STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

BCD PULLMAN LLC
Regency Pullman
1285 SW Center St
Pullman, WA 99163

RE: Regency Pullman License # 2060

Dear Administrator:

This letter addresses Compliance Determination(s) 38838 (Completion Date 04/16/2024) and 33261 (Completion Date 02/01/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/16/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-4, WAC 388-78A-2450-2-b, WAC 388-78A-2462-2-b, WAC 388-78A-2474-4, WAC 388-78A-2510, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1, WAC 388-78A-2660-3, WAC 388-78A-2660-4, WAC 388-78A-2660-7

The Department staff who did the on-site verification:
Amy Wright, NCI Complain Investigator

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Regency Pullman
Provider Type: Assisted Living Facility
License/Cert.#: 2060
Compliance Determination #: 33261
Intake ID: 108137
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/01/2023 through 02/01/2024
Complainant Contact Date(s):

Allegation(s):
Staff provided forceful care.

Investigation Methods:

Sample:
Total residents: 63
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Business Office Manager
Administrative Assistant
Alleged Victim
Residents
Caregiver
Medication Aides

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident investigations
Abuse/Neglect/Misappropriation Policy
Staff training records
Staff background checks
Staff references
Staff credentials

Investigation Summary:
The facility failed to ensure the Alleged Victim was protected during the facility

investigation, and that staff providing direct care to the Alleged Victim and sampled residents met hiring and training requirements. The facility failed to report the alleged abuse to appropriate parties in a timely manner. Failed facility practice was cited under WAC 388-78A-2371 Investigations, WAC 388-78A-2450 Staff, WAC 388-78A-2462 Background checks-Who is required to have, WAC 388-78A-2474 Training and home care aide certification requirements, WAC 388-78A-2510 Specialized training for dementia, WAC 388-78A-2630 Reporting abuse and neglect, and WAC 388-78A-2660 Resident rights.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Regency Pullman
Provider Type: Assisted Living Facility
License/Cert.#: 2060
Compliance Determination #: 33261
Intake ID: 104906
Investigator: Amy Wright
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/01/2023 through 02/01/2024
Complainant Contact Date(s):

Allegation(s):
Resident did not get proper care.

Investigation Methods:

Sample:
Total residents: 63
Resident sample size: 3
Closed records sample size: 0

Observations:
Alleged Victim
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Business Office Manager
Administrative Assistant
Alleged Victim
Residents
Caregiver

Record Reviews:
Disclosure of Services
Characteristic roster
Staff roster
Resident face sheets
Resident care plans
Incident investigations
Abuse/Neglect/Misappropriation Policy
Staff training records
Staff background checks
Staff references
Staff credentials

Investigation Summary:
The facility failed to ensure that staff providing direct care to the Alleged Victim and sampled residents met hiring and training requirements. The facility failed to report

the alleged neglect to appropriate parties in a timely manner. Failed facility practice was cited under WAC 388-78A-2450 Staff, WAC 388-78A-2462 Background checks-Who is required to have, WAC 388-78A-2474 Training and home care aide certification requirements, WAC 388-78A-2510 Specialized training for dementia, and WAC 388-78A-2630 Reporting abuse and neglect.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2060	Compliance Determination # 33261
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/01/2023, 12/01/2023 and 12/01/2023 of:

Regency Pullman
1285 SW Center St
Pullman, WA 99163

This document references the following complaint number(s): 108137, 104906

The following sample was selected for review during the unannounced on-site visit: 3 of 63 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Amy Wright, NCI Complain Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

S.M
Residential Care Services

02/06/2024
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) 2/15/24 Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to protect residents during the course of an abuse investigation by allowing the alleged perpetrator ongoing access to residents for 1 of 1 resident (Resident 1) reviewed for investigations. This failure resulted in staff being instructed to physically restrain Resident 1 when they refused care and placed residents at risk for abuse.

Finding included...

The facility's "Abuse/Neglect/Misappropriation Policy," last revised on 08/2018, stated that the first priority is to protect the residents(s) from further harm and that the facility is to ensure the alleged perpetrator is kept away from the resident or other residents.

Review of staff statements included in a facility investigation, initiated on 11/28/2024, showed that on 11/22/2023, Staff A, Executive Director, restrained Resident 1 by holding their hands while providing Resident 1 care they had refused. In the investigation, the writer, Staff B, Regional Director of Clinical Operations, acknowledged there had been a delay in initiating the investigation for the alleged abuse which they stated was not reported until 11/26/2023, two days prior to Staff A being suspended, and four days after the initial abuse occurred.

In an interview on 12/01/2023, Staff L, Medication Aide, stated that Staff N, Medication Aide, informed them during a shift report on 12/23/2023 that Staff A had instructed staff to restrain Resident 1 during incontinence care. Staff L stated they didn't think they were supposed to restrain residents as they had a right to refuse care. Staff L stated that Staff N reported that the Resident 1 had been restrained twice that day.

In an interview on 12/01/2023 at 2:25 PM, Staff R, Business Office Manager, stated that the initial incident involving Resident 1 occurred on 11/22/2023. Staff R stated they became aware of the incident on 11/27/2023 though Staff A had continued to work until 11/28/2023.

In a statement provided on 12/01/2023 for a facility investigation, Staff A stated that on 11/22/2023, Resident 1 had refused care, so Staff A held onto Resident 1's hands while

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Staff D, Medication Aide, and Staff F, Caregiver, picked Resident 1 up and put them in their wheelchair. Staff A stated that they held Resident 1's hands again while staff put Resident 1 on the toilet. Staff A stated they returned to the facility on 11/23/2023 and assisted with providing care to Resident 1. The statement showed that Staff A returned to the facility again on 11/24/2023 and that Resident 1 frowned at them. The statement showed that Staff A returned to the facility on 11/26/2023 and 11/27/2023, visualizing Resident 1 both times. The statement showed that Staff A returned to the facility again on 11/28/2023, and was not suspended until 9:15 AM that day, 6 days after the first incident of alleged abuse occurred. The statement further showed that Staff K, Resident Care Coordinator, notified Staff A on the morning of 11/26/2023, that staff were concerned that Staff A had abused a resident.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) ~~3/10/24~~ 3/17/24 RR 3/7/24.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Ryan Zorne — Administrator (or Representative)

2/14/24 — Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff persons' work references were verified prior to being hired for 7 of 9 staff (Staff D, F, G, L, N, P, and Q) reviewed for hiring requirements. This failure placed residents at risk of inadequate care by staff with potentially undesirable work history.

Finding included...

Review of an undated facility employee roster showed the following:

-The facility hired Staff D, Medication Aide, on 08/25/2022.

-The facility hired Staff F, Caregiver, on 10/19/2022.

-The facility hired Staff G, Caregiver, on 09/28/2022.

-The facility hired Staff L, Medication Aide, on 05/31/2022.

-The facility hired Staff N, Medication Aide, on 06/07/2022.

-Staff P, Caregiver, was not listed on the roster. Their date of hire is unknown.

-The facility hired Staff Q, Medication Aide, on 11/23/2021.

On 12/04/2023, Staff O, Wellness Director, and Staff B, Regional Director of Clinical Operations, were requested to provide documentation of work references for Staff P. No documentation of work references for Staff P was provided.

Review of facility personnel records on 12/05/2023 showed no documentation of work references for Staff P.

On 01/17/2024, Staff O, Staff B, and Staff S, Executive Director, were requested to provide documentation of work references for Staff D, Staff F, Staff G, Staff L, Staff N, Staff P, and Staff Q. No documentation of work references was provided for these staff.

On 01/24/2024, Staff B was requested again to provide documentation of work references for Staff D, Staff F, Staff G, Staff L, Staff N, Staff P, and Staff Q. No documentation or work references was provided for these staff.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 3/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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Zoar Rose 2/14/24
Administrator (or Representative) Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff had completed national fingerprint background checks within the required timeframe for 7 of 8 staff (Staff A, F, L, N, Q, D, and G) reviewed for having unsupervised access to residents. This failure placed residents at increased risk of harm from staff with potentially disqualifying criminal history.

Findings included...

The facility's "Abuse/Neglect/Misappropriation Policy," last revised on 08/2018, stated that state specific guidelines will be followed related to criminal background checks.

Review of an undated facility employee roster showed the following:

-Staff A, Executive Director, was hired by the facility on 06/19/2023.

-Staff F, Caregiver, was hired by the facility on 10/19/2022.

-Staff L, Medication Aide, was hired by the facility on 05/31/2022.

-Staff N, Medication Aide, was hired by the facility on 06/07/2022.

-Staff Q, Medication Aide, was hired by the facility on 11/23/2021.

-Staff D, Medication Aide, was hired by the facility on 08/25/2022.

-Staff G, Caregiver, was hired by the facility on 09/28/2022.

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On 12/04/2023, Staff O, Wellness Director, and Staff B, Regional Director of Clinical Operations, were requested to provide documentation of background checks for Staff A. No documentation of a national fingerprint background check was provided for Staff A.

Review of facility records on 12/05/2023 showed no documentation of a national fingerprint background check for Staff A.

On 01/17/2024, Staff O, Staff B, and Staff S, Executive Director, were requested to provide documentation of national fingerprint backgrounds checks for Staff A, Staff F, Staff L, Staff N, Staff Q, Staff D, and Staff G. No documentation of national fingerprint background checks was provided for these staff.

On 01/24/2024, Staff B was requested again to provide documentation of national fingerprint background checks for Staff A, Staff F, Staff L, Staff N, Staff Q, Staff D, and Staff G. No documentation of national fingerprint background checks was provided for these staff.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 3/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Robert Rose — Administrator (or Representative)

2/14/24 — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff who provided direct resident care obtained their home care aide certification within the required timeframe for 7 of 7 staff (Staff A, F, L, N, Q, D, and G) reviewed for certification requirements. This failure placed residents at risk of receiving inadequate care from untrained staff.

Finding included...

Review of an undated facility employee roster showed the following:

-The date of hire for Staff A, Executive Director, was 06/19/2023.

-The date of hire for Staff F, Caregiver, was 10/19/2022.

-The date of hire for Staff L, Medication Aide, was 05/31/2022.

-The date of hire for Staff N, Medication Aide, was 06/07/2022.

-The date of hire for Staff Q, Medication Aide, was 11/23/2021.

-The date of hire for Staff D, Medication Aide, was 08/25/2022.

-The date of hire for Staff G, Caregiver, was 09/28/2022.

In an interview on 12/01/2023 at 2:25 PM, Staff T, Administrative Assistant, stated that Staff A worked the floor to cover shifts when needed.

On 12/04/2023, Staff O, Wellness Director, and Staff B, Regional Director of Clinical Operations, were requested to provide documentation of work credentials for Staff A. No documentation of home care aide certification was provided for Staff A.

On 01/17/2024, Staff O, Staff B, and Staff S, Executive Director, were requested to provide documentation of home care aide certification for Staff A, Staff F, Staff L, Staff N, Staff Q, Staff D, and Staff G. No documentation of home care aide certification was provided for these staff.

On 01/24/2024, Staff B was requested again to provide documentation of home care aide certification for Staff A, Staff F, Staff L, Staff N, Staff Q, Staff D, and Staff G. No documentation of home care aide certification was provided for these staff.

Review of the department's provider credential search on 01/30/2024 showed that Staff A, Staff F, Staff L, Staff N, Staff Q, Staff D, and Staff G held no home care aide certifications.

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Roxanne Rowe — Administrator (or Representative)

2/14/24 — Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff persons completed the required specialized training for dementia prior to caring for residents with dementia for 5 of 5 staff (Staff A, F, D, G, and P) reviewed for caregiver qualifications. This failure placed residents with dementia at increased risk of inadequate care by untrained staff.

Findings included...

Review of the facility's undated Disclosure of Services showed that the facility provided care to residents with dementia, a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement. The Disclosure of Services specified that facilities that choose to serve residents with dementia were required to provide their staff specialized training.

Review of the facility's undated characteristic roster showed there were 20 residents residing at the facility who had dementia, Alzheimer's, or other cognitive impairments. The characteristic roster showed there were residents with dementia living in both the memory care and the assisted living.

Review of an undated facility employee roster showed the following:

-Staff A was the facility's Executive Director.

-Staff F was a Caregiver at the facility.

-Staff D was a Medication Aide at the facility.

-Staff G was a Caregiver at the facility.

-Review of a facility investigation, dated 11/06/2023, showed that Staff P was a Caregiver at the facility who had been terminated.

Review of Resident 1's move in record, dated [redacted] 2017, showed they had a diagnosis of [redacted].

Review of Resident 2's move in record, dated [redacted] 2017, showed they had a diagnosis of [redacted].

In an interview on 12/01/2023 at 2:25 PM, Staff T, Administrative Assistant, stated that, when necessary, Staff A worked the floor to cover shifts.

In an interview on 12/01/2023 at 2:25 PM, Staff R, Business Office Manager, stated that Staff P had been working a lot of shifts and was being terminated for neglect of Resident 2.

In a statement provided on 12/01/2023 for a facility investigation, Staff A stated that on 11/22/2023, they assisted Staff D, Staff F, and Staff G in providing direct care to Resident 1. The statement showed that Staff A provided direct care to Resident 1 again on 11/23/2023.

On 01/17/2024, Staff O, Wellness Director, Staff B, Regional Director of Clinical Services, and Staff S, Executive Director, were requested to provide documentation of specialized training for dementia for Staff A, Staff F, Staff D, Staff G, and Staff P. No documentation of specialized training for dementia was provided.

On 01/24/2024, Staff B was requested again to provide documentation of specialized training for dementia for Staff A, Staff F, Staff D, Staff G and Staff P. No documentation of specialized training for dementia was provided.

Plan/Attestation Statement

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 3/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Robert Power 2/14/24

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff persons made immediate reports to the department's Complaint Resolution Unit hotline and law enforcement for suspected physical abuse of a resident for 2 of 2 residents (Resident 1 and Resident 2) reviewed for reporting. This failed reporting practice precluded the department from having immediate knowledge to conduct an investigation and placed facility residents at increased risk for ongoing abuse.

Findings included...

The facility's "Abuse/Neglect/Misappropriation Policy," last revised on 08/2018, stated that individual mandated reporters and the facility must immediately report to the Abuse Hotline when there is reasonable cause to believe an incident is abuse, neglect, or exploitation.

<Resident 1>

Review of staff statements included in a facility investigation, initiated on 11/28/2024, showed that on 11/22/2023, Staff C, Caregiver, Staff D, Medication Aide, Staff E, Caregiver, and Staff F, Caregiver, witnessed Staff A, Executive Director, restrain Resident 1 during the provision of care. The investigation showed that the department was not

notified until 11/28/2023, 6 days after the initial restraint of Resident 1 occurred. The facility provided no documentation to show that law enforcement was notified.

In a statement provided on 11/29/2023 for a facility investigation, Staff B, Regional Director of Clinical Operations, stated that on 11/28/2023, Staff A told them there was talk going around that facility staff felt Staff A should be reported to the state for holding onto Resident 1's hands during care.

In a statement provided on 11/29/2023 for a facility investigation, Staff F stated that how Staff A directed them to care for Resident 1 on 11/22/2023 had not "felt right".

In a statement provided on 12/01/2023 for a facility investigation, Staff K, Resident Care Coordinator, stated that Staff L, Caregiver, and Staff M, Caregiver, reported having concerns on 11/24/2023, related to Staff A restraining Resident 1.

In a statement provided on 12/01/2023 for a facility investigation, Staff N, Medication Aide, stated that Staff A told staff during a huddle on 11/23/2023 that they may have to hold onto residents' hands to provide care, and that Staff A acknowledged some staff may have been uncomfortable with that. The statement from Staff N also showed that upon telling Staff L, Medication Aide, about Staff A's instructions, Staff L expressed to Staff N that they had not been comfortable with the instructions given by Staff A.

In a statement provided on 12/01/2023 for a facility investigation, Staff L stated that on 11/25/2023, they told Staff N they did not think staff were allowed to restrain Resident 1 while doing incontinence care, and that Staff N agreed. Staff L stated they texted Staff O, Wellness Director, about their concerns related to Resident 1 being restrained on 11/26/2023 but got no response.

In a statement provided on 12/01/2023 for a facility investigation, Staff A stated that Staff K told them around 9:30 AM on 11/26/2023, that Staff L had expressed concern about how Staff A had held Resident 1 down, stating that it was reportable. Staff A stated that Staff K told them Staff N had also expressed concern about Staff A's treatment of Resident 1. Staff A stated that they told Staff O about the incident on 11/26/2023. Staff A stated that on 11/27/2023, at the morning stand-up meeting, they addressed Staff L's concerns about the care Staff A provided Resident 1, then instructed the managers that if staff were going to "complain", they were to direct their complaints to Staff A. The staff in attendance at the morning stand-up meeting were Staff R, Business Office Manager, Staff U, Dining Services Assistant Manager, Staff V, Lead Housekeeper, Staff O, Staff W, Life Enrichment Coordinator, and Staff X, title unknown.

Review of the department's reporting data base on 01/28/2024 showed that the facility made no reports of Resident 1's abuse until 11/28/2023, six days after the initial abuse occurred.

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<Resident 2>

Review of a facility investigation, dated 11/06/2023, showed that Resident 2 was allegedly neglected by Staff P, Caregiver, on 10/30/2023. The investigation showed that on that day, Staff E found Resident 2 sitting at the edge of their bed, with urine-soaked sweats on, no shirt, had a blanket over their shoulders and head, and was cold and shivering. The investigation showed that Staff O was notified of the alleged neglect on 10/30/2023. The department and law enforcement were not notified until 11/02/2023.

Review of the department's reporting data base on 01/28/2023 showed that the facility made no reports of Resident 2's alleged neglect until 11/02/2023, three days after the incident occurred.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 3/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Robert Rowe — Administrator (or Representative)

2/14/24 — Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(7) Not allow any staff person to abuse or neglect any resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that residents were protected from being physically restrained for 1 of 1 resident (Resident 1). This failure resulted in a violation of Resident 's1 right to refuse unwanted care by staff and placed residents who refused care by staff at risk of being restrained.

Findings included...

The facility's "Abuse/Neglect/Misappropriation Policy", last revised on 08/2018, stated that the definition of abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. The policy also stated that in instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. It further states that mental abuse is defined as a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult.

Review of a facility investigation, initiated on 11/28/2023, showed that Staff A, Executive Director, had been assisting four staff members with providing Resident 1 care, as the resident had been refusing care all shift. The investigation did not clearly state what the allegation was or when it occurred, though multiple witness statements included in the investigation clarified that Resident 1 had been restrained multiple times, beginning on 11/22/2023.

In a statement provided on 11/29/2023 for a facility investigation, Staff C, Caregiver, stated that on 11/22/2023, Resident 1 had been refusing care and that Staff C, Staff D, Medication Aide, Staff E, Caregiver, Staff F, Caregiver, and Staff A transferred Resident 1 into their wheelchair to take them to the bathroom against Resident 1's wishes. Staff C stated that during the provision of Resident 1's care, Staff F, Caregiver, kept Resident 1 from kicking staff, and Staff A, Executive Director, held Resident 1's hands. Staff C stated that after they were done providing care, the staff "put [Resident 1] back on the couch."

In a statement provided on 11/29/2023 for a facility investigation, Staff D stated that on 11/22/2023, Staff F called Staff A to let them know Resident 1 had been refusing care all day. Staff D stated that Resident 1 continued to refuse care even after Staff A talked to Resident 1. Staff D stated that Staff A called staff over and told them "We are going to do this," then instructed staff to place themselves under each of Resident 1's arms, and that one of them would hold Resident 1's hands. Staff D stated that Resident 1 told them no, said they didn't want to, and that the staff took Resident 1 to the bathroom anyway. Staff D stated that they apologized to Resident 1 for what they were doing.

In a statement provided on 11/29/2023 for a facility investigation, Staff E, Caregiver, stated that on 11/22/2023 around 2:10 PM, they, Staff C, Staff F, Staff A, and Staff J, Caregiver, changed Resident 1. Staff E stated that it had been the first time they had been instructed to change a resident when they refused. Staff E further stated that Staff A had instructed staff to provide care even if a resident refused.

In a statement provided on 11/29/2023 for a facility investigation, Staff F stated that Resident 1 had refused care, so staff called Staff A for help. Staff F stated that Staff A told Resident 1 they would either allow staff to change them or they would call 911 and fire fighters would come and change them. Staff F stated that Resident 1 continued to refuse, so Staff A told Staff F and Staff D they were going to change Resident 1 as it was Staff A's job to make sure Resident 1 got the care they needed. Staff F stated that Resident 1 told staff they were afraid they were going to fall, and that they were having pain. Staff F stated that Staff A had the staff provide care anyway.

In a statement provided on 11/29/2023 for a facility investigation, Staff H, Caregiver, stated that Resident 1 became shaky, almost cried, seemed nervous, said they were fearful of falling, and became embarrassed during toileting. Staff H stated they worked with Resident 1 on 11/25/2023, and that Resident 1 had refused care all shift. Staff H stated they recalled they were to change Resident 1 at least once a shift, so they, Staff D, and Staff I, Caregiver, put Resident 1 in their wheelchair while holding Resident 1's hands. Staff H stated that Resident 1 was scratching, hitting, and kicking at them, and they put Resident 1 on the toilet anyway.

In a statement provided on 12/01/2023 for a facility investigation, Staff N, Medication Aide, stated that on 11/23/2023, Staff A told staff during huddle that they could not leave residents wet, and that sometimes they may have to hold onto a resident's hands to get the cares done.

In a statement provided on 12/01/2023 for a facility investigation, Staff L, Medication Aide, stated that in shift report 11/25/2023, they were told by Staff N that Staff A said they were to restrain Resident 1 when providing incontinence care. Staff L stated that Staff N said staff had already held Resident 1's arms and legs down during incontinence care. Staff L stated that when Staff K, Resident Care Coordinator, came in and was asked about it, Staff K told staff that restraining residents was okay "when a resident gets to a certain point."

In a statement provided on 12/01/2023 for a facility investigation, Staff A stated that on 11/22/2023 around 9:30 PM, they came to the facility as staff had texted them because Resident 1 had been refusing care since earlier that morning. Staff A stated that when they approached Resident 1 about changing them, Resident 1 told Staff A to leave them alone and go away. Staff A stated they decided they would hold Resident 1's hands while Staff D and Staff F picked Resident 1 up from both sides and put them in their wheelchair. Staff A stated they then took Resident 1 to their bathroom and held Resident 1's hands again so the other staff could put Resident 1 on the toilet.

In an interview on 02/01/2024 at 1:03 PM, Staff N stated that on 11/23/2023, during shift report between day and evening shift, Staff A told staff they could not leave a resident unchanged and that if a resident refused care, staff were to hold onto their hands if that is what it took to get care done.

In an interview on 02/01/2024 at 1:38 PM, Staff L stated that when they came into work the night shift on 11/23/2023, the evening shift told them that Staff A had directed staff that if a resident refused care, staff were to hold onto their hands to ensure care was provided. Staff L further stated that Staff O told them holding onto a resident's hands was allowed if the resident was in memory care.

Statement of Deficiencies	License #: 2060	Compliance Determination # 33261
Plan of Correction	Regency Pullman	Completion Date
Page of 15	Licensee: BCD PULLMAN LLC	02/01/2024

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Regency Pullman is or will be in compliance with this law and / or regulation on (Date) 3/12/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Ryan Rowe — 2/14/24

Administrator (or Representative) — Date