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	04/07/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	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 timely identify and address a decline in condition for 1 of 3 residents (Resident 1) started on a new medication. Resident 1 experienced harm when they had a decline in condition as evidenced by nausea/vomiting, change of level of consciousness, were difficult to arouse, and became unresponsive after starting a new partial opioid (buprenorphine-naloxone (suboxone) - a central nervous system depressant used to treat opioid addiction) medication. Findings included .Review of Resident 1's electronic medical record (EMR) showed they were admitted to the facility on [DATE], at the age of 54, with diagnoses of diabetes, bilateral below knee amputations, and chronic kidney disease (inability of the kidneys to filter waste effectively).Resident 1's EMR showed on [DATE] at 1:00 PM they saw Collateral Contact 1 (CC1), community primary medical doctor, in their office and were prescribed buprenorphine-naloxone to help with their report of unrelieved nerve pain. The dose was documented in the medical provider summary note, dated [DATE] at 1:13 PM, to be 8 milligram (mg) -2 mg sublingual film (placed under the tongue to dissolve): place 0.5 film under the tongue every 12 hours.Review of Resident 1's [DATE] MAR (Medication Administration Record) showed an order, entered during the night shift on [DATE] into [DATE] by Staff D, Registered Nurse (RN), dated to start [DATE] at 6:00 AM, which stated: Alert charting: Medication change-adverse side effects r/t (related to) start of Buprenorphine-Naloxone for 3 days. Stop medication if [they have] severe nausea, confusion, disorientation, or other significant symptoms and contact [CC1]. The box for [DATE], on the [DATE] MAR, was then checked off by Staff E, RN, for day shift on [DATE], indicating they had followed the ordered direction to monitor for and report adverse side effects related to starting the new medication. Review of Resident 1's [DATE] MAR showed an order, entered on the night shift of [DATE] into [DATE], by Staff D, dated to start on [DATE] at 8:00 AM, for buprenorphine-naloxone 8 mg -2 mg sublingual film: give 1 film every 12 hours. The box for [DATE] was then checked as given by Staff E, in the AM on [DATE]. Further review of Resident 1's MAR showed no order for an antiemetic (a medication used to treat or prevent nausea and vomiting) nor any other narcotic pain medication since their admission.Review of Resident 1's nursing progress notes, showed a note written by Staff E on [DATE] at 9:43 AM which stated, Resident initial dosed N.O. (new order) suboxone (buprenorphine-naloxone is generic drug name for the commercial drug name suboxone) sublingual this morning. Resident had c/o (complained of) moderate to severe n/v (nausea/vomiting) and stated that [they]no longer wanted to take the medication. Nurse educated resident on the expected side effects of the medications and offered PRN (as needed) antiemetic medication. Resident accepted the PRN and stated that [they] will try the dose again tomorrow to allow [their] body to adjust to the new medication.On [DATE] at 4:58 PM, Staff E documented in the nursing progress notes, F/U (follow-up) to resident initial dosing of N.O medication suboxone. After resident c/o nausea, [they] stated that [they were] going to lay down. Resident could be heard snoring from the hallway ongoing from 11:00-13:00 (1:00 PM). After which resident cont. (continued) sleeping. Resident did not awake for lunch or oral medications.Review of staffing documentation, for [DATE], showed Staff F, Nursing Assistant (NA) was assigned to work from 6:00 AM until 6:00 PM, on the hallway where Resident 1 resided. Staff G, NA, was assigned for (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

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	04/07/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	the same shift to assist with resident showers, and another NA who was assigned to work on the same hallway, was marked as no show.During an interview on [DATE] at 11:45 AM, Staff C, Staffing Coordinator, stated that an NA had called off early on the morning of [DATE]. They stated that they called around but could not find coverage. They stated that they did not communicate with the remaining building staff to adjust the resident assignments related to one staff not being in the building. Staff C stated that Staff F would have been responsible for the care of about 17 residents and that Staff G should have moved into the open NA spot instead of focusing on showers, but that they did not communicate the need to adjust assignments to the nursing staff the morning of [DATE].During an interview on [DATE] at 3:00 PM, Staff G, stated that they had worked with Resident 1 on multiple occasions but were not assigned to work with Resident 1 on [DATE] and that day they helped residents with showers and kind of floated around. Staff G stated Resident 1 was friendly, outgoing, and would often take time to talk with staff and other residents in a friendly manner. They stated Resident 1 normally snored when sleeping and would often take a nap before lunch. Staff G stated on [DATE], Resident 1s snoring was different, that it was really loud and could be heard all the way to the main nurses' station (about 150 feet away). Staff G stated they brought Resident 1 their lunch tray about 12:30 PM and that Resident 1 was really drowsy and did not talk to them as they typically did. Staff G stated that they needed to assist with continuing to pass out lunch trays to other residents and left the room before Resident 1 started eating. Staff G stated that they did not know that Resident 1 had started a new medication that day and they did not notify the nurse related to Resident 1 being really drowsy or acting differently than was normal.During an interview with Staff F, Nursing Assistant on [DATE] at 9:57 AM, they stated they had worked with Resident 1 on multiple occasions. They stated Resident 1 was usually very active, would leave the facility to self-propel in their wheelchair across the street to get snacks, sometimes several times a day, talked loudly, laughed a lot, was friendly and social with other residents and staff. They stated the day shift on [DATE] had been a very busy day, due to one NA staff not showing up for their shift. They further stated that they did not remember being assigned to work with Resident 1 on [DATE] and had not provided direct care assistance to Resident 1 on that shift. They stated that during lunch time on [DATE], they could not remember the exact time, but thought it would have been about 1:00 PM, another resident stopped them in the hallway and asked them to go check on Resident 1 as they could hear them snoring very loudly and were concerned. Staff F stated upon entering Resident 1s room, they were snoring really loudly and their lunch tray was untouched on their bedside table. Staff F stated Resident 1 was hard to rouse. Staff F stated that Resident 1 snored normally but the snoring that day was different and really loud. Staff F stated they thought snoring was a sign the resident could be Od'ing (overdosing) or that their blood sugar might be high or low but that they did not tell the nurse of their concerns. Staff G further stated that it was very busy that day and in retrospect they should have told the nurse about their concerns.During an interview with Staff E, on [DATE] at 3:00 PM, they stated that [DATE] was the second shift they had worked in the facility. Staff E stated that they were not very familiar with any of the residents and relied on the staff who knew the residents to notify them if there was anything different or unusual happening. Staff E stated that Resident 1 had started a new pain medication that morning ([DATE]) and that Resident 1 had approached them at the main nurses station a little before 10:00 AM and told them they were very nauseous. Staff E then stated they borrowed Zofran (a prescription antiemetic medication used to prevent nausea and vomiting) from another resident and had given it to Resident 1, after which Resident 1 went to their room and slept for most of the remainder of the shift. Staff E stated they checked the resident's blood sugar prior to lunch, about 11:00 AM, and gave them insulin (a medication used to help turn sugar into energy and manage blood sugar levels). They stated the resident had been snoring very loudly and they had to reposition the resident so their face was not in the mattress. Staff E stated that they again checked the resident's blood sugar at about 4:00 PM, again administered the prescribed insulin, noticed the resident was still sleeping on their stomach, (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	04/07/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	moved pillows to keep the resident's face off of the mattress and went about their other assigned duties. Staff E stated that they did not receive any kind of notification, from any staff, that Resident 1's behavior was not typical or abnormal. Staff E stated that they did not call any medical provider to notify them of the need for medication to treat Resident 1's complaint of nausea or signs/symptoms of sedation. They stated that after dinner, probably about 6:00 PM, a NA had come out of Resident 1's room and started yelling for help. When they got to the room, they realized that Resident 1 was not breathing, assisted other staff to turn the resident onto their back and started cardiopulmonary resuscitation (CPR) as they did not know the resident's code status (a medical directive indicating a resident's preference for life-saving interventions - specifically CPR).During an interview on [DATE] at 12:26 PM, Staff H, NA, stated that they came into work at 2:00 PM on [DATE]. They stated that they brought Resident 1 their dinner tray that day, probably a little after 5:00 PM, and thought it was weird when they noticed the resident's lunch tray, on their bedside table, was untouched, as they usually ate well. Staff H stated that Resident 1 was very drowsy, was difficult to rouse and did not speak to them but only grunted. Staff H stated they thought Resident 1 was awake when they grunted and left the room to go assist another resident to eat. Staff H stated they then returned to pick up Resident 1's dinner tray, at about 6:00 PM, and found them laying on their stomach, their dinner tray was untouched. Staff H stated they approached Resident 1 and noticed they had visibly voided their bladder in bed, which was not normal. Staff H stated when they tried to rouse Resident 1, they were unresponsive and not breathing. Staff H stated they yelled out into the hallway for help and then tried to turn Resident 1 onto their back to start CPR, as they did not know the resident's code status During an interview with CC1, on [DATE] at 3:59 PM, they stated they had been Resident 1's medical provider for awhile and that on [DATE] Resident 1 had an appointment with them, in their office, where they had discussed Resident 1's level of unrelieved pain and different methods for controlling the pain. After discussion with Resident 1, CC1 decided to start Resident 1 on suboxone to try and control the resident's pain to tolerable levels, without the side effects caused by typical narcotics (addiction). CC1 stated that they did not receive any calls from staff at the facility until they were notified of Resident 1's death on the evening of [DATE] in a voicemail and then of the medication error on [DATE]. CC1 stated that they were surprised by the notification, as they had just seen Resident 1 the day before and they had reviewed their lab results. During that visit, Resident 1s lab results showed improved numbers indicating better control of their diabetes which also indicated they were making better lifestyle choices and CC1 was cautiously hopeful the resident would continue to improve.During an interview with Staff B, Chief Nursing Officer, they stated that they had been made aware of the short facility staffing on [DATE] but had not called to provide directions to staff for changing resident assignments. Staff B stated they thought that Staff C would have provided direction. They stated that they did not think nursing staff had notified Resident 1's medical provider of any side effects of the newly started medication. Staff B stated nursing staff should have notified either CC1 or the facility on-call medical provider, who worked on the weekends, of the nausea and sedation as directed on the resident's MAR. They stated they had become aware of the medication error affecting Resident 1, on [DATE], after they had passed away, and that their death had been unexpected. Staff B stated that it looked like Staff D had incorrectly entered the dose of the new medication, on the night shift of [DATE] into [DATE], for Resident 1 to have 1 full strip versus the actual order to give 0.5 a strip, . Staff B stated Staff D had not had a second nurse check the accuracy of the order prior to administration, as was facility policy.During an interview on [DATE] at 2:00 PM, Staff A, Administrator, stated that Staff C would be responsible for calling nursing staff to adjust assignments when a staff called off and another staff could not be found to cover the shift. They further stated that it was the expectation that nursing staff follow facility policy for checking orders for accuracy, administer medical orders as written, and notify medical providers when directed to do so.See citation for F 760 dated [DATE]Reference: WAC 388-97-1060(1)

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	04/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1), received medications as ordered and were free from significant medications errors. This failure placed residents at risk for adverse medication side effects, and worsening condition. Findings included . Review of Resident 1's electronic medical record (EMR) showed they were admitted to the facility on [DATE] with diagnoses of diabetes, with bilateral below knee amputations and chronic kidney disease (inability of the kidneys to filter waste effectively). Further review of Resident 1's EMR showed on 03/13/2026 they saw their community medical provider and were prescribed buprenorphine-naloxone (prescription medication primarily used for the treatment of opioid dependence. It is not intended for pain management) to help with their report of unrelieved pain. The dose was documented in the medical provider summary note to be 8 milligrams (mg) - 2 mg sublingual film (placed under the tongue to dissolve): place 0.5 film under the tongue every 12 hours. Review of Resident 1's March 2026 Medication Administration Record (MAR) showed an order, dated to start on 03/14/2026 at 8:00 AM, for buprenorphine-naloxone 8 mg-2 mg sublingual film: give 1 film every 12 hours. The box for 03/14/2026 was then checked as given by Staff F, Registered Nurse (RN), in the AM on 03/14/2026. Further review of Resident 1's MAR did not show an order for an antiemetic medication (a medication used to treat or prevent nausea and vomiting). Further review of the same MAR also showed an order dated 03/14/2026 at 6:00 AM which stated: Alert charting: Medication change-adverse side effects r/t (related to) start of Buprenorphine-Naloxone for 3 days. Stop medication if [they have] severe nausea, confusion, disorientation, or other significant symptoms and contact [Staff C]. The box for 03/14/2026 was then checked off by Staff F, Registered Nurse, for day shift on 03/14/2026. Review of Resident 1's nursing progress notes, located in their EMR, found a note written by Staff F, on 03/14/2026 at 9:43 AM which stated, Resident initial dosed N.O. (new order) suboxone (buprenorphine-naloxone is generic drug name for the commercial drug name suboxone) sublingual this morning. Resident had c/o (complained of) moderate to severe n/v (nausea/vomiting) and stated that [they] no longer wanted to take the medication. Nurse educated resident on the expected side effects of the medications and offered PRN (as needed) antiemetic. Resident accepted the PRN and stated that [they] will try the dose again tomorrow to allow [their] body to adjust to the new medication. Further review of nursing progress notes found another nursing note written by Staff F on 03/14/2026 at 4:58 PM, which stated, F/U (follow-up) to resident initial dosing of N.O medication suboxone. After resident c/o nausea, [they] stated that [they were] going to lay down. Resident could be heard snoring from the hallway ongoing from 11:00-1300 (1:00 PM). After which resident cont. (continued) sleeping. Resident did not awake for lunch or oral medications. Nurse has frequently had to turn resident on [their] side to prevent [them] from sleeping face down in [their] mattress. At the time of this note, resident cont. to sleep and snore loudly. During an interview with Staff F, on 03/25/2026 at 3:00 PM, they stated that they worked for a staffing agency and the shift they worked on 03/14/2026 was the second shift they had worked in the facility. They further stated that they gave Resident 1 the new order for suboxone on 03/14/2026 a little after 8:00 AM and the resident came back to tell them they were nauseous a little before 10:00 AM. Staff F stated that they then offered Resident 1 a medication called Zofran (antiemetic), that was prescribed for another resident. Resident 1 took the medication and went to lay down after which they were heard snoring loudly and slept most of the day. Staff F stated that they did not notify the medical provider, Staff C, of Resident 1's sedation or nausea and only found out the next day that the resident had received double the dose of suboxone that they should have been administered. During an interview on 03/18/2026 at 12:45 PM, Staff B, Chief Nursing Officer, stated that on 03/15/2026 they were made aware that Resident 1 had experienced a significant medication error when they were administered a full strip of suboxone, instead of the ordered half a strip. They stated that they did not (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	04/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	think that the RN who administered the drug notified the medical provider of side effects from the medication error until after the resident was found unresponsive, after dinner, on 03/14/2026. See citation for F 684 dated 04/07/2026. Reference: WAC 388-97-1060 (3)(k)(iii)