towel-dried and small pieces of dead skin came off on the repositioning pads under the resident. Staff D used the towel to gently relieve the itching then applied a protective ointment. On the residents upper mid-back, an old dressing that was saturated with bloody drainage was removed. An irregular shaped wound approximately three finger widths in size began to ooze bloody drainage. Staff D stated the wound was caused by Resident 30's psoriasis and had vastly improved in the amount of bleeding and size. An area of bloody drainage similar in size to a grapefruit had saturated the repositioning pads. The wound required application of a powder to the wound bed to decrease the amount of bleeding. During an interview on 03/03/2026 at 2:44 PM, Staff D stated they were aware the resident had been unable to get aprimilast for a period of time. When medications were unavailable, they called the provider, but Staff D stated there should have been follow up on the medication sooner. Staff D stated it was important for Resident 30 to get the aprimilast because it helped treat their psoriasis. <Resident 4> The 01/26/2026 annual assessment documented Resident 4 had diagnoses that included high blood pressure, delusional disorder (false beliefs) and depression. Resident 4 had severe cognitive impairments and required supervision to maximal assistance with activities of daily living. (continued on next page)

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	03/03/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 had the following medication orders: -Amlodipine 10mg (milligram) one tablet daily for high blood pressure, hold for systolic blood pressure (SBP, the top number of the blood pressure that measured the maximum pressure in the arteries when the heart contracted and pumped blood) less than 120 -Carvedilol 25mg twice daily for high blood pressure, hold for SBP less than 120 and apical pulse (a pulse obtained by listening to the heartbeat with a stethoscope) less than 60 -Cetirizine 10mg one tablet daily for allergies -Buspirone 15mg twice daily for anxiety -Lactobacillus one capsule twice daily for supplement -Risperdal 1mg three times a day for delusional disorder -Sucralfate 1gm (gram) three times a day for stomach pain Review of the January 2026 and February 2026 MAR showed Resident 4 received the Amlodipine on 01/07/2026, 01/12/2026, 01/17/2026, 02/14/2026 and 02/15/2026 when the SBP was less than 120. Resident 4 received the Carvedilol on 01/06/2026, 01/07/2026, 01/12/2026, 01/14/2026, 01/17/2026, 01/22/2026, 01/23/2026, 01/25/2026, 01/29/2026, 02/04/2026, 02/06/2026, 02/12/2026, 02/13/2026, 02/14/2026 and 02/15/2026 when the SBP was less than 120. The MAR was blank for the Risperdal and Sucralfate on 01/25/2026 and 02/06/2026, Cetirizine on 02/06/2026, and Buspirone and Lactobacillus on the evening of 02/13/2026. <Resident 48> The 02/17/2026 admission assessment documented Resident 48 had diagnoses that included pain, benign prostatic hyperplasia (BPH, enlargement of the prostate that caused urinary frequency or urgency) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that made it difficult to breathe). The resident was cognitively intact, able to make their needs known and required continuous oxygen. Resident 48 had the following medication orders: -Diclofenac Sodium 2% topical gel apply to affected joints four times a day for pain -Gabapentin 800mg three times a day for nerve pain -Lidoderm patch apply to affected area topically in the morning for pain and remove the affected area topically one time a day, off for 12 hours -Tamsulosin 0.4mg twice daily for BPH -Oxygen 1-4 liters continuously for COPD Review of the February 2026 MAR showed Resident 48 had blanks for oxygen administration during (continued on next page)

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	03/03/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the evening shift on 02/17/2026 and 02/18/2026 and on 02/22/2026 for the day shift. The Lidoderm patch for 02/18/2026 had a code 9 which meant see progress notes. The progress notes stated there was no patch to remove. There was a code 9 for the Lidoderm patch on 02/22/2026 without a progress note. The Gabapentin and Tamsulosin had a code 6 on 02/22/2026 which meant the medication was not available. In an interview on 03/02/2026 at 2:39 PM, Staff P, Registered Nurse, stated when a medication was not available, they would check the electronic emergency medication dispensing machine, if the medication was not in there, they would call the pharmacy and order the medication, and it came on the next delivery. Staff P stated it was important to administer medications as ordered for the residents' health. In an interview on 03/02/2026 at 3:02 PM, Staff B, Director of Nursing, stated their expectation was for the residents to receive their medications as ordered. Staff B stated there were times when they were waiting for the medications to be delivered from pharmacy and nursing staff needed to write a progress note. Staff B stated to re-order medications the nurses went to the resident's MAR and clicked the medication, and it was sent directly to the pharmacy. Staff B stated the medications needed to be ordered timely, so they did not run out. Staff B stated they had a lot of medications available in the electronic emergency medication dispensing machine and were also able to order medications and have them satellited (sent the same day) from the pharmacy. Staff B stated it was important to give the residents their medications as ordered to treat their acute and chronic conditions. In an interview on 03/03/2026 at 9:22 AM, Staff B acknowledged the above medications were not given as ordered and should have been and stated the blood pressure medications should have been held per the parameters. Reference: WAC 388-97-1060(3)(k)(iii)

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	03/03/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to perform hand hygiene during the meal service for 2 of 2 staff (Staff S and T) and to maintain the cleanliness of 1 of 1 ice machines (ice machine). These failures placed residents at risk for foodborne illnesses.Findings included . <Hand Hygiene>In an observation on 02/28/2026 at 11:53 AM, Staff S, Cook, had a pair of gloves on, plated food and touched the biscuits once on the plate to keep them from falling off. At 11:55 AM Staff S, while wearing the same gloves, moved a cart that other staff had touched and continued to plate food. In an observation on 02/28/2026 at 11:58 AM, Staff S, wearing the same gloves, pushed two other carts and continued to plate food. At 12:10 PM, Staff S used the same gloved hands to open the microwave, cut up chicken strips and touched them with their gloved hands. At 12:14 PM, Staff S, wearing the same gloves touched the blender, placed a plate in the dirty dish area and then added gravy to the blender. At 12:15 AM, Staff S opened a drawer with the same gloved hands and continued plating food without changing their gloves or performing hand hygiene. At 12:17 PM, Staff S, while wearing the same gloves, placed more dishes in the dirty dish area, picked up a meal card and continued plating food. At 12:21 PM, Staff S, wearing the same gloves, moved a cart, opened drawers, and continued plating food without hand hygiene performed throughout the meal service. In an observation on 02/28/2026 at 12:33 PM, Staff T, Dietary Manager, removed their gloves and put a plate of chicken in the microwave without performing hand hygiene. Staff T then removed other chicken from the oven and checked the temperature. Staff T put on a pair of gloves, did not perform hand hygiene, opened the microwave and rechecked the temperature of the chicken. Staff T then closed the microwave, cleaned the thermometer off with a wipe and touched the counter with their gloved hands. At 12:40 PM, Staff T gave the plate to Staff S, wiped the thermometer again with the same gloved hands, touched the counter with gloved hands, then used the tongs to flip the pork in the pan. At 12:44 PM, Staff T continued to wear the same gloves, opened the microwave, heated pork, and touched the pork with their gloved hands while checking the temperature. At 12:49 PM, Staff T removed their gloves, did not perform hand hygiene, and used tongs to turn over the pork in the pan. <Sanitary Environment>In an observation of the kitchen on 02/28/2026 at 1:43 PM, the right side of the ice machine was pushed up against a metal stand where dishes were washed. The filter on that side was unable to be observed.In an interview on 02/28/2026 at 2:18 PM, Staff E, Maintenance Director, stated the ice machine was cleaned monthly and filters were changed every six months. Staff E lifted the top off the ice machine and the filter slats on the right side were covered in dust debris. They stated that dust debris may enter the ice machine and it was important to keep the filteer clean in order to keep the machine cool and for sanitation reasons. Reference: WAC 388-97-1100 (3), 2980

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	03/03/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to routinely maintain documentation of staff's COVID-19 (a highly contagious viral illness that caused fever, breathing difficulty and potential hospitalization) vaccination status, provide education regarding the risks versus (vs) benefits and offer the COVID-19 vaccine if desired to 4 of 6 sampled staff (Staff I, J, K, and L), reviewed for immunizations. In addition, the facility failed to develop and implement 1 of 1 policies (COVID-19 immunization policy) to educate and offer each staff the COVID-19 vaccine. This failure placed residents and staff at risk of exposure to and illness from COVID-19.Findings included .Review of the facility policy titled, COVID-19 Immunization revised January 2026 showed, each resident was offered the COVID-19 vaccine unless medically contraindicated. Education on the potential risks vs benefits was to be provided and documented in the resident's medical record. The resident was to sign a consent prior to receiving the vaccine, if desired. The policy included no documentation related to the staff COVID-19 vaccination process.According to The Centers for Disease Control and Prevention website, www.cdc.org, Recommended Adult Immunization Schedule 2026 for ages 19 years or older adults age [AGE]-64 years, or adults age [AGE] or older who were unvaccinated for COVID-19, were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of the COVID-19 vaccine unless contraindicated. Those previously vaccinated before the 2024-2025 were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of 2025-2026 COVID-19 vaccine unless contraindicated.<Staff I>In an interview on 03/03/2026 at 9:59 AM, Staff I, Registered Nurse, stated they were unable to recall if the facility offered them the COVID-19 vaccine for the 2025-2026 season.Staff I's COVID-19 vaccination documentation was requested from Staff B, Director of Nursing, on 03/03/2026 at 10:07 AM.Review of Staff I's COVID-19 records included a mobile phone screen shot that showed a timestamp of 10:47 AM that documented Staff I received the COVID-19 vaccine on 01/06/2021. The screen shot was signed and dated 03/03/2026, the same day Staff I's COVID-19 vaccination documentation was requested. Additional review showed a COVID-19 vaccine declination, dated 03/03/2026 containing no documentation Staff I was provided education on the potential risks vs benefits.During an interview on 03/03/2026 at 11:36 AM, Staff A, Interim Administrator, stated they were unsure of the facility process for tracking staff's COVID vaccination status or how education was provided regarding the seasonal COVID-19 vaccine. COVID-19 vaccination documentation for Staff J, K, and L was requested at that time.<Staff J>Review of Staff J's, Nursing Assistant, COVID-19 records showed no documentation of their COVID-19 vaccination status or that they were provided education on the potential risks vs benefits or offered the seasonal COVID-19 vaccination.<Staff K>Review of Staff K's, Registered Nurse, COVID-19 records showed no documentation of their COVID-19 vaccination status or that they were provided education on the potential risks vs benefits or offered the seasonal COVID-19 vaccination.<Staff L> Review of Staff L's, Nursing Assistant, COVID-19 records showed no documentation of their COVID-19 vaccination status or that they were provided education on the potential risks vs benefits or offered the seasonal COVID-19 vaccination.In an interview on 03/03/2026 at 2:00 PM, Staff D, Infection Preventionist, stated they assumed the role in January 2026 and were still developing a process to track, educate, and offer the COVID-19 vaccine to staff. Staff D further stated the facility was able to obtain the COVID-19 vaccine. Staff D acknowledged they offered Staff I the COVID-19 vaccine today, but they declined.In an interview on 03/03/2026 at 2:27 PM, Staff A, Interim Administrator, stated they expected staff COVID-19 vaccine status to be tracked, staff provided education on potential risks vs benefits and offered the seasonal COVID-19 vaccine.The facility policy related to staff COVID-19 vaccines was requested from Staff A and Staff C, Facility Manager, on 03/03/2026 at 2:52 PM, no documentation was provided. Reference WAC 388-97-1620 (2)(b)(i)(ii)

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	03/03/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to maintain a safe and sanitary environment for staff and residents. 1 of 1 Laundry Rooms (Laundry Room) had significantly large holes from water damage and a majority of the cement floor contained large cracks, chips and had large sections missing. This failure placed staff at risk for potentially avoidable accidents and residents at risk of receiving unsanitary laundry services.Findings included.<Laundry Room>During observation and interview on 03/02/2026 at 12:03 PM, the laundry room was observed with Staff E, Maintenance Director. The designated area in the laundry room where the soiled linens and clothing were placed before being washed, showed a section of the drywall that had a large hole at knee level that was approximately 3 feet long by 2 inch wide. Staff E explained the drywall damage was caused by a water leak that occurred at the beginning of this winter and they had not gotten around to fixing the damaged area. The laundry room cement floor was observed to be significantly damaged, and a majority of the cement had large cracks, chips, and large chunks were missing. The damage to the cement floor created an uneven walking surface and made it difficult for it to be thoroughly sanitized. Staff E explained the laundry room cement had been in disrepair for over a year.During observation and interview on 03/02/2026 at 2:02 PM, the laundry room's damaged cement floor was observed with Staff D, Infection Preventionist. Staff D acknowledged the damaged cement floor was not the best cleanable surface and should be repaired timely.During observation and interview on 03/03/2026 at 12:35 PM, the laundry room's damaged drywall and cement floor was observed with Staff A, Interim Administrator. Staff A acknowledged the area was not safe or sanitary.Reference WAC 388-97-3220 (1)

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	03/03/2026

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue notices of potential insurance non-coverage of services for 2 of 3 sampled residents (Residents 30 and 31) reviewed for beneficiary notices. This failure placed the residents at risk of not being informed of their insurance coverage changes and paying for services they no longer wanted. Findings included .<Resident 30>A review of the record showed that Medicare Part A Skilled Services for Resident 30 began on 11/26/2025. The last day of covered services was 01/14/2026. Further record review showed Resident 30 had remained at the facility but was not issued a notice in advance that informed them of any services that may no longer be covered once their insurance coverage ended as required. <Resident 31>A review of the record showed that Medicare Part A Skilled Services for Resident 31 began on 01/02/2026. The last day of covered services was 02/28/2026. Further record review showed Resident 31 remained at the facility but was not issued a notice in advance that informed them of any services that may no longer be covered once their insurance ended as required. When interviewed on 02/28/2026 at 3:00 PM, Staff C, Facility Manager, confirmed Residents 30 and 31 were not provided notice of their benefits when their insurance coverage changed. Staff C stated it was important that the residents received advanced notice of insurance changes so they could be informed of the potential costs associated with the change and make decisions based on that information. Reference: WAC 388-97-0300(1)(e)(5)(6)

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	03/03/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to provide a clean, comfortable, and homelike environment for 1 of 3 sampled residents (Resident 41), reviewed for environment. This failure placed residents at risk for possible illness from unclean equipment, a lack of dignity, and a decreased quality of life. Findings included .A 02/02/2026 annual assessment documented Resident 41 had diagnoses including heart failure, depression, and hemiplegia (paralysis on one side of the body). Resident 41 had moderate cognitive impairments, required partial to substantial assistance for activities of daily living and used a wheelchair for mobility.In an observation on 02/05/2026 at 10:27 AM, Resident 41 was lying in bed. Resident 41 had a right arm trough (device used to hold the resident's arm in place) on their wheelchair and had an ace wrap like material wrapped around the outer edges and on the brake extender (an addition to the wheelchair brake that made it easier for the resident to use) and a large piece of foam in the center. The ace wrap material was hanging off the edges, was unraveled and was not kept in a manner which allowed it to be cleaned. Similar observations of Resident 41's wheelchair were made on 02/26/2026 at 9:05 AM, 02/27/2026 at 9:47 AM, 02/28/2026 at 9:11 AM, and 03/01/2026 at 9:21 AM.In an interview on 03/02/2026 at 11:20 AM, Staff F, Nursing Assistant, stated they notified maintenance when a resident's equipment was in disrepair. Staff F stated it was important to keep resident equipment clean and in good condition for sanitary reasons. In an interview on 03/02/2026 at 11:28 AM, Staff G, Therapy Director, stated they were notified by staff when there was an issue with a resident's equipment. Staff G stated resident equipment needed to be in good repair and able to be kept clean for infection control. At 11:30 AM that same day, Staff G observed Resident 41's wheelchair and stated a reassessment needed to be completed as it was not a cleanable surface. Staff G stated it looked like the ace wrap like material was added to Resident 41's wheelchair and was not sure if the foam came with the wheelchair. Staff G stated they thought the resident's foam piece had a cover that was able to be cleaned. In an interview on 03/03/2026 at 1:47 PM, Staff A, Interim Administrator, stated their expectation was for resident equipment to be maintained in a sanitary manner and in good repair. Staff A stated it was important for infection control and to prevent hazards. Reference: WAC 388-97-0880

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	03/03/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to ensure residents or representatives were provided the opportunity to participate in care planning conferences for 1 of 1 sampled residents (Resident 4) reviewed for care planning. This failure placed the residents at risk for unmet needs and a diminished quality of life. Findings included . An undated facility policy titled Resident Participation - Assessment/Care Plans documented the facility invited residents and their representatives to participate in the development of the resident assessment and care planning conference. The policy instructed the Social Services Director (SSD) or designee to maintain records that showed their efforts to invite the residents and representatives to the care planning conference, including refusal of participation.The 01/26/2026 annual assessment documented Resident 4 had diagnoses including dementia, anxiety and a stroke. Resident 4 had severe cognitive impairments. In an interview on 02/26/2026 at 10:13 AM, Resident 4's guardian (a person appointed by the courts to make decisions for the residents unable to make their own decisions) stated they had never been invited to a care planning conference and had brought it to the facility's attention numerous times.Review of Resident 4's medical record showed the last care conference was held on 01/23/2025, over a year ago. The above findings were shared with Staff H, Social Services Director, on 03/03/2026 at 9:15 AM. Staff H stated care conferences were held quarterly, and Resident 4 did not have a care conference because their cognition was impaired and had no family involved in their care. Staff H stated Resident 4's guardian was not invited to the care conference and stated they should have had a care conference but did not. Staff H stated it was important to have care conferences to discuss possible changes and to have someone advocate for the residents. Staff H acknowledged the last care conference was held on 01/23/2025.In an interview on 03/03/2026 at 9:22 AM, Staff B, Director of Nursing, stated care conferences were important to assess and monitor changes in the residents, discuss any needs the residents may have and discharge plans. Staff B stated family and guardians needed to be invited to the care conferences to be aware of what was happening with the residents and acknowledged Resident 4 had not had a care conference. Reference: WAC 388-97-1020(2)(e)(f)(4)(b)(d)-(f)

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	03/03/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to seek podiatry services (a physician that specialized in care and treatment of the feet) and implement provider orders for a skin ointment for 1 of 3 sampled residents (Resident 36) reviewed for skin conditions. This failure placed the resident at risk for further skin breakdown and unintended health consequences.Findings included.Provider orders on admission, dated 01/29/2026, showed Resident 36 required dressings and wraps to open wounds on both lower legs from their ankles to their knees related to cellulitis and those treatments were completed. Staff were to monitor both lower legs for edema (increased swelling) and notify the provider if a change in the edema was noted. Additionally, there was an order for the resident to be seen by the Podiatrist as needed for mycotic/hypertrophied (thickened, discolored yellow/brown brittle nails caused by fungal infection) toenails. The Podiatrist order was discontinued on 02/06/2026. The 01/30/2026 care plan documented Resident 36 had actual impairments of their skin and was at risk for pressure injuries. Staff were instructed to avoid scratching the skin, keep the skin free from excess moisture, encourage good nutrition and hydration, use lotion on dry skin, check skin when assisting with cares, report abnormalities and document the location, size and treatment of skin injuries weekly.The 01/30/2026 admission Clinical Assessment documented Resident 36 had skin tears on both elbows, an open wound that measured 4.0x5.0x0.1 centimeters (cm) on the front of the left lower leg that looked like rug burn, and an open venous ulcer that measured 5.0x3.0x0.1cm, and cellulitis on the rear of the right lower leg. There was no description of the condition of the skin on the resident's feet.The 02/05/2026 admission assessment documented Resident 36 had diagnoses that included diabetes (high blood sugar) and cellulitis (common infection of the skin) of the left lower leg. Resident 36 was mildly cognitively impaired and required partial assistance from staff for bed mobility.Weekly skin evaluations completed on 02/06/2026, 02/16/2026 and 02/23/2026, documented Resident 36 had warm skin with good elasticity that was normal in color and condition and there were no skin concerns. There were no further measurements of the lower leg wounds identified on the admission assessment and no descriptions of the skin on the resident's feet.The 02/19/2026 physician admission History and Physical documented Resident 36 was pleasant, frail, and was concerned about their legs. The skin on both lower extremities below the knees was dry and irritated. The plan was to continue antibiotics for cellulitis, complete wound care, monitor for improvement, and apply A&D ointment (moisturizer containing lanolin and petrolatum that soothed chapped or cracked skin) for dry skin on the legs. Review of a provider order, dated 02/20/2026, showed staff were to apply two A&D ointment packets to both legs daily for routine dry skin care for four weeks.A review of the February 2026 and March 2026 Medication and Treatment Administration records (MAR/TAR) had no entries or documentation of A&D ointment applications to the resident's legs. A review of the Certified Nursing Assistant (NAC) skin monitor task forms from 01/29/2026 to 02/27/2026 showed three entries dated 01/29/2026, 02/14/2026 and 02/20/2026 that documented Resident 36's toenails needed clipped. All other entries documented the resident's toenails were clean. On 02/27/2026 at 11:32 AM, Resident 36 was observed lying in bed. The resident had a sheet over their abdomen and their lower legs and feet were uncovered and visible. The resident's heels were resting on the mattress. The calves and tops of the feet were edematous (tissue that is abnormally swollen with excess fluid) and discolored shades of pink. The calves had large scales of dry skin and small scabbed areas present. The resident's toenails were thick, yellow, and deformed. Some of the toes had scabbed areas at the cuticles or on the tops of the toes, and several nailbeds contained dried dark brown bloody appearing discoloration. The soles, and sides of the feet were covered in thick yellow calloused skin that was cracked and peeling and large pieces were on the bed sheet. Resident 36 stated they thought the Podiatrist was going to see them but had not visited when they were at the facility the day prior. Resident 36 stated staff were not doing any special treatments or applying any lotion to their legs and feet. On 03/01/2026 at (continued on next page)

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	03/03/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:57 AM, Resident 36 was observed lying in bed. They lifted the blanket off their legs. The lower legs and feet continued to be discolored and edematous. The lower legs had large scales of dead skin on them, and the feet had thick calloused cracked skin. The toenails were unchanged from the 02/27/2026 observation. Resident 36 inquired about a visit by the Podiatrist and stated regular lotion had been applied to their legs twice but not A&D ointment. During an interview and observation on 03/02/2026 at 12:24 PM, Staff M, NAC, stated a nursing assistant was able to apply lotion to a resident, but anything medicated was to be applied by the licensed nurse. The supply room was entered, and there were no containers or packets of A&D ointment present. Resident 36's room was entered, and their nightstand contained no A&D ointment, only an anti-fungal cream and a barrier cream. Staff M stated they had never applied any creams or ointments to Resident 36's legs. Resident 36's legs and feet were observed and were in the same condition as observed on 03/01/2026.On 03/03/2026 at 12:48 PM, Resident 36 was observed in bed eating their meal. They stated no one had observed their feet.During an interview on 03/03/2026 at 12:49 PM, Staff H, Social Services Director, stated they were responsible for making Podiatry appointments, but were not aware that Resident 36 requested a podiatrist appointment. Staff H stated the Podiatrist visited the facility quarterly and had just been to the facility but had only seen residents already established. They were unsure why the 02/06/2026 Podiatrist order for Resident 36 had been discontinued. During an interview on 03/03/2026 at 1:17 PM, Staff O, Licensed Practical Nurse, stated they were passing medications that day, and did not remember seeing an order for A&D ointment for Resident 36. The orders were reviewed and confirmed that the A&D ointment was not on the MAR/TAR. The A&D order was corrected at that time. Staff D, Infection Prevention Registered Nurse (RN), was present and stated they saw Resident 36's legs and feet when they first admitted and at that time the resident's legs required dressing changes and had been scabbed and crusty. Staff D stated the resident no longer needed those treatments. Staff O and Staff D stated it was important for Resident 36 to have their feet examined because they had a history of diabetes and were at risk of complications. Staff O added an order for Resident 36 to have diabetic foot checks weekly by a licensed nurse at that time.During an interview on 03/03/2026 at 2:17 PM, Staff N, Assistant Director of Nursing, RN, stated they expected staff to check each resident's skin daily when they provided cares. They stated that after Resident 36's leg dressings were done, other interventions for their feet got missed. They acknowledged that the order for A&D ointment had been missed.Reference: WAC-388-97-1060(1-3)

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	03/03/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement preventative measures to prevent avoidable pressure ulcer/pressure injuries (PU/PI) for 1 of 3 sampled residents (Resident 36) reviewed for PU/PI prevention. This failure caused Resident 36 to develop an avoidable deep tissue injury (DTPI, a pressure injury to deep layers of the skin that may resolve without opening or that may open to reveal a serious injury that involved muscle or even bone) on their left heel and created a risk for further skin compromise and decreased quality of life. Findings included.Findings included.The National Pressure Injury Advisory Panel Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide Fourth Edition. [NAME] Haesler (Ed.). 2026. [cited: 03/09/2026], available from: https://internationalguideline.com, defined a DTPI as a non-blanchable deep red, maroon or purple discoloration of intact or non-intact skin that resulted from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may be resolved without tissue loss. Recommendations for prevention included:-Develop and implement a risk-based prevention plan for individuals identified as being at risk of developing pressure injuries and to consider factors that decrease blood flow to the skin such as diabetes (high blood sugar) or peripheral arterial disease.-Evaluate the skin regularly and develop a structured skin care regimen.-Frequently reposition and elevate the heels of individuals at risk of pressure injuries so the heels are not in contact with support surfaces.<Resident 36>The 01/30/2026 admission Clinical Assessment documented Resident 36 had skin tears on both elbows, an open wound on their left lower extremity, and an open venous ulcer and cellulitis on the right lower extremity. There were no wounds documented regarding the resident's heels.The 01/30/2026 care plan documented Resident 36 had actual impairments on their skin and was at risk for pressure injuries. Staff were instructed to avoid scratching the skin, keep the skin free from excess moisture, encourage good nutrition and hydration, use lotion on dry skin, check skin when assisting with cares, report abnormalities and document the location, size, type of tissue, any drainage and treatment of skin injuries weekly. The resident required the assistance of one staff member to turn and reposition in bed every 2 hours and as necessary.There were no care-planned interventions developed regarding the use of assistive devices or positioning to offload pressure when Resident 36 was in bed.The 02/05/2026 admission assessment documented Resident 36 had diagnoses that included diabetes (high blood sugar) and cellulitis (common infection of the skin) of the left lower leg. Resident 36 was mildly cognitively impaired, required partial assistance from staff for bed mobility, and was at risk for pressure ulcers and used a pressure relieving mattress for their bed. Additionally, a Braden Scale Assessment (a tool used to assess one's risk for developing PU/PI) completed as part of the admission Clinical Assessment on 01/30/2026, documented Resident 36's risk for pressure ulcer development was moderate related to limited sensory perception, occasional moist skin, severely limited ability to walk and change body positions, and probable inadequate food intake.Weekly skin evaluations completed on 02/06/2026, 02/16/2026 and 02/23/2026, documented Resident 36 had warm skin with good elasticity that was normal in color and condition and there were no skin concerns. The area of the evaluations where one could document the location and description of any skin concerns were blank.On 02/27/2026 at 11:32 AM, Resident 36 was observed lying in bed on a pressure reducing mattress positioned on their back. The resident had a sheet over their abdomen and their lower legs and feet were uncovered and visible. The resident's heels were resting on the mattress. The calves and tops of the feet were edematous (tissue that is abnormally swollen with excess fluid) and discolored shades of pink. The calves had large scales of dry skin and small scabbed areas present. The resident's toenails were thick, yellow, and deformed. Some of the toes had scabbed areas at the cuticles or on the tops of the toes, and several nailbeds contained dried dark brown bloody appearing discoloration. The soles and sides of the feet were covered in thick (continued on next page)

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	03/03/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yellow calloused skin that was cracked and peeling and large pieces were on the bed sheet. Resident 36 stated staff were not doing any special treatments for their legs and feet. Additional observations of Resident 36 lying on their back with their heels resting on their mattress were made on 03/01/2026 at 11:57 AM, and 03/02/2026 at12:24 PM. On 03/03/2026 at 12:48 PM, Resident 36 was observed in bed eating their meal. Their heels were resting on their mattress. They stated no one had observed their feet. On 03/03/2026 at 1:40 PM, Resident 36's lower legs and feet were observed with Staff O, Licensed Practical Nurse. The legs and feet remained discolored with large dry skin scales and thick cracked skin. There remained small, scabbed areas on the toes and at the cuticles. Resident 36's feet were lifted off the mattress and were observed. The left heel had a purple discolored area similar in size to a quarter that did not blanch when pressed. The area was not open or draining. Staff O notified Staff N, Assistant Director of Nursing, Registered Nurse. Staff N cleaned the resident's left heel and assessed their heel. They determined the purple area was similar in size to a quarter and was a deep tissue pressure injury. The area was coated with skin prep, a substance that when dried provided a layer of protection to the skin. Staff O retrieved a foam pressure relieving boot (an assistive device that kept the heel suspended off the mattress) and placed it on Resident 36's left foot. The right heel was left resting on the mattress.During an interview on 03/03/2026 at 2:17 PM, Staff N stated they added orders for Resident 36 regarding the pressure injury. Staff N stated they expected staff to check each resident's skin daily when they provided cares. They stated interventions for the resident's heels had been missed. Reference: WAC 388-97-1060(3)(b)

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	03/03/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nutritional requirements and assessments were completed timely by the Registered Dietician for 2 of 4 sampled residents (Residents 22 and 30) reviewed for nutritional services. This failure placed the residents at risk of nutritional decline and unintended health consequences.Findings included .According to the website www.mayoclinic.org, referenced on 3/10/2026, Post Traumatic Stress Disorder (PTSD) was a mental health condition that could develop after witnessing or being part of an extremely stressful or terrifying event. Symptoms could include flashbacks (feelings that the traumatic event was occurring again), nightmares (repeated disturbing dreams), intrusive thoughts, severe anxiety, avoidance (not wanting to think or talk about a traumatic event), changes in mood or thinking and physical and emotional reactions. These symptoms last more than one month can cause major problems in social or work situations and affect how well a person gets along with others.Review of the undated facility policy titled, Trauma-Informed and Culturally Competent Care documented a resident's experiences were accounted for in the development of a plan to eliminate or mitigate triggers that may cause re-traumatization. The policy listed examples of potential trauma which included experiencing or witnessing physical abuse or domestic violence. The policy documented all residents would be screened for trauma to determine if additional referrals and services were needed. Review of medical record documented Resident 46 admitted to the facility on [DATE] with diagnoses including PTSD, depression and insomnia. Resident 46 was cognitively intact and able to make their needs known. In an observation and interview on 02/25/2026 at 11:02 AM, Resident 46 was lying in bed. Resident 46 stated they had PTSD related to a lifetime of torture, guns and sexual abuse. Resident 46 stated they told staff they could not speak to them in a fast manner because it caused them to have seizures. The resident stated loud noises triggered their seizures that were psychologically induced. Resident 46 stated staff came into their room without making a noise and they could not visualize them out of their right eye and they turned and saw a man standing in their room and it was terrifying. Resident 46 stated they tried to tell a therapist they could not speak fast to them and needed time to respond before being asked the next question.The 02/21/2026, Resident 46's baseline care plan showed the social service section was incomplete. The areas that showed social services provided mental health needs, behavioral concerns, social service goals and depression screening were blank. The 02/23/2026 social service trauma evaluation documented Resident 46 experienced physical and sexual assault, life threatening injury or illness, sudden or violent death, unexpected death by someone close to them, bullying and discrimination. Resident 46 experienced repeated disturbing thoughts, images, dreams, physical reactions, heart pounding, trouble breathing, avoidance of certain situations due to reminders of past events, loss of interest in activities they once enjoyed, felt distant or emotionally numb from other people, felt angry/had angry outbursts, had difficulty concentrating, and felt jumpy, watchful or was easily startled.The 02/26/2026 care plan addressed depression but did not address PTSD, triggers or interventions to prevent re-traumatization. Review of a social service progress note on 02/26/2026 at 10:57 AM, documented the trauma assessment was not completed due to Resident 46 having a migraine and once it was finished their care plan would be updated to include trauma care if needed. In an interview on 03/02/2026 at 12:35 PM, Resident 46 stated the facility had not asked them what their triggers were or what caused them fear or re-traumatization and interventions that helped until today. The resident stated their counselor had moved a year ago and they had been without counseling and their PTSD was extreme. Resident 46 stated they suffered multiple events over a span of 20 years.On 03/02/2026 at 12:41 PM, Staff F, Nursing Assistant, stated they knew what care to provide the residents by looking at their Kardex (part of the plan of care that is generated from information on the care plan) and if a resident had PTSD the information would be there. Staff F pulled up Resident 46's Kardex on the computer and (continued on next page)

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	03/03/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there was nothing specific regarding triggers or interventions. Staff F stated there was a sign on Resident 46's door to knock but was unsure why and knocked because of the sign.In an interview on 03/02/2026 at 1:06 PM, Staff P, Registered Nurse, stated they knew what care to provide the resident by looking at the care plan. Staff P stated baseline care plans and comprehensive care plans were formed based off the residents' diagnoses and orders. Staff P stated behaviors and mood were placed on the baseline care plan. Staff P stated it was important to include resident specific needs on the care plans to enable person-centered care. Staff P stated they knew if a resident had PTSD if it was in their care plan and followed the interventions when providing care. Staff P pulled up Resident 46's comprehensive care plan on the computer and stated PTSD was not on their care plan. Staff P stated it was important for PTSD to be on their care plan so they had guidelines on how to properly care for the residents and be aware of ways to handle their triggers and not trigger them. Staff P stated residents with PTSD were offered mental health services upon admission or when exhibiting behaviors.In an interview on 03/02/2026 at 2:16 PM, Staff H, Social Service Director, stated residents were interviewed for mood upon admission and then quarterly. Staff H stated they were working on trauma informed evaluations because they did not create a trauma plan unless there was something severe marked on the evaluation. Staff H stated they were now making a plan if there were any questions answered yes. Staff H stated the trauma evaluations were completed within three days of admission and trauma informed care was placed on the care plan within 24 hours of admission. Staff H stated resident specific triggers needed to be put on the care plan for nursing staff to follow, and it was important that triggers and interventions were put in their care plan to ensure the residents were not triggered and had a PTSD episode. Staff H stated if a resident experienced sexual abuse they would care plan for the resident not to have cares provided by the opposite sex. Staff H stated Resident 46 was startled by unexpected noises, people coming up behind them and their care plan was going to ensure that same sex staff provided cares. Staff H stated Resident 46 should have had interventions placed on their care plan sooner and that they should have completed their plan after Resident 46's migraine to finished the trauma evaluation. In an interview on 03/02/2026 at 2:26 PM, Staff B, Director of Nursing stated it was important to care plan PTSD to prevent the residents from being triggered and to monitor their symptoms. Staff B stated it was their expectation that care plans are completed in a timely manner for residents who have PTSD. Staff B stated they were currently working on this as they were not identifying residents with PTSD and offering them therapy.Reference: WAC 388-97-1620(2)(b)(i)(ii)

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	03/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to accurately reconcile all controlled medications in 2 of 2 medication carts (North and South Carts), reviewed for medication storage. In addition, the facility failed to discard expired medication in 1 of 1 medication rooms. This failure placed residents at risk for misappropriation of their controlled medications, placed the facility at increased risk for controlled substance drug diversion and residents receiving medications that may not be effective. Findings included.In an observation of the medication room on 03/01/2026 at 3:31 PM with Staff D, Infection Preventionist, there was a bottle of Lansoprazole (medication used to treat heartburn) in the refrigerator for Resident 49. The medication expired on 02/23/2026. A review of the medication administration records for February 2026 and March 2026 showed Resident 49 received their Lansoprazole. The medication room refrigerator only contained one bottle of Lansoprazole, and it was almost empty.In an interview on 03/01/2026 at 3:42 PM, Staff R, Licensed Practical Nurse, stated they gave Resident 49 the Lansoprazole that morning. Staff R stated expired medication needed to be discarded as the efficacy of the medication may be affected.In an interview on 03/01/2026 at 3:43 PM, Staff D stated they had checked the refrigerator and missed that medication because it was in the side of the door. In an observation on 03/01/2026 at 3:55 PM, the narcotic book on the North Cart showed a discharged resident's Hydrocodone (narcotic medication used to treat pain) was destroyed by Staff I, Registered Nurse, with no documentation a second staff member was present. Staff R stated two staff members were required to destroy narcotics. The South cart narcotic book was observed, and a discharged resident's Pregabalin (analgesic medication used to treat pain) was destroyed by Staff I without a second staff member present. In an interview on 03/02/2026 at 9:59 AM, Staff I stated two nurses had to sign the narcotic book verifying the number of narcotics destroyed. Staff I stated narcotics were destroyed by placing them in Drug Buster (a chemical mixture that broke down and destroyed medication). Staff I stated it was important for two nurses to destroy narcotics to prevent drug diversion. In an interview on 03/02/2026 at 10:02 AM, Staff B, Director of Nursing, stated it was important to discard expired medications as they may lose their effectiveness. Staff B added narcotics were destroyed using Drug Buster by two nurses and it was important to prevent drug diversion. Staff B acknowledged Staff I signed the narcotic sheets by themselves and stated their expectations were to have two nurses present. Reference: WAC 388-97-1300(1)(b)(ii)(c)(ii)-(iv), (a)(4)(e)

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	03/03/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nutritional requirements and assessments were completed timely by the Registered Dietician for 2 of 4 sampled residents (Residents 22 and 30) reviewed for nutritional services. This failure placed the residents at risk of nutritional decline, and unintended health consequences.Findings included .<Resident 22>The 10/28/2025 admission comprehensive assessment documented Resident 22 was admitted on [DATE] and had diagnoses that included obesity, diabetes with foot ulcers, and heart failure. The resident was cognitively intact, was dependent on staff for bed mobility and toileting, and had no pressure ulcers.A review of 10/10/2025 admission orders documented Resident 22 was to have a consistent carbohydrate diet with large protein portions. Staff were to follow the Registered Dietician (RD) recommendations for diet changes and supplements and to give the provider notice of the changes.Further review of the provider orders showed the resident was to take a multi-vitamin, Vitamins C & D as supplements, and required injections of long-acting insulin with additional short-acting insulin injections based on blood sugar readings. The 10/10/2025 Care Plan showed, Resident 22 had a diabetic foot ulcer of the heel, was dependent on staff for mobility, but refused to be repositioned except when toileted. The care plan was updated on 10/13/2025 to show Resident 22 was at nutritional risk related to excessive carbohydrate intake, food and nutrition knowledge deficit, undesirable food choices and obesity. Staff were to administer medications as ordered, reinforce the importance of maintaining the diet ordered, explain and document consequences of poor choices, and monitor the resident's weight weekly. The 11/07/2025 Provider History and Physical showed Resident 22 weighed 455 pounds (lbs) as of 10/30/2025 and had 90 lbs of fluid removed through medication while at the hospital. The plan was to continue weight loss measures, but noted Resident 22 was non-compliant with wound care, dietary measures and their blood sugar was poorly controlled. The initial Dietary Profile, a general recording of cultural or personal likes or dislikes of foods or dietary concerns, was completed on 12/26/2025, which was more than two months after Resident 22 was admitted . The profile documented Resident 22 had no concerns regarding the consistencies of their food and fried eggs were the only food the resident did not like. The 01/21/2026 provider progress note showed staff reported Resident 22 had a 25 lb weight gain since 10/2025, and the provider considered an increase in medication to rid the resident of extra fluid accumulation. The note documented the resident became combative and refused the medication increase.On 02/02/2026 a Registered Dietician Nutrition Assessment documented Resident 22 was reviewed in a Nutrition at Risk (NAR) meeting related to non-pressure related wounds. The form had no entries related to the following: medications, pertinent lab data, estimated caloric, protein, fluid needs, what percentage of meals the resident consumed, if the resident's nutritional needs were met with the current diet and intake, nutritional goals, interventions and the nutritional plan.There were no RD assessments or entries in Resident 22's record prior to 02/02/2026. On 02/26/2026 at 10:47 AM, Resident 22 was observed lying in a bariatric bed (a heavy-duty bed with a reinforced frame that supported higher weight capacity). Resident 22 stated they had spent large amounts of money on food since they had been at the facility because they did not like many of the meals. They stated they had not been seen by the RD. < Resident 30>The 12/01/2025 admission assessment documented Resident 30 was admitted on [DATE] and had diagnoses that included paraplegia (loss of function in the lower half of the body), obesity, and diabetes. Resident 30 was cognitively intact, was dependent on staff for activities of daily living, and had a history of pressure ulcers. The 11/27/2025 Care Plan documented Resident 30 had wounds on their back related to psoriasis and pressure, was at nutritional risk and at risk for dehydration related to obesity, diabetes and paraplegia. Staff were to monitor the resident's weight and notify the provider of significant gain or loss, explain the importance of maintaining the (continued on next page)

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	03/03/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed diet and adequate nutritional intake, and were to provide supplemental protein, vitamins and minerals as ordered to promote wound healing. A review of the 11/26/2025 admission orders showed Resident 30 was to receive a regular diet. Staff were to follow RD recommendations for diet changes and supplements and give the provider notice of the changes. The resident took oral medications to manage their diabetes and psoriasis, and a multi-vitamin and iron supplement. On 01/12/2026, an order was added for the resident to take Prosource (a concentrated protein supplement that aided wound healing) daily.The 12/01/2025 initial Interdisciplinary Team (IDT) meeting note documented only Resident 30 and the Social Services Director were in attendance. The Nutrition Summary sections of the document were left blank. The 12/02/2025 provider History & Physical documented the resident received wound care to the buttocks and sacrum area and the resident's blood sugar was well controlled. The plan for treatment did not mention the resident's nutrition status or make recommendations regarding the resident's obesity.The RD admission Assessment was completed on 01/12/2026, over 6 weeks after the resident was admitted . The assessment documented Resident 30 weighed 309 lbs, averaged 60% intake for most of their meals, and their needs were met with the current diet and intake. The RD recommended Prosource be added daily and the order was added.Review of the February 2026 Medication Administration Record showed that Resident 30 refused the Prosource and received only 4 doses for the month.During an interview on 03/03/2026 at 10:30 AM with Staff B, Director of Nursing, and Staff N, Assistant Director of Nursing, Staff N stated they completed the initial nutrition section in the admission comprehensive assessment. Staff N stated the initial assessment was required to be completed within 14 days of admission. Staff N stated new admissions were to be seen by the RD within the first 14 days. Staff B stated the RD and nursing department conducted NAR meetings each Monday but acknowledged progress notes for NAR were not a substitute for a comprehensive nutrition assessment when a resident was admitted .During an interview on 03/03/2026 at 11:33 AM, Staff U, RD, stated if there was something pressing, they saw a new admission right away; if not, the admission assessment was to be completed within 14 days and was reassessed quarterly, annually or if needed. Staff U stated residents with diabetes, obesity and wounds were complex, and they had missed completing the admission assessments for Residents 22 and 30. Staff U stated they were not aware Resident 30 had been refusing the Prosource and would have made a recommendation to change the Prosource to a different supplement. Staff U acknowledged they were responsible for calculating the caloric, protein and fluid needs for the residents. Reference: WAC 388-97-1160(1)