

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Colfax of Cascadia, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 West Fairview Road Colfax, WA 99111	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242</p> <p>Based on interviews and record review, the facility failed to provide care that maintained a resident's dignity for 1 of 3 residents (Resident 1) reviewed for quality of care. This failure placed the resident at risk for psychological harm, worsening skin problems and a diminished quality of life.</p> <p>Findings included .</p> <p><Resident 1></p> <p>Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included stroke with left sided weakness. Review of Resident 1's comprehensive assessment, dated 09/18/2024, showed they had no cognitive impairments. Review of the resident's plan of care, dated 03/27/2024, showed the resident was at risk for skin problems due to fragile skin, history of pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin), incontinent of bowel and bladder, and dependent on staff for turning. Review of the resident's plan of care, dated 08/16/2024, showed the resident had potential/actual skin impairment due to a yeast infection (a fungal infection caused by an overgrowth of the yeast Candida with symptoms that included itching, rash, white discharge, and burning) to their perineal area.</p> <p>Review of physician's orders, dated 09/16/2024, showed a topical medication was ordered to be applied twice daily to treat the resident's yeast infection to their perineal area.</p> <p>Review of Progress Notes, dated 09/19/2024, showed Resident 1 was incontinent of bowel and bladder, required total assistance by staff with perineal care, maximum assistance by two staff for turning/repositioning in bed and transfers using a mechanical lift device.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility investigation report, showed Staff A, Social Services Director (SSD), had answered a telephone call from Resident 1's representative at 7:55 AM on 09/24/2024. The representative stated they had received a telephone call from Resident 1 that they had turned on their call light at 5:00 AM on 09/24/2024 to request assistance to be changed following a urinary incontinence episode. Resident 1 informed their representative that they were told by Staff B, Nursing Assistant (NA), they would get help from Staff C, female NA, as the resident requested female staff only. Staff B stated they would be back, but they never returned. The investigation report stated Staff C was unavailable to assist Resident 1 as they were providing care to another resident. Staff D, female Licensed Nurse for the night shift, reported they would have assisted Resident 1 but Staff B had not communicated to them they needed assistance. The investigation showed dayshift NA staff had changed Resident 1.</p> <p>Review of the facility computerized call light form, dated 09/24/2024, showed Resident 1 activated their call light at 5:06 AM and it remained on for one hour and 23 minutes. It was activated again at 7:24 AM and remained on for 39 minutes and 42 seconds.</p> <p>During an interview on 10/17/2024 at 10:15 AM with Resident 1, they stated they put their call light on at 5:00 AM to be changed as they were incontinent of urine. When no staff came they began yelling. Resident 1 stated they were in tears as they had a yeast infection and every time they urinated it would hurt. They stated a male NA came to their room and stated they would find the female NA to assist the resident. However, the male NA never returned to their room. Resident 1 called their representative when no staff came to assist them. The resident was angry about being left so long without being changed. The resident stated they were finally changed by the NAs on the dayshift.</p> <p>During an interview on 10/17/2024 at 10:42 AM with Resident 1's representative, they stated the resident had called them at 6:49 AM and 7:00 AM on 09/24/2024. The resident informed them their call light had been on for quite a while as they were wet with urine and needed to be changed. A male NA on the night shift had responded to their call light and informed the resident they would get assistance from the female NA but the male NA never returned. The female NA on the night shift never came to their room to assist them with being changed.</p> <p>During an interview on 10/17/2024 at 2:30 PM with Staff E, NA, they stated when they and another NA went to change Resident 1 at approximately 7:30 AM on 09/24/2024, they were completely soaked with urine, including blankets, sheets and pillowcase. Due to the amount of urine it had extended up the resident's back. Resident 1 had stated they were frustrated with the male NA that had answered their call light as they were going to get help, and they never returned. The resident was angry regarding the incident due to waiting so long for staff assistance.</p> <p>Reference (WAC) 388-97-0180(1)(2)(3)</p>		