STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505251	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax Health and Rehabilitation of Cascadia	1150 West Fairview Road Colfax, WA 99111

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(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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide wound care treatment and address refusal of care for 1 of 7 residents (Resident 4), failed to obtain wound supplies timely for 2 of 7 residents (Resident 5 and 6), and failed to enter orders for wound care for 2 of 7 residents (Resident 3 and 7) reviewed for non-pressure skin conditions. This failure placed residents at risk for worsening skin conditions.Findings included: <Resident 4> According to Resident 4's admission Minimum Data Set (MDS-a tool for implementing standardized assessment and for facilitating care management in nursing homes), dated 08/15/2025, they admitted to the facility on [DATE] with five ulcers (open wounds) on their lower legs, were at risk for development of further skin issues and had scheduled wound care. According to Resident 4's care plan, dated 08/14/2025, they had actual wounds to bilateral [NAME]'s (lower extremities) and left front thigh folds and rash. Interventions included to administer medications and treatments as ordered. Monitor /document for side effects and effectiveness. No care plan focus was found to address Resident 4's documented refusal to accept wound care. Further review found an additional care plan focus was found to be added on 12/24/2025, [Resident 4] has infection of the bilateral lower extremity wounds. Wound culture + (positive) for Staph (Staphylococcus-bacteria commonly found on the skin, most of the time does not cause harm but can sometimes causes infections) and Pseudomonas (a bacteria commonly found in the environment, particularly in water and soil). According to Resident 4's MAR's (medication administration record) for November and December 2025 and January 2026, the resident refused dressing changes or dressing changes were coded as not completed. November 2025 MAR:Apply [NAME] boot (a specialized, non-elastic, gauze bandage with medication impregnated into the gauze used for treating leg ulcers) to bilateral lower extremities with light compression. cleanse legs after removal with wound cleanser and pat dry. Apply Unna wrap (same as [NAME] boot), apply kerlex (brand of sterile woven gauze) and coban (a brand of light weight, self-adherent cohesive bandage that sticks to itself) or ace wrap (a compression bandage). Every day shift, every Monday, Wednesday, Friday. Dated 11/07/2025 through 12/02/2025.11/12/2025 marked as NN (other/progress note).an associated progress note, dated 11/12/2025 at 5:09 PM stated, Dressings change held today, unna wrap ordered today, dressing to be changed on Friday.no associated order or medical provider note was found with an order to hold the wound dressing. No indication was found that the medical provider was aware of the dressing not being completed. December 2025 MAR:12/01/2025 box is blank. This order ended on 12/02/2025.A new wound care order was entered and effective from 12/03/2025 through 12/15/2025 and was written as follows: xeroform (brand name of a medicated wound dressing) to [NAME] wound, followed by compression wrap and light Ace bandage over it. Every day shift every Monday, Wednesday, Friday.12/03/2025 box was blank, 12/08/2025 was marked as NN, 12/10/2025, 12/12/2025 and 12/15/2025 were all marked as MR (medication refused).no associated progress notes for 12/08/2025 was found. A new wound care order was entered on 12/21/2025 (6 days after last order ended) with an end (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date of 12/24/2025 and was written as follows: Cleanse wound cleanser and pat dry, alginate () to open areas, cover with abdominal pads () and cover with stockinet (). Twice weekly with one time being done a wound clinic. Every day shift, every Sunday.12/21/2025 box was marked as refused. A new wound care order was entered on 12/28/2025 and was effective through 01/12/2026 and was written as follows: Cleanse with wound cleanser and pat dry, absorptive silver to open areas, cover with kerlix and cover with stockinet. Twice weekly with one time being done at wound clinic. Every day shift, every Sunday. An antibiotic order was entered on 12/25/2025 to continue through 01/05/2026 for wound infection BLE (bilateral lower extremities). January 2026 MAR:-boxes to document wound care were marked as refused for 01/04/2026 - 01/11/2026. No other scheduled wound care for resident 4's lower extremities were found through 01/15/2026. The order for an antibiotic for the bilateral lower extremity infection shows a blank box on 01/04/2026. During an interview on 12/30/2025 at 12:20 PM with Resident 4, they stated that they were worried about the wounds on their legs, that the dressings were not being done regularly, and they thought their legs were starting to smell bad. During an interview with Staff B, Resident Care Manager, on 01/28/2026 at 10:56 AM, they stated that Resident 4 had been admitted with a lot of wounds and that there had been challenges finding a wound care provider to treat the wounds. They stated that they were now being seen at a local wound clinic and that they had an infection in the wounds in their legs. They stated that the resident would often refuse wound care and that there were no interventions in the resident's care plan for how to address refusals, nor was there a risk versus benefit discussion documented related to the possible consequences of refusing wound care. <Resident 5> According to hospital discharge orders, dated 11/06/2025, Resident 5 was discharged to the facility on [DATE] with an infection in their right anterior (front) lower leg that had required surgical debridement (medical procedure where dead or infected skin tissue is removed) leaving an open surgical wound that required treatment with a wound vac (Vacuum-Assisted Closure therapy -uses controlled suction to remove fluid, reduce swelling, and promote healing in open wounds) for the wound to heal. Orders on the discharge summary included details for the frequency the wound vac needed to be changed (Monday, Wednesday, Friday), gave the settings for the machine and indicated that the device would be discontinued by recommendation of the surgeon. According to Resident 5's care plan they admitted to the facility on [DATE], had cellulites (infection in the skin) of their right lower limb. A care plan intervention indicated the resident had an infection of the right lower extremity, but did not detail anything related to the wound vac order. The care plan also did not describe any interventions to address the Resident's refusal to accept wound care. According to Resident 5's December 2025 MAR they had an order started on 11/07/2025 for NPWT (negative pressure wound therapy - wound vac) dressing change three times a week and PRN (as needed). Clean wound bed with normal saline (a sterile solution of water and salt), apply skin prep (a liquid impregnated pad used to prepare intact skin for medical adhesive devices) to surrounding tissue. Apply adaptic or mepitel (non-adherent, mesh-structured wound dressing designed to protect wounds) to wound bed if fragile and indicated. Cut sponge to wound size and place in wound. Cover with transparent dressing. Every day shift Mon, Wed, Fri. Further review of the November 2025 MAR found entries for 11/7/2025, 11/10/2025, 11/12/2025, 11/14/2025 and 11/17/2025 all with code NN (other/progress note). Review of Resident 5's progress notes showed a progress note on 11/07/2025 at 5:09 PM, that stated, Resident is ordered to have wound vac in place. Resident did not arrive from hospital with wound vac in place. Therefore resident has a wet to dry dressing (packing saline-moistened gauze into the wound bed, allowing it to dry completely and then removing it to take away dead tissue) in place on right lower leg. Further review found a progress note for 11/10/2025 at 5:23 PM that stated, Resident is ordered to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have wound vac in place. Resident did not arrive from hospital with wound vac in place. Therefore resident has a wet to dry dressing in place on right lower leg. Further review found a progress note for 11/12/2025 at 5:41 PM that stated, Resident is ordered to have wound vac in place. Resident did not arrive from hospital with wound vac in place. Therefore resident has a wet to dry dressing in place on right lower leg. Further review found a progress note for 11/14/2025 at 6:24 PM that stated, Resident is ordered to have wound vac in place. Resident did not arrive from hospital with wound vac in place. Therefore resident has a wet to dry dressing in place on right lower leg. Further review found a progress note for 11/17/2025 at 11:52 PM that stated, Resident went to wound clinic today. Returned from clinic with new dressing clean, dry and intact. Review of Resident 5's December 2025 MAR shows the same order as the November MAR with a blank box on 12/01/2025 and 12/03/2025. Additionally 12/08/2025 and 12/29/2025 were marked as refused and 12/10/2025 was marked as held. Review of Resident 5's progress notes found a progress note on 12/05/2025 at 8:10 PM, Wound vac was not suctioning today. This LN (licensed nurse) found res wound vac canister full and wound vac dressing dripping with fluid. On 12/10/2025 at 11:38 a progress note indicated Has routine dressing changes with wound vac but using wet to dry as awaiting supplies. Review of Resident 5's January 2026 MAR through January 21,2026, showed the same order as the November and December MAR with a blank box on 01/05/2026. Additionally, 01/09/2026 was marked with NN and 01/19/2026 was marked as refused. During an interview with Staff B, Resident Care Manager, on 01/28/2026 at 10:56 AM, they stated that Resident 5 did not come from the hospital with a wound vac and it took a little while to get one. Then we were running out of supplies because the staff were not telling me when the supplies were running low and it would take about seven days to get a new supply delivered. <Resident 6> According to Resident 6's December 2025 MAR they admitted to the facility on [DATE] with diagnosis including laceration of their small intestine. The same MAR had an order, started on 08/08/2025 and stopped on 01/06/2026 that stated, Negative pressure wound therapy (wound vac) to abdominal wound: black foam to be placed in cavity. Run at 125 mmHg (millimeters of mercury-pressure setting for the machine) continuously. Every day shift Mon, Wed, Fri related to laceration of unspecified part of small intestine. On the same MAR the boxes indicating if treatment was completed for 12/01/2025, 12/10/2025, 12/17/2025 and 12/29/2025 were blank. 12/08/2025 was marked as NA, and 12/24/2025 and 12/31/2025 were marked as refused. Review of the Resident's January 2026 MAR showed a blank box for 01/05/2026 and then the order was discontinued the next day. During an interview with Staff B, Resident Care Manager, on 01/28/2026 at 10:56 AM, they stated that Resident 6 did have a wound vac for a large open wound on their abdomen. They stated that we were running out of supplies because the staff were not telling me when the supplies were running low and it would take about seven days to get a new supply delivered. <Resident 3> According to hospital discharge orders, Resident 3 underwent a left below knee amputation (LBKA) related to an infection on 11/05/2025. No wound care orders were found on the hospital discharge document. According to a facility admit assessment, dated 11/11/2025, a comment was found on page 9, left bka with surgical wounds/sutures. Resident removed shortly after admission stating it was itchy. Some bleeding noted to incision site. Redressed with sterile gauze and ace wrap, educated resident on the importance of not removing dressing. Review of Resident 3's care plan, initiated 11/11/2025, found no focus or interventions for wound care for the resident's surgical wound related to their left BKA. Review of Resident 3's November 2025 MAR found an order for some wound care on 11/22/2025 (11 days after admission), without a specifically stated site to perform the wound care and without a specific strength for the solution to be applied. Documentation of the order being completed showed the entry NN for 11/22/2025, 11/23/2025, 11/28/2025, 1129/2025 and 11/30/2025. Review of progress notes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the period showed the order was not clear and needed to be clarified. It is unclear if wound care was performed during this period or how it was performed. Review of Resident 3's December 2025 MAR shows that same order as the November MAR with boxes blank on 12/03/2025 and 12/05/2025 and the order discontinued on 12/05/2025. The next order for wound care for the same surgical site was found as entered 12/16/2025 (11 days after the last order was discontinued) to include details for the strength of the solution to be applied to the wound and direction for how to perform the dressing. During an interview with Staff B, Resident Care Manager, on 01/28/2026 at 10:56 AM, they stated that Resident 3 came from the hospital with unclear surgical wound care instructions. They further stated that wound care was performed by them the day Resident 3 admitted but that they did not know why there were no orders entered for wound care for the resident's LBKA surgical incision until 11 days after admission. <Resident 7> According to hospital discharge orders, Resident 7 experienced a fall at home with a fractured right hip that required surgical repair on 12/27/2025. The resident was then discharged to the facility on [DATE] without clear surgical wound care instructions. According to Resident 7's admission MDS, dated [DATE], the resident admitted to the facility on [DATE], had a surgical wound and required surgical wound care. Review of Resident 7's December 2025 MAR showed no surgical wound care or monitoring of the surgical wound site was ordered to occur. Review of Resident 7's January 2026 MAR showed no surgical wound care or monitoring of the surgical wound site was ordered to occur. Further review of the Resident's medical record showed they were discharged from the facility on 01/02/2026, with their family, and were admitted to another facility. During an interview with Staff B, Resident Care Manager, on 01/28/2026 at 10:56 AM, they stated that Resident 7 came from the hospital with unclear surgical wound care instructions and they were not sure if wound care was performed during their stay at the facility. Reference: WAC 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement measures to prevent skin breakdown for 1 of 7 residents (Resident 1), failed to address resident refusal of care and consistently provide wound care for worsening pressure ulcers for 1 of 7 residents (Resident 2), and failed to enter wound care orders timely and collect ordered wound cultures timely for 1 of 7 residents (Resident 3) reviewed for pressure ulcers. Failure to implement interventions timely resulted in the development of potentially avoidable pressure ulcers, failure to address refusal of care and provide consistent wound care resulted in worsening pressure ulcers and failure to enter wound care orders timely and collect wound cultures, as ordered, resulted in delayed care of pressure ulcers. Findings included: The website nih.gov - in which nih refers to national institute of health- described the revised National Pressure Ulcer Advisory Panel pressure injury staging system and showed a pressure injury is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.-Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema (redness that does not disappear when pressure is applied to the area).-Stage 2 pressure injury: partial thickness (involving epidermis and/or dermis) loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.-Stage 3 pressure injury: full thickness (wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper) skin loss, in which adipose (fat) or granulation (new connective tissue) tissue is visible in the ulcer.-Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia (connective tissue), muscle, tendon (strong cords of tissue that connect muscle to bones), ligament (bands that connect bones and joints], cartilage (tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears), or bone in the ulcer.- Unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough (dead skin or tissue that can appear in a wound) or eschar (dead tissue that forms over healthy skin and eventually falls off). - Deep Tissue Pressure Injury (DTPI or DTI): intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation reveling a dark wound bed or blood filled blister <Resident 1>According to preadmission hospital notes, dated 11/30/2025, Resident 1 had a pressure injury to their right heel, without description of the size or depth of the injury.According to an admission skin assessment, dated 12/03/2025, inspection of the resident's feet revealed no issues.According to Resident 1's admission Minimum Data Set (MDS-a tool for implementing standardized assessment and for facilitating care management in nursing homes), dated 12/09/2025, showed the resident admitted to the facility on [DATE] with no pressure ulcers or injuries and no pressure ulcer or injury care, but were at risk for development of pressure ulcers.According to Resident 1's care plan, dated 12/03/2025, the resident had an actual unstageable to bilateral heels r/t (related to) decreased mobility and had on admission. Further direction dated 12/03/2025 states Assess/record/monitor wound healing ((FREQ (frequency)). Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements or declines to the MD (medical doctor). Further direction, dated 12/03/2025 stated offload heels when in bed (keep pressure off of heels by elevating them above surfaces).Review of Resident 1's December Medication Administration Record (MAR) showed blank boxes for skin assessments on 12/10/2025, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into the resident medical record as, Wound 12/20/2025 1109 pressure injury left plantar (bottom) heel assessment, with further description of the periwound (edge of the wound) with redness, base of the wound as blistered and ecchymotic (dark purple), with the injury being unstageable. The right heel was described as being identified on 11/30/2025, with an assessment completed on 12/20/2025 at 11:11 AM describing the area as having a red periwound, with the base of the wound being blistered and reddened, with the wound being unstageable and the length of the wound being 8.5 cm.During an Interview on 01/28/2026 at 10:56 AM, Staff B stated that they were told by a floor nurse on 12/19/2025 that Resident 1 had pressure injuries to their heels. They stated that they were then told by one of the resident's family members that the pressure areas had been there upon admit. They further stated that they did not know why skin checks had not been completed or why there had not been any documentation of the condition of Resident 1's heels during their stay. They stated that the resident's heels looked like they had blisters covering them on 12/19/2025, prior to leaving AMA with their family on 12/20/2025.During a phone interview with Staff A, Chief Nursing Officer, on 1/28/2026 at 12:45 PM, they stated that they had been told Resident 1 had pressure injuries to their bilateral heels on 12/19/2025 and that they then understood that the pressure areas had been there since admission. They could not say why the resident's heels did not have any evidence of monitoring having been performed or any wound care orders prior to 12/19/2025. They, further, could not explain why the resident had not had skin checks documented during their stay at the facility. <Resident 2>According to Resident 2's admission MDS, they were admitted to the facility on [DATE] with two, Stage 3 pressure ulcers and two unstageable -DTI pressure wounds. The MDS further indicated that pressure injury care was being performed.According to a skin assessment, dated 07/28/2025 the resident had four pressure injuries.Right scapula (shoulder blade) that measured 5.9 cm by 4.7 cm.Left scapula that measured 7.5 cm by 13.1 cm.Left gluteus (buttock) that measured 6.9 cm by 5.7 cm.Left lateral calf that measured 2.3 cm by 4.2 cm.According to a wound assessment, dated 01/21/2026 the resident had four pressure injuries.Right scapula that measured 6.0 cm by 17.0 cm.Left scapula that measured 9.0 cm by 19.0 cm.Left gluteus (buttock) that measured 13.0 cm by 6.0 cm.Left lateral calf that measured 21.0 cm by 9.0 cm.According to Resident 2's MAR's for November and December 2025 and January 2026, the resident refused dressing changes or dressing changes were coded as not completed.November 2025 MAR:Cleanse Left gluteus pressure ulcer with wound cleaner, NS, or soap and water. Pat dry. Apply Collagen pad. cover with bordered super absorbent foam/silicone dressing. Change daily and as needed every day shift -blank boxes on 11/4, 11/25, 11/27, with four refusals documented.Cleanse left lateral calf DTI with wound cleaner, NS, or soap and water. Pat dry. Apply Collagen pad. May use Xeroform with excess bleeding. Cover with bordered super absorbent dressing. Wrap with kerlix then ace wrap with light compression. Change daily and as needed everyday shift.-blank boxes on 11/4, 11/25, 11/27, with three refusals documented.Cleanse Left scapula pressure ulcer with wound cleaner, NS, or soap and water. Pat dry. Apply Collagen pad. Cut to fit. cover with bordered super absorbent foam/silicone dressing. Change daily and as needed every day shift -Start Date-blank boxes on 11/4, 11/25, 11/27, with four refusals documented.Cleanse right scapula pressure ulcer with wound cleaner, NS, or soap and water. Pat dry. Apply Collagen pad. cover with bordered super absorbent dressing. Change three times weekly and as needed every day shift every Mon, Wed, Fri.-Two refusals documented.December 2025 MAR:Left gluteus: four blank boxes and five refusals documented.Left lateral calf: four blank boxes and five refusals documented.Left scapula: four blank boxes and five refusals documented.Right scapula: one blank box and two refusals documented.January 2026 MAR:Left gluteus: two blank boxes and one refusal documented.Left lateral calf: two blank boxes and one refusal documented.Left scapula: two blank boxes 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
	505251	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax Health and Rehabilitation of Cascadia	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one refusal documented.Right scapula: one blank box documented.Review of Resident 2's care plan, initiated 07/09/2025, indicated the resident had actual pressure ulcers of their left scapula: stage 3, right scapula: stage 3, left gluteal: DTI, and left lateral calf: DTI. No interventions for how to address refusals of care were found.Review of the resident's medical record did not show any risk versus benefit discussions related to the possibility of the resident's pressure ulcers/injuries worsening related to their documented refusal of care.During an Interview on 01/28/2026 at 10:56 AM, Staff B, stated that Resident 2 would frequently refuse wound care. They further stated that they thought there had been a discussion with the resident related to their wounds possibly worsening if they continued to refuse care. They further stated that they did not monitor the Resident's MAR to determine if wound care was consistently being provided, they were not sure why there would be blank boxes and blank boxes indicated that wound care was not performed.During a phone interview with Staff A, on 1/28/2026 at 12:45 PM, they indicated that they were unable to locate any risk versus benefit discussions with Resident 2. They further stated that they thought the resident's pressure injuries were improving. Further they stated that the resident did not have care plan interventions to address wound care refusals and blank boxes on the MAR indicated that wound care was not performed. <Resident 3>According to an admission skin assessment, dated 11/11/2025, Resident 3, had a pressure injury to their left hip that measured 11.0 cm by 5.4 cm, with a depth of 0.1 cm.According to Resident 3's MDS, they were admitted to the facility on [DATE] and had one, Stage 3, pressure ulcer and were provided with pressure ulcer wound care.According to the Resident's November 2025 MAR, an order for wound care for the resident's left hip pressure wound, identified as being present on admission, was not entered until 11/19/2025 (eight days after admission). Further review of the Resident's December 2025 MAR showed an order for a left hip wound culture (a lab test that takes a sample of fluid or tissue from a wound to identify infectious microorganisms like bacteria or fungi) to be completed between December 4-7, with a signed box on 12/04/2025, indicating the resident was out of the facility, and all other boxes were blank. Another wound culture order was then entered on 12/09/2025 and was signed off as having occurred.According to Resident 3's wound culture result, dated as having been collected on 12/09/2025 (five days after the initial order), and resulted on 12/10/2025, showed the resident had mixed bacteria in their wound and antibiotics were then prescribed to treat the infection.During an Interview on 01/28/2026 at 10:56 AM, Staff B, stated that when Resident 3 was admitted to the facility there were not clear wound care instructions on the discharge orders from the hospital and orders were not entered until about a week later. They further stated that the original order for the left hip wound culture was not completed and had to be re-entered and therefore the results were delayed. Reference: WAC 388-97-1060(3)(b)