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	06/14/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review, the facility failed to honor residents' choices regarding having the hoyer sling (a sling used for a full body mechanical lift transfer) left under them after being transferred into their wheelchairs, for 2 of 4 sampled residents (Residents 10 and 20), reviewed for choices. This failure placed residents at risk for not receiving resident specific care, not having their preferences honored, and a diminished quality of life. Findings included . <Resident 10> The 05/08/2025 assessment documented Resident 10 had diagnoses which included heart failure, diabetes, and chronic pain. Resident 10 was cognitively intact, able to make their needs known, and required total assistance with transfers. In an observation and interview on 06/09/2025 at 11:49 AM, Resident 10 was observed sitting in their wheelchair with a hoyer sling underneath them. The resident stated they did not like having the sling underneath them because it was uncomfortable and caused pain. A similar observation of Resident 10 with the hoyer sling underneath them was made on 06/11/2025 at 12:05 PM. The resident stayed in bed during further observations made during the survey. <Resident 20> The 05/08/2025 assessment documented Resident 20 had diagnoses which included a stroke, hemiplegia (paralysis on one side of the body), and chronic pain. Resident 20 was cognitively intact, able to make their needs known, and required total assistance with transfers. In an observation and interview on 06/09/2025 at 11:18 AM, Resident 20 was observed sitting in their wheelchair with the hoyer sling underneath them. The resident stated the sling was very uncomfortable. Resident 20 stated the staff told them they had to leave the sling underneath them because they did not have enough staff to take it out and put it back on later. A similar observation of Resident 20 with the hoyer sling underneath them was made on 06/11/2025 at 12:06 PM. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/2025 at 3:38 PM, Staff H, Nursing Assistant (NA), stated hoyer slings were left underneath the residents. Staff H further stated it was important to remove hoyer slings from under the residents to prevent ulcers (wounds caused by unrelieved pressure). In an interview on 06/14/2025 at 6:34 AM, Staff I, NA, stated hoyer slings were kept under the residents because it was safer and easier. Staff I added they did not ask the residents if they wanted the hoyer slings left under them because they have compromised mobility. In an interview on 06/13/2025 at 2:24 PM, Staff B, Director of Nursing, stated hoyer slings created pressure on the resident's skin and should not be left underneath residents. Reference: WAC 388-97-0900(1)-(4) Refer to F725 for additional information.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide written information regarding the right to formulate an advance directive (legal document that outlined wishes for medical care if a person was unable to make decisions for themselves) for 1 of 4 sampled residents (Resident 195), reviewed for advanced directives. This failure placed residents at risk of not being able to exercise their rights, not having their wishes honored, and a diminished quality of life. Findings included . Review of the facility policy titled, Advanced Directives/Health Care Decisions dated [DATE] showed, the facility would determine if a resident had executed an advanced directive or had given other instructions to indicate what care he or she desired in case of subsequent incapacity, upon admission. If the resident or their legal representative executed one or more advanced directives, copies would be obtained, incorporated, and maintained in the resident's medical record to be readily retrievable by any facility staff. If the resident had not executed an advanced directive, the facility would advise the resident and/or family of the right to establish an advanced directive and document in the resident's medical record discussions regarding advanced directives and any healthcare decision that resident executes. If the resident wished to formulate an advanced directive, a nurse or social worker provided the resident with written information concerning the right to make decisions regarding medical care, including the right to specify ahead of time whether a health care provider begins or continues life-sustaining treatment. The policy further showed the facility identified, clarified, and periodically reviewed, at least quarterly, after a life altering event, and after return from a hospitalization, as part of the comprehensive care planning process, the existing care instructions and whether the resident wished to change or continue these instructions. According to the [DATE] significant correction assessment, Resident 195 admitted to the facility on [DATE]. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of the [DATE] care plan showed Resident 195 chose to have cardiopulmonary resuscitation (CPR) in case of a medical emergency if and/or when their heart stopped beating. Interventions instructed staff to review advanced directives, CPR code status, scope of treatment with the resident and/or their appointed health care representative upon admission, change of condition, and at least quarterly. No documentation was found to show Resident 195 was informed and/or provided with written information regarding the right to formulate an advanced directive, as required. Review of the [DATE] care conference evaluation showed Resident 195 participated in an admission care conference held on [DATE]. The evaluation showed Resident 195 did not have an advanced directive. No documentation was found to show Resident 195 was informed and/or provided with written information regarding the right to formulate an advanced directive, as required. Review of [DATE] through [DATE] nursing progress notes showed no documentation that Resident 195 was informed and/or provided with written information regarding the right to formulate an advanced directive, as required. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 9:26 AM, Resident 195 stated the facility only reviewed their CPR status with them and did not inform and/or provide them with written information regarding their right to formulate advanced directives. In an interview on [DATE] at 10:29 AM, Staff C, Resident Care Manager, stated social services offered and provided residents with information on the right to formulate advanced directives upon admission and during care conferences. Staff C explained advanced directives were important because they allowed staff to know what a resident's healthcare wishes were. In an interview on [DATE] at 12:58 PM, Staff E, Social Services, stated information on advanced directives was offered upon admission and during care conferences. Staff E stated an information packet on formulating advanced directives would be provided during care conferences and documented in the care conference evaluation. Staff E reviewed Resident 195's medical record. Staff E acknowledged they were unable to find documentation Resident 195 was informed and/or provided with written information regarding the right to formulate an advanced directive, as required. In an interview on [DATE] at 3:46 PM, Staff A, Administrator, stated they expected staff to provide residents with information on the right to formulate advanced directives. Refer to WAC 388-97-0280 (3)(c)(i-ii), 0300 (1)(b), (3)(a-c)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility repeatedly failed to ensure resident hospital transfer documentation was completed as required to include the basis for hospital transfer, specific resident needs unable to be met by the facility, facility attempts to meet the needs, services available at the receiving facility to meet needs, what information was conveyed to the receiving provider, bed hold offered upon transfer, and notification to the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes who protected and promoted resident rights under federal and state law and regulations) of discharges and/or transfers, as required for 3 of 4 sampled residents (Resident 28, 195, and 44), reviewed for hospitalization . This failure placed residents at risk of potential delays in emergent hospital treatment, potential medical complications, and precluded the residents and/or their representatives to participate in decisions regarding their right to return to the same facility upon hospital return. Findings included . Review of the facility policy titled, Discharge and Transfer revised April 2025 showed, a resident's medical record should reflect the basis for transfer and/or discharge and should be documented before or as close as possible to the actual time of transfer or discharge. In the event the discharge or transfer was necessary for the resident's welfare and the facility could not meet the resident's needs, documentation should include specific needs that could not be met, facility efforts to meet those needs, specific services the receiving facility would provide to meet the needs of the resident which could not be met at the current facility. Information provided to the receiving provider should include a minimum of the practitioners responsible for care of the resident, resident advocate information, advanced directive information, special instructions and/or precautions for ongoing care as appropriate, the resident's comprehensive care plan goals, and all information necessary to meet the resident's needs to include the resident's status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs, diagnoses, allergies, medications (including when last received), and the most recent relevant blood work or diagnostic tests. The Ombudsman office was to be notified of transfers and/or discharges on a monthly basis. <Resident 28> According to the 04/04/2025 admission assessment, Resident 28 admitted to the facility on [DATE] with diagnoses including medically complex conditions. Resident 28 had moderate cognitive impairment. Review of April 2025 through May 2025 nursing progress notes showed Resident 28 was transferred to the hospital three times. -On 04/03/2025 Resident 28 was transferred to the hospital to have their buttock wound assessed. -On 04/10/2025 Resident 28 was transferred to the hospital after they cut their left hand with a dinner knife. -On 05/31/2025 Resident 28 was transferred to the hospital related to abdominal pain. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No documentation was found to show what information was provided or communicated to the receiving facility, as required. Additional record review showed no documentation a bed hold was offered upon hospital transfer on 04/10/2025 or 05/31/2025. During an interview on 06/09/2025 at 11:37 AM, Resident 28 stated they had been transported to the hospital three times, since their admission to the facility. In an interview on 06/13/2025 at 10:17 AM, Staff C, Resident Care Manager (RCM), stated staff should document a detailed progress note if and/or when a resident was transferred to the hospital. Staff C acknowledged staff had not been completing hospital documentation, as required and it was often a scavenger hunt trying to find information. Staff C stated they expected staff to document as required. <Resident 195> According to the 05/29/2025 significant correction assessment, Resident 195 admitted to the facility on [DATE] with diagnoses including fractures. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of May 2025 through June 2025 nursing progress notes showed Resident 195 was transferred to the hospital four times. -On 05/25/2025 Resident 195 was transferred to the hospital for pain management. -On 05/26/2025 Resident 195 was transferred to the hospital after they sustained a fall out of bed. -On 06/01/2025 Resident 195 was transferred to the hospital related to blood-tinged urine. -On 06/07/2025 Resident 195 was transferred to the hospital for unrelieved bladder pain. No documentation was found to show what information was provided or communicated to the receiving facility, as required. In an interview on 06/09/2025 at 1:54 PM, Resident 195 stated they had been transported to the hospital a couple of times, since their admission to the facility. <Resident 44> According to the 03/29/2025 admission assessment, Resident 44 admitted to the facility on [DATE] with diagnoses including fractures. Review of March 2025 nursing progress notes showed Resident 44 admitted to the facility on [DATE] around 6:00 PM. On 03/29/2025 at 9:47 AM, Resident 44 was transferred to the hospital for chest pain. No documentation was found to show what information was provided or communicated to the receiving facility or that a bed hold was offered upon hospital transfer, as required. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ombudsman transfer and/or discharge notifications, September 2025 through current, were requested from Staff A, Administrator, on 06/12/2025 at 3:32 PM and again on 06/13/2025 at 1:09 PM. No documentation was provided. In a follow-up interview on 06/13/2025 at 10:25 AM, Staff C, RCM, reviewed Resident 44's medical record. Staff C stated Resident 44's record did not show sufficient documentation related to their 03/29/2025 hospital transfer to include a documented resident assessment or interventions attempted with effectiveness or results. Staff C acknowledged no documentation was found to show what information was provided or communicated to the receiving facility, as required. In an interview on 06/13/2025 at 10:30 AM, Staff E, Social Services, explained they had only notified the Ombudsman of discharges against medical advice because they were unaware the Ombudsman was to be notified of hospital transfers and normal discharges. In an interview on 06/13/2025 at 10:55 AM, Staff B, Director of Nursing, stated when a resident was transferred to the hospital, they expected staff to document a resident assessment, interventions attempted, and what information was conveyed to the hospital. In an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expected staff to document what information was conveyed to the hospital, offer a bed hold upon transfer, and notify the Ombudsman of transfers and/or discharges as required. No associated WAC Refer to F842 for additional information.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Preadmission Screening and Resident Reviews (PASRR, a two-part screening; Level I determined presence of a Severe Mental Illness [SMI] or Developmental Disability. If present, a Level II evaluation by a specialized evaluator determined if nursing home placement was the appropriate level of care, and if behavioral health or other community services were recommended. A Level II was required to be completed prior to nursing home admission) were completed correctly, PASSR Level II were referred for evaluation when indicated, and Level II evaluation recommendations were incorporated into the plan of care, as required for 4 of 6 sample residents (Resident 18, 28, 6, and 30), reviewed for PASRR. This failure placed residents at risk of behavioral health needs not being met and diminished quality of life. Findings included . Review of the facility policy Behavioral Health Services, revised April 2025, documented if a resident met criteria for facility admission, the facility initiated a plan of care to meet the resident's behavioral health needs at the time of admission. The PASRR was to be reviewed for specialized services a resident needed and to assist with implementing a plan as indicated. If a resident did not qualify for specialized services but required more intensive behavioral health services such as individual counseling, the facility demonstrated reasonable attempts to provide services. Residents were assessed and monitored for signs and/or symptoms of depression, adjustment difficulties, and suicidal tendencies to identify and address reversible and treatable causes promptly. If a resident was identified as having a mental health disorder, the care plan was to address the individualized needs a resident had related to the disorder. <Resident 18> A review of the record showed Resident 18 was admitted on [DATE] and had diagnoses that included major depressive disorder, delusional disorder (false beliefs not based in reality), and suicidal ideation. The 05/30/2025 quarterly assessment documented Resident 18 was cognitively intact and had an assessment for depression that showed the resident had thoughts they would be better off dead, had trouble concentrating, felt bad about themselves, felt down, depressed or hopeless, and had little pleasure doing things. Resident 18 received antidepressant medications daily. A PASRR Level II Notice of Determination dated 01/29/2025 documented Resident 18 had a mental health diagnosis, met criteria for nursing facility level of care, and may benefit from specialized behavioral health services. A PASRR Level II Initial Psychiatric Evaluation Summary, the detailed findings of the Level II evaluation, was not included in Resident 18's record. Further record review found no assessments or behavioral health provider notes in Resident 18's record. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/2025 at 9:04 AM, Resident 18 was in their room eating breakfast. They stated they had admitted themselves to a locked psychiatric unit in January of 2025 to get help adjusting their antidepressant medications. Resident 18 was unable to finish the process there after being admitted to the hospital. Resident 18 stated they were agreeable to behavioral health services because it had helped them through a dark period in their past but had not seen anyone yet. During an interview on 06/12/2025 at 1:20 PM, Staff E, Social Services, stated a referral had been sent to the behavioral health provider in April of 2025, but did not see in the resident's record that Resident 18 had been seen yet. During an interview on 06/14/2025 at 6:27 AM, Staff A, Administrator, stated if the summary of the PASRR Level II evaluation was not received by the facility, they would not know what interventions or recommendations needed to be incorporated into Resident 18's plan of care as required. <Resident 6> According to the 05/12/2025 quarterly assessment, Resident 6 had diagnoses including dementia and was administered antipsychotic (medication that affected the brain, emotions, and behaviors) medications. The assessment further showed Resident 6 had moderate cognitive impairment. Review of the 08/21/2024 PASRR showed Resident 6 exhibited indicators of having a mood disorder and a level II evaluation referral was required to assess for a serious mental illness. Review of the 03/10/2025 psychosocial evaluation showed Resident 6 had a PASRR level I and no further action was needed. The assessment further showed Resident 6 received antipsychotic medications. Review of August 2024 through June 2025 nursing progress notes showed no documentation Resident 6's PASRR was sent to a PASRR level II evaluator, as required. During an interview on 06/12/2025 at 1:20 PM, Staff E, Social Services, stated they reviewed PASRRs prior to admission to ensure accuracy, if a PASRR was found to be incorrect the hospital was contacted for PASRR correction. Staff E further stated a resident would not be admitted without a PASRR or with an inaccurate PASRR. Staff E reviewed Resident 6's medical record. Staff E acknowledged Resident 6's 08/21/2024 PASRR had not been referred for evaluation yet and this was not timely. <Resident 28> According to the 04/04/2025 admission assessment, Resident 28 admitted to the facility on [DATE] with diagnoses including depression. Resident 28 had moderate cognitive impairment. Review of the 03/21/2025 PASRR level I screen showed Resident 28 exhibited indicators of having an anxiety and mood disorder. A Level II evaluation referral was required to assess for a serious mental illness. Review of the 03/25/2025 hospital progress notes showed on 03/19/2025 Resident 28 attempted to stab themselves with a butterknife, while hospitalized . Resident 28 was evaluated by psychiatry and Resident 28's behavior was likely largely driven by an underlying personality disorder and would benefit from focused outpatient therapy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 03/24/2025 PASRR level II psychiatric evaluation summary showed determinations including plan of care were made based on diagnosis and need for treatment. The evaluation showed Resident 28 made a suicide attempt during hospitalization by attempting to stab [themselves] in the abdomen with a butter knife. Resident 28 endorsed persistent depression at baseline and indicated they intended to die from the attempt due to the distress of feeling helpless about [their] medical conditions. The evaluation further showed given Resident 28's report of depressive symptoms throughout their life and multiple suicide attempts, seeking ongoing psychiatric consultation would be useful and offering counseling/therapy was recommended. Resident 28 would likely benefit from an additional psychiatric assessment for diagnostic clarification and medication evaluation to explore efficacy of medications. The summary included numerous recommendations for Resident 28's plan of care to include staff approaches, behavioral supports, activities, environmental adjustments, mental health services, and other medical services. Review of the 03/30/2025 psychosocial evaluation completed by the facility showed Resident 28 had a PASRR level I and materials were sent to the State Agency. The assessment further showed Resident 28 did not show indicators of a serious mental illness but received psychotropic medications. Review of the 04/07/2025 care plan showed Resident 28 had adjustment issues related to admission and instructed staff to adjust Resident 28's routine to imitate home routines and provide them the opportunity to communicate their feelings. A 04/07/2025 depression care plan instructed staff to administer medications as ordered, help Resident 28 with constructive ways to manage feelings, monitor/document depressive symptoms, watch for indicators of suicidal ideation, and ensure Resident 28 did not have sharp objects close to them. No documentation was found to show the 03/24/2025 PASRR level II psychiatric evaluation recommendations for Resident 28's plan of care were incorporated into the care plan, as required. Review of March 2025 through May 2025 nursing progress notes showed Resident 28 was anxious and agitated. On 03/29/2025 Resident 28 expressed feelings of depression stating, I want to die. Resident 28 denied having any suicide plans or intent stating, it's only up to God and nothing could help them. On 04/10/2025 911 was called at approximately 6:30 PM because Resident 28 had a dinner knife, superficially cut their left hand, attempted to stab staff when they approached to discuss the situation, and Resident 28 then took the knife like [they] were going to stab [their] stomach. Resident 28 was accompanied to the hospital by law enforcement. The hospital emergency room doctor stated Resident 28 has a long standing [history] of these behaviors and requested Staff M, Medical Doctor, call them to discuss Resident 28. On 04/29/2025 staff were asked to look into Death with Dignity but Resident 28 would not qualify unless they had six months or less to live. On 05/19/2025 Resident 28 was seen and assessed by the facility mental health counselor, 52 days after admission and 39 days after the suicidal gesture with a dinner knife. No documentation was found to show the 03/24/2025 PASRR level II psychiatric evaluation recommendations for Resident 28's plan of care were incorporated into the care plan, as required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview and record review on 06/12/2025 at 2:03 PM, Staff E, Social Services, stated when a PASRR level II evaluation with recommendations was received, the findings were reviewed, interventions implemented, and evaluation filed a binder. Staff E acknowledged they were behind on referring PASRR Level II's for evaluations as required and had a to do list. A copy of the list was requested. Review of the list showed 11 residents needed to be referred for PASRR Level II evaluations, including Resident 6 and Resident 30. Staff E reviewed Resident 28's medical record. Staff E acknowledged Resident 28's care plan did not incorporate the Level II evaluation recommendations. Staff E further stated if behavioral health services would have been implemented timely Resident 28 might not have experienced the 04/10/2025 suicidal ideation with a suicidal gesture or requested death with dignity. <Resident 30> According to the 05/28/2025 quarterly assessment, Resident 30 had diagnoses including depression, bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels), and a psychotic disorder (mental illness where a person's thoughts and perceptions are significantly disturbed, leading to a disconnect from reality). The assessment further showed Resident 30 was cognitively intact. Review of the 06/13/2024 hospital discharge summary showed Resident 30 started a sentence and forgot their thoughts mid-sentence. Resident 30 was paranoid and suspicious of health care systems. Psychiatry (doctor that specialized in understanding, diagnosing, treating, and preventing mental, emotional, and behavioral disorders) was consulted and Resident 30 was identified as having a possible personality disorder (mental health condition characterized by long-term patterns of thinking, feeling, and behaving in a manner that significantly deviated from expectations and cause distress or impairment in daily life). Review of the 06/06/2024 PASRR showed Resident 30 did not exhibit indicators of having a personality disorder or other indicators of a serious mental illness and a Level II evaluation was not indicated. Review of the 05/26/2025 psychosocial evaluation completed by the facility showed Resident 30 had a PASRR level I and no further action was needed. The assessment further showed Resident 30 showed indicators of a serious mental illness and did not receive psychotropic (medication that affected the brain, emotions, and behaviors) medications. A summary showed Resident 30 was apprehensive to cares and sometimes refused to help themselves. Review of the 06/14/2025 psychosocial evaluation completed by the facility showed Resident 30 had a PASRR level I and no further action was needed. The assessment further showed Resident 30 showed indicators of a serious mental illness and did not receive psychotropic medications. In a follow-up interview on 06/12/2025 at 2:23 PM, Staff E, acknowledged Resident 30's PASRR had not been sent off for a Level II evaluation yet. In an interview on 06/12/2025 at 3:46 PM, Staff A, Administrator, stated they expected staff to review a PASRR for accuracy prior to admission, redo a PASRR if and/or when a resident had a change or when indicated, refer PASRR Level II for evaluation when indicated, and implement PASRR Level II recommendations into a resident's plan of care, as required. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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Colfax Health and Rehabilitation of Cascadia	1150 West Fairview Road Colfax, WA 99111

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1915 (4) Refer to F740 for additional information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure residents requiring assistance with their activities of daily living (ADLs), were provided timely assistance according to their needs and preferences for 2 of 2 sampled residents (Residents 10 and 23), reviewed for ADLs. Specifically, Resident 10 was not provided bathing per their preference and Resident 23 was not provided nail care when indicated. This failure put residents at risk for a decreased quality of life. Findings included . <Resident 10> The 05/08/2025 admission assessment documented Resident 10 had diagnoses which included heart failure, diabetes, and chronic pain. The resident was cognitively intact and required substantial assistance for bathing. In an observation and interview on 06/09/2025 at 11:49 AM, Resident 10 was observed sitting in their wheelchair. The resident stated they did not get their bed baths very often. The 05/02/2025 ADL care plan documented Resident 10 was to be offered a bed bath if they could not tolerate a shower. The Nursing Assistant shower task documentation showed Resident 10 received bathing on 05/25/2025 and not again until 06/07/2025, a period of 12 days. Review of shower sheets and documentation showed no further bathing for the resident and no refusals. In an interview on 06/12/2025 at 3:48 PM, Staff H, Nursing Assistant, stated bathing was provided twice a week. Staff H stated bathing was documented on shower sheets and in the computer and refusals were also documented. In an interview on 06/13/2025 at 2:24 PM, Staff B, Director of Nursing, stated the residents needed bathing for dignity, proper hygiene and infection control. <Resident 23> The 04/15/2025 quarterly assessment documented Resident 23 had diagnoses which included dementia, high blood pressure and depression. The resident had severe cognitive impairment and required partial to moderate assistance with personal hygiene. In an observation on 06/09/2025 at 11:04 AM, Resident 23 was observed lying in bed. The resident had long fingernails, some were jagged and had brown matter under them. The 08/22/2022 ADL care plan documented staff were instructed to provide Resident 23 moderate assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Assistant nail care documentation from 05/10/2025 through 06/04/2025 showed Resident 23 was referred to the nurse on 05/15/2025, 05/16/2025, 05/21/2025 and 05/28/2025. The trimmed and filed portion of the documentation was blank. Nursing progress notes reviewed from 03/01/2025 through 06/09/2025 showed Resident 23 refused nail care on 05/19/2025, 05/26/2025, 06/02/2025, and 06/09/2025. There were no refusals documented for the above listed dates in which the resident was referred to the nurse for nail care. Similar observations of Resident 23 having long, jagged nails with brown matter were made on 06/10/2025 at 3:43 PM and 06/11/2025 at 8:45 AM. In an observation on 06/11/2025 at 12:23 PM, Resident 23 ate a roll with their fingers and their nails had brown matter under them. In an interview on 06/14/2025 at 6:23 AM, Staff I, Nursing Assistant, stated nail care was completed on shower days and consisted of cutting and cleaning the fingernails. Staff I stated Resident 23 did not refuse nail care. In an interview on 06/14/2025 at 7:15 AM, Staff B, Director of Nursing, stated nail care was provided on shower days. Staff B stated nail care was important to prevent injuries and infections. Reference: WAC 388-97-1060(2)(a)(ii).

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	505251	A. Building B. Wing	06/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement wound care orders for 1 of 3 sampled residents (Resident 195), reviewed for non-pressure related skin conditions. This failure placed residents at risk for wound complications, unidentified skin infections, and diminished quality of life. Findings included . According to the 05/29/2025 significant correction assessment, Resident 195 admitted to the facility on [DATE] with diagnoses including pelvis (bones at the base of the spine that make up the hips, buttocks and pubic area, between the abdomen and thighs) fractures and muscle weakness. The assessment further showed Resident 195 underwent a major surgical procedure during the prior inpatient hospital stay that required active skilled nursing care and had surgical wounds that required wound care. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of the 05/21/2025 hospital transfer orders showed Resident 195 had pelvis fractures that were surgically repaired and had a suprapubic (above the pubic bone) indwelling catheter (flexible tube placed into the bladder to drain urine when unable to urinate) surgically placed. Resident 195 had surgical wounds to their right and left hip and bilateral [both sides] pubis [one of three bones that make up each side of the pelvis]. Resident 195 was to have surgical site wound care with dressing changes every 2-3 days or earlier if the dressing had excessive drainage, upon hospital discharge. Review of provider orders showed no documentation the bilateral pubis surgical wound care orders were transcribed into Resident 195's medical record and implemented. Review of the 05/22/2025 clinical admission evaluation showed no documentation Resident 195 had surgical wounds and/or required surgical wound care. Review of the 05/29/2025 skin care plan showed Resident 195 had surgical wounds to their right and left hip, pubic area and abdomen. Interventions instructed staff to administer medications as ordered, monitor dressings daily to ensure they remain intact, assess and monitor wound healing and for signs and/or symptoms of infection. During observation and interview on 06/12/2025 at 9:26 AM, Resident 195 stated the facility had not changed the dressing to their pubic area for 2-3 weeks and the current dressing was from a recent hospital visit. Resident 195 lifted their shirt to expose the undated transparent dressing over gauze, they had to their pubic area. The gauze had dark yellow drainage on it, similar in color to the urine in their urine collection bag, the gauze covered visibility of the skin underneath. In an interview on 06/13/2025 at 10:07 AM, Staff C, Resident Care Manager (RCM), explained the cart nurse and/or RCM were to review paperwork from hospital or doctor visits, and transcribe and implement any new orders into the resident's medical record. Staff C reviewed Resident 195's medical record. Staff C acknowledged the 05/21/2025 hospital transfer orders showed Resident 195 was to have surgical site wound care to bilateral hips and pubis with dressing changes every 2-3 days, but the pubis wound care orders were not processed or implemented and should have been. Staff C further stated it was important to monitor wounds for potential signs and/or symptoms of infection. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/2025 at 10:58 AM, Staff B, Director of Nursing, stated they expected staff to review provider notes and hospital paperwork, implement any orders into the resident's medical record, and update the care plan as indicated. Reference WAC 388-97-1060 (1) Refer to F842 for additional information.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care-planned restorative interventions and do periodic evaluations of current programs for 2 of 3 sampled residents (Residents 14 and 23), reviewed for restorative services (interventions developed to promote the resident's ability to achieve and maintain optimal physical, mental, and psychosocial functioning). The facility further failed to assess the need for restorative services for a resident (Resident 2). This failure placed the residents at risk for a decline in mobility and a decreased quality of life. Findings included . Review of the Facility assessment dated [DATE] documented services offered were based on resident needs. Services regarding mobility and fall prevention included transfers, ambulation, restorative nursing, contracture prevention, and supporting resident independence in doing as much of these activities by themselves. <Resident 14> In an interview on 06/10/2025 at 9:24 AM, Resident 14 stated staff did not have time to do exercises with them. The resident stated therapy showed two nursing assistants how to put their splint on and they were to show the others how to apply it, but one nursing assistant left the facility and the other felt it was not their job to do so. Resident 14 stated they were told by therapy that they had done as much as they could and it was the nursing assistants' job to do the programs. The 05/01/2025 quarterly assessment documented Resident 14 had diagnoses which included traumatic spinal cord dysfunction with quadriplegia (paralysis to arms and legs). The resident was cognitively intact and required total assistance with activities of daily living (ADL's). The assessment showed the resident was bed bound. The 05/16/2025 comprehensive care plan had the following care areas: -Resident required a splinting and ROM (range of motion) restorative nursing program related to limited ROM (quadriplegia). -Restorative program; left wrist splint to be worn at night (up to 10 hours) after ROM was completed to prevent contractures (the abnormal shortening of muscle, tendons, ligaments, or skin, leading to reduced ROM and joint stiffness). Passive ROM to right and left upper extremities from shoulders to fingers, one set of 10 ROM to each joint. The restorative program was to be reviewed routinely to validate its effectiveness and to adjust the program as indicated. A review of the Restorative task documentation completed by nursing assistants showed from 05/16/2025 to 06/13/2025, Resident 14 was not offered the passive ROM program on 05/20/2025, 05/29/2025 and 06/10/2025. The splint program showed no documentation that it was offered on 05/25/2025 through 05/26/2025, 05/31/2025, 06/06/2025 through 06/07/2025 and 6/13/2025. <Resident 23> (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 04/15/2025 quarterly assessment documented Resident 23 had diagnoses which included dementia and muscle weakness. The resident was cognitively impaired, required set up to touching assistance with ambulation and used a walker. The 05/16/2025 comprehensive care plan had the following care areas: -Resident required a restorative program related to ability to ambulate. -Restorative program; walk to dine, ambulate with walker with one person assistance, keep resident's wheelchair behind them. The restorative program was to be reviewed routinely to validate its effectiveness and to adjust the program as indicated. A review of the Restorative task documentation completed by nursing assistants showed from 05/14/2025 through 06/11/2025, Resident 23 was not offered their ambulation program on 05/14/2025, 05/19/2025, 05/31/2025, 06/01/2025 and 06/02/2025. In an observation on 06/12/2025 from 11:24 AM through 12:47 PM, Resident 23 self-propelled their wheelchair toward the dining room, up and down the hall, and then entered the dining room at 11:39 PM. The resident finished eating and wheeled themselves out of the dining room. During this continuous observation, Resident 23 was not offered to ambulate to or from the meal service. The documentation showed the resident had refused to ambulate. In an interview on 06/12/2025 at 3:55 PM, Staff J, Nursing Assistant (NA), stated nursing assistants completed the restorative programs with the residents and refusals were documented in the computer. Staff J stated it was hard to complete the restorative programs when staff called off for work. In an interview on 06/14/2025 at 6:23 AM, Staff I, NA, stated Resident 23 refused the ambulation program at times. Staff I stated they walked Resident 23 from their bed to their bathroom instead of in the hallway because the hallway distracted the resident. In an interview on 06/13/2025 at 10:26 AM, Staff C, Resident Care Manager, stated restorative programs were completed daily and documented in the plan of care. Staff C added refusals were also documented. Staff C stated it was important to do the restorative programs to maintain muscle tone, their ability to ambulate, and to prevent contractures. In an interview on 06/14/2025 at 7:49 AM, Staff O, Registered/Restorative Nurse, stated they assessed restorative programs monthly to see if they were effective and had just started documenting this in the progress notes about a month ago. Staff O stated the restorative program was not being well followed. <Resident 2> In an interview on 06/10/2025 at 9:52 AM, Resident 2 stated they used to work with therapy, and nobody was doing exercises with them. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 03/19/2025 quarterly assessment documented Resident 2 had diagnoses which included chronic obstructive lung disease (COPD, a group of lung diseases that made it difficult to breathe), neuralgia (nerve pain) and depression. The resident was cognitively impaired and required total assistance for most ADLs. The 02/12/2025 comprehensive care plan had the following care areas: -Resident has an ADL self-care performance deficit related to reduced mobility, and pain, amongst others. -The goal was for Resident 2 to improve their current level of functioning in bed mobility, transfers, dressing, eating, bathing, toileting, personal hygiene, oral care, ambulation and wheelchair locomotion. -There were no interventions to assist Resident 2 in obtaining these goals. In an interview on 06/14/2025 at 6:29 PM, Staff I stated Resident 2 did as much as they could for themselves and would benefit from a restorative program because it brought them quality of life, helped them with mobility and depression. In an interview on 06/13/2025 at 10:54 AM, Staff C, Resident Care Manager, stated restorative programs were placed when therapy was completed. In an interview on 06/13/2025 at 3:18 PM, Staff P, Physical Therapist, stated residents were placed on restorative programs when they met their goals and needed a functional maintenance program. Staff P stated Resident 2 was appropriate for a restorative program but the facility did not have the staff to do the restorative programs. Reference: WAC 388-97-1060(3)(d)

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	505251	A. Building B. Wing	06/14/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to repeatedly ensure the facility had enough staff to provide care according to the facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 7 of 10 sampled residents (Resident 98, 195, 14, 20, 28, 10, and 2), reviewed for sufficient staffing. This failure placed all residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed 02/18/2025 showed the facility had an average daily census of 40 and provided 24-hour nursing care including restorative, therapy, and behavior services. Staffing levels were based on the Washington State minimum standards and/or acuity levels. Daily staffing levels were reviewed daily to ensure sufficient staff were scheduled to meet licensed nurse coverage and meet the state requirement. Staff ratios were additionally reviewed to ensure care was provided to meet the needs of the current resident population. The facility utilized temporary contracted staff as needed. <Resident 98> According to the 05/30/2025 admission assessment, Resident 98 admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of disorders that affect movement, muscle tone, and posture) and muscle weakness. The assessment further showed Resident 98 sustained falls within the last month prior to admission and had major surgery during the prior inpatient hospital stay that required skilled nursing level of care. Resident 98 was cognitively intact and able to clearly verbalize their needs. Review of the 05/27/2025 impaired mobility care plan showed Resident 98 was at risk for falls and instructed staff to keep the call light within reach, anticipate Resident 98's needs, and respond to resident requests timely. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 98 activated their call light and experienced excessively long call light wait times on the following dates: - 05/28/2025 at 10:27 AM, 32-minutes - 05/29/2025 at 6:56 AM, 39-minutes - 05/30/2025 at 3:55 AM, 51-minutes; at 7:59 PM, 31-minutes, at 9:09 PM, one hour and 18-minutes - 06/01/2025 at 1:11 PM, 57-minutes; at 5:33 PM, one hour and 10-minutes - 06/03/2025 at 6:41 PM, 30-minutes - 06/06/2025 at 8:32 AM, 50-minute; at 6:26 PM, 54-minutes (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 06/07/2025 at 8:33 AM, 50-minutes; at 9:17 PM, 47-minutes - 06/08/2025 at 8:27 AM, 57-minutes; at 1:12 PM, 52-minutes; at 7:53 PM, 34-minutes - 06/09/2025 at 12:40 PM, 30-minutes - 06/11/2025 at 1:46 AM, 50-minutes In an interview on 06/10/2025 at 12:35 PM, Resident 98 stated staff did not want to work. Resident 98 explained they experienced excessively long call light wait times and sometimes waited over an hour. <Resident 195> According to the 05/29/2025 significant correction assessment, Resident 195 admitted to the facility on [DATE] with diagnoses including pelvis (bones at base of spine that make up the hips, buttocks and pubic area, between abdomen and thighs) fractures and muscle weakness. The assessment further showed Resident 195 underwent a major surgical procedure during the prior inpatient hospital stay that required skilled nursing level of care. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of provider orders showed an active 05/22/2025 order Resident 195 was not to bear weight on either leg. Review of the 05/22/2025 self-care performance deficit care plan showed Resident 195 was a pedestrian injured in a traffic accident resulting in fractures and instructed staff to provide maximal assistance for most of their activities of daily (ADL) needs including bed mobility, toileting, and transfers. The 05/23/2025 impaired mobility care plan showed Resident 195 was at risk for falls and instructed staff to keep the call light within reach, anticipate Resident 195's needs, and respond to resident requests timely. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 195 activated their call light and experienced excessively long call light wait times on the following dates: - 05/31/2025 at 10:57 AM, 1 hour and 24-minutes; at 2:02 PM, 1 hour and seven minutes - 06/02/2025 at 12:52 AM, 29-minutes; at 1:18 PM, 38-minutes In an interview on 06/09/2025 at 1:38 PM, Resident 195 explained they were involved in a car accident that resulted in a broken pelvis and numerous surgeries. Resident 195 stated they should not be bearing weight, but sometimes self-transferred because they experienced excessively long call light wait times, sometimes waiting over an hour for assistance. <Resident 14> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 05/01/2025 quarterly assessment, Resident 14 had diagnoses including quadriplegia (paralysis in all four limbs, meaning both arms and both legs were unable to move normally). The assessment further showed Resident 14 had range of motion impairments to bilateral (both sides) upper and lower extremities and was dependent on staff assistance to perform most of their ADLs. Resident 14 was cognitively intact and able to clearly verbalize their needs. Review of the 10/31/2023 care plan showed Resident 14 was at risk for falls related to quadriplegia and instructed staff to keep the call light within reach, anticipate Resident 14's needs, and respond to resident requests timely. The 10/31/2023 self-care deficit care plan instructed staff to encourage Resident 14 to utilize their pressure sensitive call light to request assistance. The 10/31/2023 skin care plan showed Resident 14 had pressure ulcers (wound caused by unrelieved pressure) and instructed staff to turn and reposition them every 2-3 hours, as per the individualized schedule, or as requested/allowed. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 14 activated their call light and experienced excessively long call light wait times on the following dates: - 05/14/2025 at 8:59 AM, 42-minutes - 05/15/2025 at 7:29 AM, 48-minutes; at 7:32 PM, 44-minutes - 05/16/2025 at 3:30 AM, 44-minutes; at 9:33 AM, 33-minutes; at 6:41 PM, 47-minutes; at 7:49 PM, 43-minutes, at 8:58 PM, 37-minutes - 05/17/2025 at 2:52 AM, 59-minutes, at 9:39 AM, 47-minutes, at 3:50 PM, 37-minutes - 05/18/2025 at 3:13 PM, 35-minutes - 05/19/2025 at 1:12 PM, 38-minutes; at 11:36 PM, 31-minutes - 05/20/2025 at 1:08 PM, 39-minutes - 05/22/2025 at 5:38 AM, one hour; at 6:55 PM, 42-minutes - 05/23/2025 at 10:50 AM, 50-minutes - 05/25/2025 at 11:54 AM, 34-minutes - 05/27/2025 at 8:03 AM, 40-minutes - 05/28/2025 at 6:20 AM, 52-minutes - 05/29/2025 at 7:47 AM, 31-minutes - 05/30/2025 at 3:46 AM, 36-minutes - 05/31/2025 at 12:41 PM, 31-minutes; at 1:45 PM, 31-minutes; at 9:31 PM, 40-minutes (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	06/14/2025

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 06/01/2025 at 7:11 AM, 51-minutes; at 10:17 AM, 52-minutes; at 3:07 PM, 58-minutes - 06/02/2025 at 1:58 AM, one hour and 17-minutes - 06/04/2025 at 5:54 AM, 33-minutes; at 1:26 PM, 41-minutes, at 2:22 PM, 44-minutes - 06/05/2025 at 9:58 AM, 51-minutes; at 1:16 PM, one hour and 11-minutes; at 10:03 PM, 31-minutes - 06/06/2025 at 12:51 AM, 49-minutes; at 7:55 PM, 33-minutes - 06/07/2025 at 2:02 AM, 37-minutes; at 6:59 AM, one hour and 30-minutes - 06/08/2025 at 6:03 AM, 46-minutes; at 9:07 AM, one hour and 38-minutes - 06/10/2025 at 4:24 PM, 47-minutes; at 7:04 PM, 34-minutes; at 9:23 PM, 44-minutes - 06/11/2025 at 7:12 AM, 33-minutes - 06/12/2025 at 2:55 AM, 37-minutes; at 11:31 PM, 49-minutes In an interview on 06/10/2025 at 9:13 AM, Resident 14 stated staff were often too busy to reposition them. Resident 14 explained they experienced excessively long call light wait times, waiting over an hour to have their needs addressed. <Resident 20> According to the 05/08/2025 admission assessment, Resident 20 admitted to the facility on [DATE] with diagnoses including stroke with weakness affecting their dominant side. Resident 20 was cognitively intact and able to clearly verbalize their needs. Review of the 05/02/2025 urinary incontinence care plan showed Resident 20 utilized incontinence products and instructed staff to check and change when soiled. The 05/02/2025 self-care deficit care plan instructed staff to provide cares with two staff and encourage Resident 20 to utilize their call light to request assistance. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 20 activated their call light and experienced excessively long call light wait times on the following dates: - 05/15/2025 at 11:25 AM, 44-minutes; at 3:31 PM, 38-minutes; at 7:57 PM, 45-minutes - 05/16/2025 at 11:47 AM, 30-minutes; at 7:21 PM, one hour and 18-minutes - 05/18/2025 at 5:55 AM, 37-minutes; at 7:55 AM, 56-minutes - 05/20/2025 at 12:28 PM, 36-minutes; at 3:50 PM, one hour and one-minute - 05/21/2025 at 8:09 AM, 34-minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 05/22/2025 at 11:43 AM, 33-minutes - 05/23/2025 at 8:22 AM, 35-minutes - 05/24/2025 at 12:38 AM, 35-minutes; at 6:18 AM, one hour and 12-minutes; at 9:07 AM, 36-minutes; at 10:41 AM, 53-minutes; at 1:20 PM, 39-minutes; at 3:49 PM, 36-minutes; at 4:47 PM, 34-minutes - 05/25/2025 at 12:10 PM, 34-minutes; at 2:31 PM, 48-minutes; at 6:39 PM, 34-minutes; at 11:49 PM, 32-minutes - 05/26/2025 at 8:49 AM, 41-minutes; at 1:31 PM, 49-minutes; at 5:11 PM, one hour and 24-minutes; at 8:30 PM, 41-minutes - 05/27/2025 at 8:11 AM, 40-minutes; at 9:43 AM, 51-minutes; at 4:11 PM, one hour and 11-minutes - 05/29/2025 at 1:11 PM, one hour and 22-minutes - 05/30/2025 at 8:11 AM, 58-minutes - 05/31/2025 at 5:38 PM, 40-minutes; at 8:33 PM, 49-minutes - 06/01/2025 at 8:01 AM, one hour and five minutes; at 12:55 PM, 38-minutes; at 6:15 PM, one hour and two-minutes - 06/02/2025 at 12:22 AM, 52-minutes; at 2:21 AM, 42-minutes; at 11:24 AM one hour and two-minutes; at 10:24 PM, 40-minutes - 06/03/2025 at 9:57 AM, one hour and two-minutes; at 7:27 PM, 58-minutes - 06/04/2025 at 6:25 AM, 51-minutes - 06/05/2025 at 6:05 PM, 48-minutes - 06/06/2025 at 12:47 AM, 49-minutes; at 8:21 AM, one hour and 18-minutes - 06/07/2025 at 8:34 AM, 51-minutes; at 12:04 PM, one hour and 24-minutes; at 5:57 PM, 47-minutes - 06/08/2025 at 12:40 AM, one hour and 15-minutes; at 12:55 PM, one hour and 10-minutes; at 3:44 PM, one hour; at 5:55 PM, 44-minutes - 06/09/2025 at 10:57 PM, 37-minutes - 06/10/2025 at 12:43 AM, 45-minutes; at 5:36 PM, 55-minutes; at 10:22 PM, one hour and 17-minutes - 06/11/2025 at 12:32 AM, 51-minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 06/09/2025 at 11:18 AM, Resident 20 stated the facility needed more staff. Resident 20 explained they experienced excessively long call light wait times and had waited over an hour to be changed; night shift was the worst. <Resident 28> According to the 04/04/2025 admission assessment, Resident 28 admitted to the facility on [DATE] with diagnoses including medically complex conditions and depression. Resident 28 had moderate cognitive impairment. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 28 activated their call light and experienced excessively long call light wait times on the following dates: - 05/14/2025 at 4:01 AM, 33-minutes - 05/16/2025 at 7:04 PM, 49-minutes - 05/17/2025 at 5:47 AM, 39-minutes - 05/18/2025 at 5:23 AM, one hour and 30-minutes - 05/22/2025 at 3:01 AM, 43-minutes - 06/03/2025 at 6:02 AM, 45-minutes - 06/08/2025 at 6:02 AM, 31-minutes In an interview on 06/09/2025 at 11:37 AM, Resident 28 stated the facility did not have enough staff which scared them. Resident 28 explained they experienced excessively long call light wait times; weekends were the worst. Resident 28 stated they suffered from really bad depression, they were surviving but they did not like to be rushed; it caused them to get frustrated and shut down. <Resident 10> According to the 05/08/2025 admission assessment, Resident 10 admitted to the facility on [DATE] with diagnoses including muscle weakness. The assessment further showed Resident 10 was frequently incontinent of bowel and bladder and was dependent on staff assistance for toileting hygiene. Resident 10 was cognitively intact and able to clearly verbalize their needs. Review of the 05/02/2025 urinary incontinence care plan showed Resident 10 utilized incontinence products and instructed staff to check and change when soiled. The 05/02/2025 impaired mobility care plan showed Resident 10 was at risk for falls and instructed staff to keep the call light within reach, anticipate Resident 10's needs, and respond to resident requests timely. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 10 activated their call light and experienced excessively long call light wait times on the following dates: - 05/14/2025 at 4:18 AM, one hour and 54-minutes; at 8:14 PM, 32-minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 05/15/2025 at 8:50 AM, 32-minutes; at 6:11 PM, 32-minutes; at 7:39 PM, one hour and three-minutes - 05/17/2025 at 8:29 AM, 54-minutes - 05/18/2025 at 6:42 PM, 46-minutes - 05/19/2025 at 7:09 PM, 36-minutes; at 11:36 PM, one hour and 24-minutes - 05/20/2025 at 12:27 PM, 37-minutes; at 2:07 PM, 32-minutes - 05/22/2025 at 3:13 AM, one hour and 14-minutes; at 11:42 AM, 33-minutes; at 4:45 PM, 43-minutes - 05/24/2025 at 12:59 AM, 38-minutes; at 1:37 AM, 57-minutes - 05/25/2025 at 2:38 PM, 41-minutes - 05/26/2025 at 8:33 PM, 38-minutes - 05/27/2025 at 9:48 AM, 46-minutes - 05/29/2025 at 1:17 PM, one hour and 16-minutes - 05/30/2025 at 4:04 AM, 50-minutes; at 11:48 AM, 53-minutes - 05/31/2025 at 8:13 AM, 58-minutes; at 9:45 AM, 40-minutes - 06/02/2024 at 11:23 AM, one hour and three-minutes; at 7:57 PM, 51-minutes - 06/03/2025 at 9:04 AM, 43-minutes; at 7:26 PM, 58-minutes - 06/05/2025 at 6:13 PM, 41-minutes; at 8:43 PM, 43-minutes - 06/06/2025 at 8:20 AM, one hour and 19-minutes - 06/07/2025 at 12:20 PM, one hour and seven-minutes - 06/08/2025 at 1:02 AM, 52-minutes; at 11:39 AM 49-minutes - 06/09/2025 at 3:48 AM, one hour and 20-minutes; at 9:23 PM, 37-minutes - 06/11/2025 at 12:32 AM, 51-minutes - 06/13/2025 at 5:16 AM, 58-minutes In an interview on 06/09/2025 at 11:49 AM, Resident 10 stated the facility did not have enough staff. Resident 10 explained they experienced excessively long call light wait times and had to wait a long time to have incontinence care provided when they were incontinent. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Resident 2> According to the 03/19/2025 quarterly assessment, Resident 2 admitted to the facility on [DATE] with diagnoses including spondyloepiphyseal dysplasia [rare genetic disorder that affected bone and cartilage (strong flexible connective tissue that protects bones and joints) development, leading to dwarfism and other skeletal abnormalities] The assessment further showed Resident 2 was always incontinent of bowel and bladder and was dependent on staff assistance for toileting hygiene. Review of the 02/12/2025 urine incontinence care plan showed Resident 2 utilized incontinence briefs and instructed staff to check and change when soiled. The 02/12/2025 care plan showed Resident 2 was at risk for falls and instructed staff to keep the call light within reach, anticipate Resident 2's needs, and respond to resident requests timely. The 02/12/2025 self-care deficit care plan instructed staff to provide cares with two staff and encourage Resident 2 to utilize their call light to request assistance. Review of the 05/14/2025 through 06/13/2025 call light activation log showed Resident 2 activated their call light and experienced excessively long call light wait times on the following dates: - 05/15/2025 at 1:43 PM, 42-minutes; at 7:21 PM, one hour and one-minute - 05/16/2025 at 7:08 PM, 57-minutes - 05/17/2025 at 3:31 PM, 51-minutes - 05/18/2025 at 6:21 PM, 48-minutes - 05/19/2025 at 9:48 PM, 39-minutes - 05/20/2025 at 12:08 AM, 53-minutes - 05/23/2025 at 7:02 PM, 42-minutes; at 8:17 PM, one hour and 10-minutes - 05/24/2025 at 9:07 PM, 36-minutes - 05/26/2025 at 9:24 AM, 38-minutes; at 12:58 PM, 34-minutes; at 9:23 PM, 37-minutes - 05/29/2025 at 2:10 PM, 37-minutes - 05/30/2025 at 9:34 AM, 37-minutes; at 7:09 PM, 38-minutes - 05/31/2025 at 9 AM, 35-minutes; at 7:08 PM, 37-minutes - 06/01/2025 at 1:38 PM, one hour and two-minutes - 06/04/2025 at 2:25 PM, 34-minutes; at 6:50 PM, 48-minutes; at 8:14 PM, 43-minutes - 06/08/2025 at 4 AM, 32-minutes; at 7:47 AM, one hour and 17-minutes; at 4:30 PM, 53-minutes; at 7:33 PM, 31-minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 06/09/2025 at 1:36 PM, Resident 2 stated they experienced excessively long call light wait times. Resident 2 explained they waited over an hour to have incontinence care provided; this happened in the last couple of days. In an interview on 06/10/2025 at 1:07 PM, the Resident Council stated the facility lacked staff. The Council explained they repeatedly and consistently experienced excessively long call light wait times, at times waiting an hour and a half for staff to respond to a call light when activated. The Council further stated staff would often place call lights out of their reach such as in a nightstand drawer and then close the drawer. In an interview on 06/13/2025 at 11:26 AM, Staff C, Resident Care Manager, was unsure if acuity was considered when staffing was determined but being out on the floor, it's doubtful acuity is considered. Staff C acknowledged residents, including Resident 195, had voiced concerns over lack of staffing and excessively long call light wait times. During observation on Saturday 06/14/2025 at 3:59 AM, a strong foul urine odor could be smelled on the 100-hall similar to that of an unclean urinal or porta potty (small, self-contained toilet that can be moved to different locations). The odor increased when nearing room [ROOM NUMBER] and approaching the conference room. The smell became significantly stronger and found to be emitted from room [ROOM NUMBER]. During observation and interview on 06/14/2025 at 4:03 AM, Staff U, Registered Nurse, and the surveyor walked down 100-hall and entered room [ROOM NUMBER]. Upon entering room [ROOM NUMBER], the only resident in room [ROOM NUMBER] was observed wearing a gown, with both legs hanging off the bed, the call light was under the resident's pillow, and a white pull up brief was on the floor at the foot of the bed. The brief appeared wet, thick, heavy, and odorous with discolored brown/dark colored urine. Staff U stated the resident was a heavy wetter and was to be checked on every two hours. Staff U further stated they tried to prioritize answering call lights. Staff U acknowledged waiting over an hour to answer a call light was not timely or safe, anything could potentially happen. In an interview on 06/14/2025 at 4:21 AM, Staff V, Nursing Assistant, stated excessively long call light wait times had been a concern recently. Staff V further stated waiting over an hour to answer a call light was not good, not safe, a resident could fall. In an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, explained staffing was determined based on Washington State minimum standards and acuity. Staff A stated the facility currently had a resident population who exhibited increased behaviors which required more staff to care for them. Staff A stated they expected adequate staffing coverage to meet the needs of the facility resident population. Staff A further stated a call light wait time ranging from 30-minutes up to nearly two hours was not timely. Staff A explained they could not say the wait time was unsafe because some residents preferred to have the call light on until care was provided, but anything could happen during the wait. Staff A further stated they expected staff to respond to call lights and resident needs timely. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F919 and WAC 1080 for additional information.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to develop and implement a system to evaluate staff competencies in skills and techniques to ensure staff provided necessary care and responded to each resident's individualized needs for 3 of 11 sampled staff (Staff EE, U, and FF), reviewed for nursing services. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed 02/18/2025 showed the facility had an average daily census of 40 and provided 24-hour person-centered direct nursing care including restorative, therapy, and behavior services. The facility utilized temporary contracted staff as needed. Staff competencies were reviewed and determined annually to meet the needs of all residents. The facility additionally provided just in time training for conducting one-on-one training, read and signs, small groups or all staff in-services. Competencies could be verified by skills return demonstration or post training quizzes. All staff training, competencies, and skill sets required were tracked via a computerized training system. <Staff EE> Review of Staff EE's, Nursing Assistant (NA), personnel file showed they were hired on 03/14/2025. Review of Staff EE's training records showed no documentation of training or competency on file. <Staff U> Review of Staff U's, Registered Nurse, personnel file showed they were an agency staff member. Review of Staff U's training records showed no documentation of training or competency on file. <Staff FF> Review of Staff FF's, Licensed Practical Nurse, personnel file showed they were hired on 04/25/2025. Review of Staff FF's training records showed no documentation of training or competency on file. In an interview on 06/10/2025 at 1:22 PM, the Resident Council stated the facility utilized agency staff but they don't care. The Council explained staff had been observed visiting at the nurses station, while residents experienced excessively long call light wait times. In an interview on 06/12/2025 at 11:45 AM, Staff A, Administrator, stated Staff U was an agency staff member and would have to reach out to the staffing agency for trainings and competencies because they had nothing on file. Staff A explained the previous Staffing Coordinator had not saved agency employee files. No documentation was provided. In an interview on 06/13/2025 at 11:26 AM, Staff C, Resident Care Manager, stated they were unsure of the facility process to ensure agency staff had adequate training, skills, and competencies to provide care to the facility resident population. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/14/2025 at 4:21 AM, Staff V, NA, stated they were an agency staff member and did not receive training, orientation or had their skills and/or competencies evaluated, they were only given a quick tour of the building. In an interview on 06/14/2025 at 4:34 AM, Staff GG, NA, stated they were an agency staff member and this was the first shift they had worked for this facility. Staff GG further stated they did not receive training, orientation or had their skills and/or competencies evaluated. In an interview on 06/13/2025 at 1:59 PM, Staff G, Human Resources/Staffing Coordinator, stated they were new to the role. Staff G stated they were unaware they needed to train and evaluate agency staff to ensure they had adequate skills and/or competencies and acknowledged this had not been done. In a follow-up interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expected staff to receive adequate training in order to have adequate skills and/or competencies to meet the need of the facility resident population. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F725 and F947 for additional information.

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	505251	A. Building B. Wing	06/14/2025

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to routinely complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 3 of 5 sampled nursing assistants (Staff I, L, and N), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, and a diminished quality of life. Findings included . <Staff I> Review of Staff I's, Nursing Assistant (NA), personnel file showed they were hired on 07/16/2021. No documentation of a performance evaluation was found on file. <Staff N> Review of Staff N's, NA, personnel file showed they were hired on 02/01/2022. No documentation of a performance evaluation was found on file. <Staff L> Review of Staff L's, NA, personnel file showed they were hired on 04/04/2023. No documentation of a performance evaluation was found on file. In an interview on 06/13/2025 at 1:54 PM, Staff C, Resident Care Manager, stated they were unsure how often or who completed staff performance evaluations. In an interview on 06/13/2025 at 1:59 PM, Staff G, Human Resources, stated they were unsure how often performance evaluations had to be completed. In an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expected staff to complete performance evaluations yearly, as required. Reference WAC 388-97-1680 (1), (2)(a-c) Refer to F726 for additional information.

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	505251	A. Building B. Wing	06/14/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure behavioral health care services were provided for 2 of 3 sampled residents (Residents 28 and 18), reviewed for mood and behavior. Resident 28 was not referred for behavioral health support until after they voiced wanting to die, used a dinner knife to inflict injury to their left hand and made stabbing motions to their abdomen which required transport to the hospital, and additionally requested death with dignity (allowing terminally ill individuals to choose when and how they die, often with medical assistance). This failure placed residents at risk of experiencing further decline in their mental well-being, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Behavioral Health Services revised April 2025 showed, the facility provided appropriate behavioral health services to residents identified through their individualized comprehensive assessment as needing support with their emotional well-being to attain or main the highest practicable physical, mental, and psychosocial well-being. The policy showed staff would review a resident upon resident inquiry for admission to evaluate if the resident needs matched the facility assessment and expertise. If the resident met criteria for facility admission, a plan of care was initiated to meet the resident's behavioral health needs at admission. The Preadmission Screening and Resident Review [PASRR, a two-part screening; Level I determined presence of a Severe Mental Illness (SMI) or Developmental Disability and if present required a Level II evaluation by a specialized evaluator to determine if nursing home placement was the appropriate level of care, and what behavioral health or other community services were recommended. A Level II was required to be completed prior to nursing home admission] would be reviewed for resident needs of specialized services and assist with implementing a plan as indicated. If a resident did not qualify for specialized services but required more intensive behavioral health services such as individual counseling, the facility would demonstrate reasonable attempts to provide services. Residents were assessed and monitored for signs and/or symptoms of depression, adjustment difficulties, and suicidal tendencies identifying and addressing reversible and treatable causes promptly. If a resident was identified as having a mental health disorder, the care plan would address the individualized needs a resident may have related to the disorder. <Resident 28> According to the 04/04/2025 admission assessment, Resident 28 admitted to the facility on [DATE] with diagnoses including depression and encephalopathy (condition where the brain did not function properly). The assessment further showed Resident 28 felt down, depressed, or hopeless nearly every day, and felt bad about themselves, though of hurting themselves or they would be better off dead, several days. Resident 28 had moderate cognitive impairment. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 03/25/2025 hospital progress notes showed on 03/19/2025 Resident 28 attempted to stab themselves with a butterknife, while hospitalized . Resident 28 was evaluated by psychiatry (doctor that specialized in understanding, diagnosing, treating, and preventing mental, emotional, and behavioral disorders) and Resident 28's behavior was likely largely driven by an underlying personality disorder (mental health condition characterized by long-term patterns of thinking, feeling, and behaving in a manner that significantly deviate from expectations and cause distress or impairment in daily life), and would benefit from focused outpatient therapy. Review of the 03/24/2025 PASRR level II psychiatric evaluation summary showed determinations including plan of care were made based on diagnosis and need for treatment. The evaluation showed Resident 28 made a suicide attempt during hospitalization by attempting to stab [themselves] in the abdomen with a butter knife. Resident 28 endorsed persistent depression at baseline and indicated they intended to die from the attempt due to the distress of feeling helpless about [their] medical conditions. The evaluation further showed given Resident 28's report of depressive symptoms throughout their life and multiple suicide attempts, seeking ongoing psychiatric consultation would be useful and offering counseling/therapy was recommended. Resident 28 would likely benefit from an additional psychiatric assessment for diagnostic clarification and medication evaluation to explore efficacy of medications. Review of provider orders showed active 03/28/2025 orders for a psychiatry/mental health consultation and Resident 28 to have behavioral health solutions evaluate and treat as appropriate. Review of the 03/28/2025 clinical admission evaluation showed Resident 28 was not identified as terminal with 6 months or less life expectancy. Review of the 03/30/2025 psychosocial evaluation showed Resident 28 showed no indicators of having a serious mental illness and did not want to talk about their sources of support or coping strategies used to deal with stress. Review of the 04/01/2025 depression screening interview identified Resident 28 as experiencing moderately severe depression. Review of Staff M, Medical Doctor, 04/01/2025 progress note showed they did not have any physician notes or hospital discharge summary to review, was unsure what Resident 28's diagnoses and plan of care was, and records were requested. Staff M reviewed Resident 28's depression screen and it was negative for signs and/or symptoms of depression. Review of Staff M's 04/07/2025 progress note showed Resident 28 had an adjustment disorder with depressed mood. Staff M validated Resident 28's feelings and held off on prescribing antidepressants, at that time. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/07/2025 care plan showed Resident 28 had adjustment issues related to admission and instructed staff to adjust Resident 28's routine to imitate home routines and provide them the opportunity to communicate their feelings. A 04/07/2025 depression care plan instructed staff to administer medications as ordered, help Resident 28 with constructive ways to manage feelings, monitor/document depressive symptoms, watch for indicators of suicidal ideation, and ensure Resident 28 did not have sharp objects close to them. No documentation was found to show Resident 28 was to be referred for a psychiatry/mental health consultation or evaluated by behavioral health solutions and treated, as ordered. Review of March 2025 through May 2025 nursing progress notes showed Resident 28 was anxious and agitated. On 03/29/2025 Resident 28 expressed feelings of depression stating, I want to die. Resident 28 denied having any suicide plans or intent stating, it's only up to God and nothing could help them. On 04/10/2025 911 was called at approximately 6:30 PM because Resident 28 had a dinner knife, superficially cut their left hand, attempted to stab staff when they approached to discuss the situation, and Resident 28 then took the knife like [they] were going to stab [their] stomach. Resident 28 was accompanied to the hospital by law enforcement. The hospital emergency room doctor stated Resident 28 has a long standing [history] of these behaviors and requested Staff M call them to discuss Resident 28. On 04/29/2025 staff were asked to look into Death with Dignity but Resident 28 would not qualify unless they had six months or less to live. On 05/19/2025 Resident 28 was seen and assessed by the facility mental health counselor, 52 days after admission and 39 days after the suicidal gesture with a dinner knife. No documentation was found to show Resident 28 was referred for a psychiatry/mental health consultation or evaluated by behavioral health solutions and treated as ordered, prior to 05/19/2025. Review of the 04/10/2025 hospital emergency department encounter notes showed Resident 28 presented to the hospital with depression and suicidal ideation with a suicidal gesture. Resident 28 acknowledged being depressed and thinking of suicide most days. Resident 28 cut themselves on the back of their left hand with a butter knife and made threatening statements to staff. Resident 28 was not on any therapies for depression or anxiety, an antidepressant was ordered, and facility staff were encouraged to pursue a behavioral health consultation or contact [Resident 28's] prior prescriber for guidance. Review of Staff M's 05/19/2025 progress note showed Resident 28 asked for euthanasia [the practice of intentionally ending life to eliminate pain and suffering]. The notes further showed Resident 28 was seen by the facility psychiatry who recommended continuation of antidepressant medication for emotional regulation. Staff M documented Resident 28 aortic valve stenosis (heart valve narrows making it hard for blood to flow out of the heart to the rest of the body) performance status and prognosis (likely disease outcome) was poor. Resident 28 likely had less than 6 months to live. In an interview on 06/09/2025 at 11:37 AM, Resident 28 stated I suffer from really bad depression, I am surviving, I don't have any good days. In a follow-up interview on 06/10/2025 at 3:35 PM, Resident 28 stated they were not doing well. When asked what was wrong. Resident 28 looked down at the floor with a frown on their face, and stated, no point in saying anything, nothing is going to change. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/2025 at 2:03 PM, Staff E, Social Services, reviewed Resident 28's medical record. Staff E stated Resident 28 was not cooperative, refused care, and threatened staff because they were unhappy about their admission to the facility. Staff E acknowledged Resident 28 admitted to the facility with a PASSR level II evaluation with recommendations for counseling/therapy that were not implemented or care planned timely. Staff E explained on 04/10/2025 Resident 28 attempted to cut themselves with a knife and they were care planned for plastic silverware and paper plates after the incident. Staff E further stated in May 2025 Resident 28 wanted death with dignity but I felt if [Resident 28] was more active and had a reason to live [they] might not of wanted death with dignity. Resident 28 was evaluated for death with dignity and qualified, but hospice (specialized medical care for person's nearing end of life) officially denied them to give Staff E some time to implement other interventions. When hospice re-evaluated Resident 28 for death with dignity, Resident 28 changed their mind because they had a reason to live. Staff E further acknowledged if behavioral health services including medication management would have been implemented as ordered Resident 28 might not have experienced the 04/10/2025 suicidal ideation with a suicidal gesture or requested death with dignity. In an interview on 06/12/2025 at 3:46 PM, Staff A, Administrator, stated they expected staff to provide behavioral health services per resident needs and document if and/or when services were offered and refused. <Resident 18> The 05/30/2025 quarterly assessment documented Resident 18 had diagnoses that included delusional disorder (false beliefs even when presented with evidence to the contrary), major depressive disorder, and suicidal ideation. The resident was cognitively intact, and reported depression symptoms of thoughts that they'd be better off dead, trouble concentrating, felt bad about themself, felt tired, had little energy, felt down, depressed or hopeless, and had little pleasure doing things for several days during the lookback period. The resident received an antidepressant medication daily. The 02/21/2025 admission Psychosocial Evaluation completed by Staff E, Social Services, documented Resident 18 had experienced trauma during their service in the armed forces, and summarized the resident would benefit from behavioral health services. The 02/25/2025 Care Plan had the following care areas: -Resident 18 had a potential psychosocial well-being problem related to ineffective coping due to placement in long term care. Staff were instructed to provide encouragement and support to identify problems that were not able to be controlled, allow the resident time to answer questions and verbalize their feelings, assist with identification of potential solutions to problems and consult pastoral, social and psychological services. -Resident 18 had depression. The resident needed time to talk weekly, and staff were to arrange for a psych consult and follow up as indicated. There were no behavioral health evaluations or provider progress notes in the resident's medical record. On 04/17/2025, Resident 18 signed a consent to receive behavioral health services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/2025 at 9:04 AM, Resident 18 stated they had admitted themselves to an adult psychiatric unit in January 2025 because they needed help. They stated their medications were adjusted to attempt to find an antidepressant medication that worked for them. Resident 18 stated the process was unable to be completed because they fell and injured their back and had to have surgery, then came to the facility after for rehabilitation. When asked if they had been offered any services for behavioral health, Resident 18 stated someone had just talked to them about it within the last few weeks. Resident 18 stated they were agreeable because behavioral health had helped them through a dark period in the past. During an interview on 06/12/2025 at 1:20 PM, Staff E stated their behavioral health services provider had requested a new consent for their services because Resident 18 had left the facility against medical advice (AMA) in the past. Additionally, Resident 18's insurance changed during the process. Staff E reviewed Resident 18's record and acknowledged there were no behavioral health provider progress notes in the record. Staff E stated they had obtained a consent from Resident 18 in April 2025, and that they had received an email from the behavioral health provider on 5/8/2025 after they had reviewed Resident 18 and further review per the email was pending. Staff E considered these steps in getting Resident 18 behavioral health services timely. During an interview on 06/14/2025 at 6:27 AM, Staff A, Administrator, stated getting a resident behavioral health services for residents was not dependent on insurance and stated behavioral health services were to be initiated timely. No associated WAC Refer to F628, F644 and F842 for additional information.

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	505251	A. Building B. Wing	06/14/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to timely act upon the pharmacy's monthly drug regimen reviews and/or pharmacist recommendations for identified irregularities for 2 of 5 sampled residents (Residents 6 and 11), reviewed for unnecessary medications. This failure placed residents at risk of inadequately monitored medications, potentially unidentified adverse consequences, and a diminished quality of life. Findings included . Review of the facility policy titled, Drug Regimen Review revised April 2025 showed, the facility pharmacy was to complete monthly drug regimen reviews to identify irregularities and clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medication use. The pharmacist was to review each resident's medical record once a month and provide a written report of any irregularities observed to the attending physician, medical director, and chief nursing officer. The policy showed the physician was to respond to irregularities within five business days. The attending physician either accepted and acted upon the recommendations or rejected all or some of the recommendations and documented the rationale in the resident's medical record. <Resident 11> The 05/13/2025 quarterly assessment documented Resident 11 had diagnoses including gout (a form of arthritis that caused severe pain, swelling, redness and tenderness in joints), an irregular heartbeat and depression. The Physician's Orders showed Resident 11 received Eliquis (a medication used to prevent strokes and blood clots in people with irregular heartbeats). A review of the 01/2025 note to the attending physician showed the pharmacist had recommended a uric acid level (test to determine flare ups of gout) be completed and for Eliquis to be decreased from 5 mg (milligrams) twice daily to 2.5 mg twice daily. A review of the 02/2025 note to the attending physician showed the pharmacist had again recommended the Eliquis be decreased from 5 mg twice daily to 2.5 mg twice daily. A review of the Physician's orders showed the uric acid level was not completed until 03/19/2025, 49 days after the recommendation was made, and the Eliquis was not reviewed until 05/12/2025, 104 days after the recommendation was made. In an interview on 06/12/2025 at 4:01 PM, Staff C, Resident Care Manager (RCM), stated they were unsure how much time they had to process the pharmacy recommendations but tried to complete them within a week. Staff C stated they were unsure why the recommendations were not completed timely for Resident 11. Staff C stated it was important to complete the recommendations in a timely manner for resident safety. <Resident 6> (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 03/12/2025 quarterly assessment, Resident 6 had diagnoses including stroke. The assessment further showed Resident 6 received antipsychotic (medications that affect the brain, feelings, and emotions) medications. Review of the 01/28/2025 note to attending physician showed the pharmacist was unable to locate an abnormal involuntary movement scale (AIMS, simple checklist used to assess the presence and severity of involuntary movements, particularly those that might be a side effect of certain medications) assessment in Resident 6's medical record and recommended one be completed. A handwritten 02/03/2025 note under provider response showed May do AIMS. Review of the 02/28/2025 note to attending physician again showed the pharmacist was unable to locate an AIMS assessment in Resident 6's medical record and again recommended an AIMS be completed. A handwritten 03/10/2025 note under provider response showed DO AIMS. Review of the 03/20/2025 AIMS showed Resident 6 had the assessment completed 51 days after first recommendation was made on 01/28/2025. In an interview on 06/12/2025 at 10:32 AM, Staff C, RCM, stated pharmacy recommendations should be processed/addressed timely in order to appropriately monitor residents for potential adverse consequences or effects of medication use. Staff C reviewed Resident 6's medical record. Staff C acknowledged Resident 6's pharmacy recommendations were not addressed timely and should have been. In an interview on 06/12/2025 at 3:46 PM, Staff A, Administrator, stated they expected staff to follow-up timely on the pharmacy's monthly drug regimen reviews and/or recommendations made. Reference WAC 388-97-1300 (4)(c)

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	505251	A. Building B. Wing	06/14/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were given their medications as ordered for 2 of 5 sampled residents (Residents 11 and 20) reviewed for medication management. This failure placed residents at risk of exacerbations of their chronic health conditions, and unintended consequences when doses of their medications were omitted. Findings included . <Resident 11> The 05/13/2025 five-day assessment documented Resident 11 had diagnoses including obstructive uropathy (a urinary tract disorder that occurred when urine flow was obstructed) and coronary artery disease (damage or disease in the heart's major blood vessels) and was cognitively intact. The 10/31/2024 care plan documented Resident 11 was incontinent of urine. Staff were instructed to monitor and report to the provider signs and symptoms of a urinary tract infection (UTI). The 04/11/2022 care plan documented Resident 11 received anticoagulant medication (blood thinning medication) related to a history of a blood clot to their lower extremities. Staff were instructed to administer medications as ordered, monitor side effects for medication and notify the provider if observed. A review of the June 2025 Medication Administration Record (MAR) documented medication orders and omissions: -Ciprofloxacin HCL 500 milligrams (mg) twice daily for a urinary tract infection. The medication was to start on the morning of 06/11/2025. The entry on the MAR was blank. There was a progress note that stated the medication needed to be picked up from the pharmacy. -Aspirin 81 mg daily for amaurosis fugax (a temporary loss of vision in one or both eyes due to a lack of blood flow to the retina). The entry on the MAR was blank and there was no further documentation in Resident 11's record as to why the medication was not given. In an interview on 06/14/2025 at 6:06 AM, Staff B, Director of Nursing, stated they used a pharmacy that delivered to the facility in the afternoon and on night shift and Resident 11's antibiotic would have been delivered at one of those times. Staff B stated they did not have Ciprofloxacin in the pyxis (a locked cart in the medication room that contained extra doses of commonly prescribed medications). Staff B stated they were not familiar with the pharmacy being able to satellite medications (the practice of dispensing medications from a local pharmacy) to the facility. Staff B stated Resident 11's aspirin was ordered as a capsule, and this was the reason it was not given. Staff B stated they called the nurse on 06/14/2025 and they were waiting for clarification from the provider, however, there was no documentation in the chart to support this. Staff B stated the resident care manager was gone that day and caught it the next day and changed the order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/14/2025 at 8:12 AM, a consultant from the pharmacist stated the pharmacy satellited medications if they were requested by the facility. The consultant stated they notified a local pharmacy to see if the medication was available and set up delivery. The consultant stated the facility ordered the Ciprofloxacin for regular delivery and stated there was a pharmacy in Spokane that was open 24 hours, and the medication could have been delivered in time for the first dose. <Resident 20> The 05/08/2025 admission assessment documented Resident 20 had diagnoses including high blood pressure and chronic pain and was cognitively intact. The 05/02/2025 care plan documented Resident 20 had no goals or interventions for high blood pressure. The 05/02/2025 care plan documented Resident 20 had chronic pain. Staff were instructed to administer medications as ordered and to monitor side effects for medication. A review of the June 2025 MAR documented medication orders and omissions: -Hydralazine HCL 10 mg as needed for high blood pressure. The order stated to administer if the systolic blood pressure (SBP, the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats) was greater than 160. The resident's SBP was greater than 160 on 05/16/2025 and 05/17/2025 and the MAR was blank. There was no further documentation in Resident 20's record as to why the Hydralazine was not given. -Voltaren gel applied to the left shoulder topically daily for pain. The Voltaren gel was marked unavailable on the MAR for 05/13/2025, 05/14/2025, 05/19/2025, 05/20/2025, and 05/21/2025. In an interview on 06/12/2025 at 4:06 PM, Staff C, Resident Care Manager, stated the nurses were responsible for ordering medications from the pharmacy. Staff C stated the Hydralazine should have been given and it was important to follow the parameters because that was what was best for the resident. In an interview on 06/13/2025 at 8:51 AM, Staff C stated Resident 20 should have received their Voltaren gel and this was important to provide pain relief. Reference: WAC 388-97-1060(3)(k)(iii)

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	505251	A. Building B. Wing	06/14/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to maintain an appropriate temperature in 1 of 1 medication storage rooms, ensure expired medications were removed from inventory and insulin vials were dated when opened for 1 of 2 medication carts, observed for medication storage. In addition, bottles of a liquid oral narcotic were not monitored for loss or diversion as required. This failure placed residents at risk of receiving less than the optimum dose of their medications, placed the facility at increased risk for potential controlled substance drug diversion and detracted from the facility's ability to promptly identify drug diversion. Findings included . Review of the 11/28/2017, last revised 10/15/2022, policy titled, Medication Management showed medications were discarded by the expiration date unless indicated by the pharmacy and/or manufacturer's instructions to discard sooner, labeled in accordance with facility requirements and State and Federal regulations and stored under proper conditions of sanitation, light, ventilation, segregation, and security. Narcotics were logged into a narcotic declining balance accountability system. <Medication Room Temperature> On 06/13/2025 at 8:56 AM, an observation of the medication room was conducted with Staff D, Corporate Nurse. The temperature of the medication room was 80 degrees. Staff D agreed the room was hot and asked Staff F, Maintenance Director, if something could be done. Staff F adjusted something outside of the medication room and stated that it would probably help. The Medication Room Temperature log for June 2025 showed the following temperatures: 06/05/2025 80 degrees 06/06/2025 80 degrees 06/08/2025 80 degrees 06/09/2025 80 degrees 06/10/2025 82 degrees 06/12/2025 80 degrees 06/13/2025 82 degrees In an interview on 06/14/2025 at 6:01 AM, Staff B, Director of Nursing, stated it was important to maintain the proper temperature of the medication room to ensure medications did not break down. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 06/14/2025 at 4:30 AM, Staff U, Registered Nurse (RN), opened the medication room and the temperature was 80 degrees. Staff U stated it was important to maintain an acceptable temperature in the medication room to ensure medications were kept in stable zones and did not deteriorate. <Narcotics in Medication Room> During an observation of the medication room on 06/13/2025 at 9:09 AM, there was an emergency kit that was locked in the bottom drawer of the refrigerator. The emergency kit had a zip tie from the pharmacy and contained two injectable vials of Ativan and three bottles of oral Ativan (a medication used for anxiety). Staff D stated the nurses counted the Ativan once it was opened. In an interview on 06/14/2025 at 4:30 AM, Staff U, Registered Nurse, stated the Ativan in the medication room was not accounted for. Staff U stated it was important to count the Ativan because it was a narcotic and diversion could occur. In an interview on 06/14/2025 at 7:12 AM, Staff B stated they spoke to Staff D and was told they did not have to count the Ativan. Staff B stated they were told they only had to verify the emergency kit was there and sealed with the pharmacy zip tie. In an interview and observation on 06/14/2025 at 8:23 AM, Staff B observed the emergency kit and stated they had not been counting the Ativan and acknowledged it needed to be tracked to prevent diversion. <Expired/Undated Insulin> In an observation on 06/13/2025 at 9:27 AM of the 200-hall medication cart with Staff AA, Licensed Practical Nurse, there was a Lispro insulin pen and a Glargine insulin pen that was opened on 05/14/2025, past the use by date of 28 days, and an opened Novolog insulin pen that was undated. In an interview on 06/13/2025 at 9:44 AM, Staff C stated it was important to discard expired insulin because it could impact the effectiveness of the medication. Reference: WAC 388-97-1300 (2), 2340

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	06/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to ensure bedtime snacks were offered to 6 of 6 sampled residents (Resident 18, 26, 7, 11, 20 and 1), interviewed during Resident Council. This failure placed residents at risk for hunger and potential weight loss due to the gap between meals. Findings included . In an interview on 06/09/2025 at 11:18 AM, Resident 20 stated snacks were not being stocked. Resident 20 explained they would request a snack around 10:00 PM but staff would tell them the refrigerator was empty. During the Resident Council meeting on 06/10/2025 at 1:07 PM, Resident 18 stated they went without snacks at times. Resident 18 stated the dietary manager had been making snacks but was on vacation. The resident stated applesauce, peaches, and mixed fruit were offered but none were available in the evenings. Residents 26, 7, 11, and 1 all agreed with this information. In an interview on 06/14/2024 at 4:16 AM, Staff U, Registered Nurse, stated they ran out of snacks, but it was much better than it was two months ago. Staff U stated they did not have access to the kitchen at night. When asked what they would do if a diabetic needed a snack, Staff U stated they had the same concern and it would be helpful to have access to the kitchen to get snacks. In an interview on 06/14/2025 at 6:03 AM, Staff B, Director of Nursing, stated the nurses did not have access to the kitchen at night. Staff B stated refrigerators were stocked with snacks for use at night. Staff B stated the facility had diabetic residents and needed to have snacks available when needed, including bedtime. Staff B added they had residents who ate a lot of snacks. Reference: WAC 388-97-1120 (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	06/14/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure opened dates were placed on food items in the refrigerator and freezer, expired foods were discarded in 2 of 3 refrigerators and in 1 of 1 dry storage areas, and ensure refrigerator temperatures were monitored. In addition, the facility further failed to maintain a clean cooking environment. These failures placed residents at risk for food-borne illnesses. Findings included . <Expired/undated food> During an initial tour of the kitchen on 06/09/2025 at 9:52 AM, the dry storage area revealed two opened cake mixes, a package of opened gyro bread, and a bag of opened tortilla chips with no receive or expiration date, and a container of rice crispies and froot loops cereal that expired 05/07/2025. The first refrigerator in the main kitchen contained two boxes of baking soda that expired on 03/16/2025, a bowl of molded grapes, and a stalk of partially used celery that had no receive or expiration date. The second refrigerator had a large container of opened salsa with no open or expiration date. The freezer contained opened bags of Salisbury steak, hashbrowns, tater tots, Texas toast, sausage patties and a partially eaten peach pie with no open or expiration dates. In an interview on 06/09/2025 at 10:14 AM, Staff S, Cook, stated all food items needed to be labeled with an opened and use by date so staff knew how long the food was good for. <Food Temperatures> During observation of tray line on 06/13/2025 at 11:36 AM, Staff T, Dietary Aide, pulled cottage cheese out of the refrigerator, the temperature was 42.4 degrees. Cold foods needed to be less than 41 degrees. Staff T placed the cottage cheese on a meal tray and was going to serve it to the resident. When Staff T and Staff S were asked about the temperature of the cottage cheese, Staff S stated the cold food items needed to be below 40 degrees. Staff T then removed the cottage cheese from the tray. Staff T obtained a canister of cottage cheese out of the refrigerator, and it was 42.9 degrees. He obtained a third canister of cottage cheese out of the refrigerator, and it was 40.9. On 06/13/2025 at 12:09 PM, Staff T placed a cooked hot dog on a plate and was going to serve it to a resident. Staff T was asked to take the temperature, and it was 128 degrees. Hot foods needed to be 140 degrees or greater. In an interview on 06/13/2025 at 1:11 PM, Staff T stated it was important to serve food items at the proper temperature to prevent food borne illness. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Hand Hygiene> In an observation of the tray line service on 06/13/2025 at 12:18 PM, Staff T was plating food when a nursing assistant walked into the kitchen and asked for ice cream for a resident. Staff T opened the refrigerator with their gloved hands they used to plate food, grabbed ice cream, and without removing their gloves or performing hand hygiene, continued plating food. Staff T grabbed a utensil that was touching the potatoes and then touched the rolls. In an interview on 06/13/2025 at 1:11 PM, Staff T stated gloves needed to be changed after opening the refrigerator door because there could be germs from others touching it. <Sanitary Environment> During an observation on 06/09/2025 at 9:56 AM, the floor in the dry storage area was unclean with food debris. In an observation on 06/09/2025 at 10:14 AM, the toaster had thick crumbs in the bottom, the stand that held the serving utensils had spilled food and splatter, the floor and edges of the floor near the kitchen sink had dirt and debris, the third refrigerator was unclean with spilled juices inside and splatter on the outside it, and the coffee machine had thick brown matter where the spouts were located. On 06/13/2025 at 1:02 PM, the cleaning schedules for April and May 2025 were requested from Staff T. Staff T stated they had no idea where the logs were and gave a copy of June's cleaning schedule. Review of the cleaning schedule provided showed multiple omissions. In an interview on 06/13/2025 at 1:11 PM, Staff T stated cleaning was done when staff were not cooking. Staff T stated it was important to keep the kitchen clean to prevent illness. In an observation on 06/13/2025 at 1:19 PM, the refrigerator at the nurse's station was unclean with spilled brown liquid on the bottom. The refrigerator had a temperature log with multiple omissions. In an interview on 06/13/2025 at 1:42 PM, Staff C, Resident Care Manger, stated the refrigerator needed to be cleaned weekly and the night shift nurse was supposed to keep track of refrigerator temperatures. Staff C stated the refrigerator needed to be kept clean, and it was important to monitor the refrigerator temperature so food did not spoil. Reference: WAC 388-97-1100 (3), 2980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505251	A. Building B. Wing	06/14/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident records were complete, accurate, readily accessible, and systematically organized for 3 of 4 sampled residents (Resident 28, 42, and 195), reviewed for transfer and discharge. This failure placed residents at risk of having an incomplete medical record, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Discharge and Transfer revised April 2025 showed, a resident's medical record should reflect the basis for transfer and/or discharge and should be documented before or as close as possible to the actual time of transfer or discharge. <Resident 28> According to the 04/04/2025 admission assessment, Resident 28 admitted to the facility on [DATE] with diagnoses including medically complex conditions. Resident 28 had moderate cognitive impairment. Review of April 2025 through May 2025 nursing progress notes showed Resident 28 was transferred to the hospital three times, once on 04/03/2025, 04/10/2025, and on 05/31/2025. Additional review of Resident 28's medical record showed no documentation of the hospital encounter details to include the resident's status, assessment, testing, treatment, and/or plan of care. <Resident 195> According to the 05/29/2025 significant correction assessment, Resident 195 admitted to the facility on [DATE] with diagnoses including fractures. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of May 2025 through June 2025 nursing progress notes showed Resident 195 was transferred to the hospital four times, once on 05/25/2025, 05/26/2025, 06/01/2025, and on 06/07/2025. Additional review of Resident 195's medical record showed no documentation of the hospital encounter details to include the resident's status, assessment, testing, treatment, and/or plan of care. In an interview on 06/13/2025 at 10:23 AM, Staff C, Resident Care Manager, stated hospital records should be scanned into a resident's electronic medical record to ensure the doctor had information to refer to and ensure a complete and accurate medical record. In an interview on 06/13/2025 at 10:56 AM, Staff B, Director of Nursing, stated they expected staff to scan and enter hospital visit notes into the medical record to ensure a complete and accurate medical record. In an interview on 06/13/2025 at 11:15 AM, Staff R, Medical Records, stated hospital encounter notes should be placed into a resident's medical record to ensure a complete and accurate medical record. Staff R acknowledged it was important to ensure information was readily available so the provider could review it and make pertinent treatment decisions. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expected staff to ensure facility residents had a complete and accurate medical record. <Resident 42> A 02/05/2025 Quarterly assessment documented Resident 42 had diagnoses that included stroke that affected the left side of their body. The resident was severely cognitively impaired and was dependent on staff for most of their activities of daily living. A review of nursing progress notes documented on 03/28/2025, Resident 42's spouse was notified that the resident had declined, yelled out randomly, and was eating and drinking very little. Medications to provide for Resident 42's comfort were ordered. On 04/14/2025, Resident 42 had declined to get out of bed for the previous two weeks, and their decreased food intake and fluid intake continued. On 04/15/2025, Resident 42's spouse was updated on the resident's condition, their decreased intake and that the resident slept more. On 04/18/2025 at 12:47 PM, the resident's spouse was notified of further resident decline and labored breathing. The progress note documented the resident had periods of apnea (lack of breathing), and at 6:44 PM, death appeared imminent, the resident groaned, had labored breathing, and received two doses of morphine. There were no other progress notes that documented the final events that led up to the time the resident passed, who assessed the resident to verify cessation of vital signs or determined the time of death for Resident 42 or who was notified of the resident's passing. A Record of Death document, scanned into Resident 42's record, documented Resident 42 passed away on 04/19/2025 at 8:10 AM and their body was released to the mortuary at 11:05 AM. When interviewed on 06/14/2025 at 8:04 AM, Staff A, Administrator, stated that as part of a complete medical record, they expected a progress note to be written that included the events regarding the resident's passing. Reference WAC 388-97-1720 (1)(a)(i-iv)(b) Refer to F628 and F740 for additional information.

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	06/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP, use of personal protective equipment such as disposable gowns and gloves when providing high contact types of care for residents with drains, tubes, or colonized with antibiotic resistant bacteria) were implemented when indicated for 4 of 5 sampled residents (Residents 14, 195, 96, and 11) reveiwed, and that hand hygiene and EBP were implemented during 2 of 2 medication administration observations and 1 of 1 wound treatment observations. These failures created risk that antibiotic resistant bacteria were spread from resident to resident, and created potential risk of illness. Findings included . The Centers for Disease Control and Prevention (CDC) 07/12/2002 Implementation of Personal Protective Equipment (PPE, gloves, disposable gowns, eye protection or masks, for example) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html recommended the use of EBP as an infection control intervention. EBP recommended the donning (to put on) of gowns and gloves during high contact resident care activities when other types of precautions did not apply for residents with wounds or indwelling medical devices, such as feeding tubes or catheters. High contact care activities included dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting. The facility policy Hand Hygiene reviewed 06/02/2025 documented hand hygiene was the single most important procedure for preventing the spread of infection. Opportunities for hand hygiene included before starting work, before donning gloves, entering a resident room, or before moving to a clean body site after caring for a soiled body site, and after contact with any objects in the immediate vicinity of the resident. MEDICATION ADMINISTRATION AND WOUND CARE/HAND HYGIENE <Staff AA observation> The 04/30/2025 annual assessment documented Resident 3 had diagnoses that included multiple sclerosis (MS, nerve damage that disrupted communication between the brain and the body) and obstructive sleep apnea (OSA, muscles in the throat relaxed during sleep which blocked the airway). Resident 3 was dependent on staff for most of their activities of daily living and had a urinary catheter in place (a tube inserted into the bladder that allowed urine to drain into a collection bag). On 06/13/2025 at 8:30 AM, Staff AA, Licensed Practical Nurse (LPN), was observed passing medications to Resident 3. A red sign was on the door that instructed staff to stop and check with the nurse before entering. Under the red sign was a white sign that indicated Resident 3 required use of EBP related to their catheter. Inside the door was a cart filled with PPE. Once inside the room, Resident 3 was observed lying in bed. Resident 3 wore their CPAP mask (continuous positive air pressure, pushed air into the airway that kept the airway open while sleeping) over their nose. Resident 3's urinary catheter collection bag was without a dignity cover and was on the floor. (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	06/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Without donning a gown and gloves, Staff AA placed a medicine cup of pills on the resident's overbed table, removed Resident 3's CPAP mask and placed it on their nightstand then bent over, picked up the urine collection bag and hung it on the bedframe then did not sanitize their hands. A nursing assistant (NA) entered the room and both staff donned disposable gloves only. Resident 3 was slumped down in their bed. Pillows were repositioned, the resident was pulled up in bed, and their covers were adjusted. The NA removed their gloves and exited the room. Staff AA gave Resident 3 the medicine cup wearing their same gloves and assisted the resident to take their pills. Staff AA removed their gloves, did not clean their hands, and returned to their medication cart and removed additional medications from their cart. When interviewed concurrently, Staff AA stated it was their understanding that they were to don a gown only when there was a chance they could be splashed by body fluids, such as when they emptied Resident 3's urine collection bag. Staff AA reviewed the EBP sign on Resident 3's door, and acknowledged that they should have worn PPE, as they had been in contact with a lot of the resident's environment. Staff AA acknowledged they should have completed hand hygiene after handling the resident's catheter before giving the resident their medications. <Staff X observation> During observation on 06/13/2025 at 9:02 AM, Staff X, Registered Nurse (RN), did not perform hand hygiene and dispensed medications for Resident 23. Staff X entered Resident 23's room, adjusted their bed and administered medications to Resident 23. Without performing hand hygiene, Staff X dispensed, and administered medications to Resident 35. Without performing hand hygiene, Staff X dispensed and administered medications to Resident 11. In an interview on 06/13/2025 at 9:42 AM, Staff X, acknowledged they did not perform hand hygiene when they dispensed and administered medications and should have. In an interview on 06/13/2025 at 11:03 AM, Staff B, Director of Nursing, stated they expected staff to perform hand hygiene when indicated. In an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expected staff to perform hand hygiene when indicated. <Wound Care> The 05/01/2025 quarterly assessment documented Resident 14 had diagnoses that included quadriplegia and traumatic spinal cord dysfunction. Resident 14 was cognitively intact, bed bound and required total assistance for activities of daily living such as dressing and mobility. The assessment further showed Resident 14 had two Stage 4 pressure ulcers (extensive tissue damage that extended into muscle, tendon and sometimes the bone), and had dressing changes. On 06/11/2025 at 2:48 PM, wound care was observed with Staff Q, RN, and Staff J, NA. Resident 14 was noted to have a Stage 4 pressure ulcer to their tailbone and right hip. (continued on next page)

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	505251	A. Building B. Wing	06/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff Q and Staff J put on a gown and two pairs of gloves each. Staff Q then sanitized the table with a bleach wipe, emptied the resident's garbage, put a new garbage bag in the can, removed their top pair of gloves, sanitized the first pair of gloves they had on and put a second pair of gloves on. Staff J removed phlegm from the resident's mouth, removed their top pair of gloves and put a second pair of gloves on. Staff J removed more phlegm from the resident's mouth, removed their top pair of gloves, sanitized the first pair of gloves they had on, and placed a second pair of gloves on. Resident 14 looked at Staff J and stated you look better like that, referring to the gown they wore, and asked if they had to throw it away after each use and Staff J said yes. Staff Q adjusted the catheter tubing, removed their top pair of gloves, sanitized the first pair of gloves they had on, applied a second pair of gloves, removed the old dressing to the right hip and removed their top pair of gloves. Staff Q then pulled up a syringe full of iodine and saline and flushed the wound, cleansed the wound with gauze and then removed their top pair of gloves, placed a second pair on, applied skin prep to the surrounding tissue of the wound, removed both pair of gloves and sanitized hands. Staff Q put on two pairs of gloves, applied more skin prep to the surrounding tissue of the wound, put on a new dressing, removed their gown and gloves and washed their hands. At 3:15 PM, the same day, Staff Q and Staff J put on new gowns and two pairs of gloves. Staff Q removed the dressing from Resident 14's tailbone, removed their top pair of gloves, sanitized their first pair of gloves, and put on a second pair of gloves. Staff Q cleansed the wound with normal saline, removed their top pair of gloves and put on a second pair of gloves, applied skin prep to the surrounding tissue of the wound and covered the wound with a dressing. In an interview on 06/13/2025 at 9:59 AM, Staff D, Infection Preventionist, stated the nurses should not have worn two pairs of gloves and it was not appropriate to sanitize gloves. Staff D stated after a pair of gloves were removed, hand hygiene should have been performed, and this was important to prevent the spread of infection. ENHANCED BARRIER PRECAUTIONS <Resident 14> The 05/01/2025 quarterly assessment documented Resident 14 had diagnoses that included quadriplegia and traumatic spinal cord dysfunction and was cognitively intact. Resident 14 had two Stage 4 pressure ulcers and received wound care. In an observation on 06/10/2025 at 9:08 AM, Resident 14 had an EBP sign on their door and a cart outside of their room that contained PPE. On 06/11/2025 at 9:05 AM, two nursing assistants were observed entering Resident 14's room with no PPE on. In an interview on 06/11/2025 at 9:10 AM. Staff J and Staff BB, Nursing Assistant, stated they had just repositioned Resident 14. They stated they wore PPE when they worked with the resident's catheter or colostomy bag. When Staff J and Staff BB were shown the EBP sign they stated they should have worn gloves and that the staff had never had them do that. Staff BB stated it was important to wear PPE to prevent infections. (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	06/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/11/2025 at 12:17 PM, Resident 14 was lying in bed. The resident stated the nursing assistants were now wearing gowns when they repositioned them. <Resident 195> According to the 05/29/2025 significant correction assessment, Resident 195 admitted to the facility on [DATE] with diagnoses that included pelvis (bones at base of spine that make up the hips, buttocks and pubic area, between abdomen and thighs) fractures and muscle weakness. Resident 195 underwent a major surgical procedure during the prior inpatient hospital stay that required active skilled nursing care, had surgical wounds that required wound care, and had an indwelling urinary catheter. Resident 195 was cognitively intact and able to clearly verbalize their needs. Review of provider orders showed an active 05/22/2025 order for Resident 195 to be on EBP related to catheter placement. Gowns and gloves were required for high-contact care that included dressing, bathing, transferring, toileting, changing linens, or during device or wound care. Review of the 05/22/2025 care plan documented Resident 195 was to be on EBP related to a urinary catheter. Staff were instructed to use EBP to prevent infection by using a gown and gloves during high-contact care that included dressing, bathing, transferring, toileting, changing linens, or during device or wound care. During observation on 06/09/2025 at 10:40 AM, an EBP sign was posted on Resident 195's room door with a white three drawer tote outside the room. The tote contained gloves, goggles, and booties but no gowns were found. During observation on 06/09/2025 at 2:16 PM, Resident 195 requested their urine collection bag be emptied. Staff Y, NA, performed hand hygiene and put on a pair of gloves but did not don a gown before they emptied the urine collection bag. During observation on 06/10/2025 at 12:56 PM, Staff L, NA, was observed wearing a pair of gloves but no gown while they placed Resident 195's pillow in a pillowcase, at the bedside. During an interview on 06/11/2025 at 2:44 PM, Resident 195 stated staff had never put on a gown when they touched or manipulated their catheter, changed their linens, or performed high contact care activities. During an interview on 06/13/2025 at 9:51 AM, Staff W, NA, was unable to explain what EBP consisted of. Staff W stated staff should follow precautions when indicated to prevent the spread of infection. Staff W acknowledged Resident 195 had an indwelling catheter and staff should wear stuff when dealing with bodily fluids and/or their bedding. During an interview on 06/13/2025 at 10:04 AM, Staff C, Resident Care Manager, explained EBP included the use of a gown and gloves when dealing with wounds, invasive (into the body) devices such as catheters, or performing high-contact care activities to prevent the spread of infection. Staff C stated Resident 195 had a catheter and staff should follow EBP with them. During an interview on 06/13/2025 at 11:02 AM, Staff B, Director of Nursing, stated they expected staff to follow EBP when implemented or indicated to provide proper infection control measures. (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	06/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 96> A record review documented Resident 96 was admitted on [DATE]. The comprehensive assessment was incomplete. Resident 96 had diagnoses that included a right below the knee amputation site infection and obstructive uropathy (blockage of urine flow). A review of provider orders documented Resident 96 had a peripheral inserted central catheter (PICC, a catheter inserted in the arm that extended into a major blood vessel near the heart and allowed for long-term administration of intravenous [IV] medications) and received IV antibiotics. Additionally, Resident 96 had a urinary catheter. On 06/09/25 at 11:26 AM, Resident 96 was observed asleep in bed. An IV pump with an empty bag of antibiotic and tubing hung on the pole. A urine collection bag for a urinary catheter was observed hanging on the bedframe. There was no EBP signage observed on the entrance to Resident 96's room, and no PPE at the entrance or in the resident's room. Additional observations of lack of EBP signage and PPE were made on 06/10/2025 at 10:12 AM. On 06/11/2025 at 9:26 AM, EBP signage and a PPE cart were positioned at the entrance of Resident 96's room, nine days after their admission. During an interview on 06/13/2025 at 2:58 PM, Staff D, Infection Preventionist, stated when a resident was admitted , the admission nurse reviewed the records from the hospital then posted EBP signage if indicated, but acknowledged that any of the nurses could implement EBP. <Resident 11> A 05/13/2025 five-day assessment documented Resident 11 had diagnoses that included sepsis (infection throughout the whole body) and cellulitis (infection of the skin and the tissues beneath the skin). On 06/10/2025, an order was given to provide wound care to the back of Resident 11's left thigh. Staff were to cleanse the area with normal saline, pat the area dry, apply calcium alginate (a type of dressing used to treat wounds that have moderate to heavy drainage), and cover with border-gauze every Monday, Wednesday and Friday and as needed. Resident 11's room was observed to have no EBP implemented (signage alerting staff to wear PPE) and no PPE in the vicinity available for use on 06/11/2025 at 2:32 PM, 06/12/2025 at 8:51 AM, and 06/13/2025 at 1:17 PM. During an interview on 06/13/2025 at 2:58 PM, Staff D reviewed Resident 11's orders and stated Resident 11 should have had EBP implemented related to their wound care. They notified Staff B, Director of Nursing, that EBP needed to be implemented. During an interview on 06/14/2025 at 6:10 AM, Staff A, Administrator, stated they expect staff to implement and follow EBP when indicated. Reference WAC 388-97-1320(1)(c)

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	505251	A. Building B. Wing	06/14/2025

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Colfax Health and Rehabilitation of Cascadia	1150 West Fairview Road Colfax, WA 99111

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure documentation that facility staff were provided education regarding risks and benefits associated with the COVID-19 (a highly contagious viral illness that caused potential severe illness including possible death) vaccine, that staff were offered the vaccine, and that the COVID-19 vaccine status of staff was maintained for 2 of 2 sampled staff (Staff F and Q) reviewed. This failure placed staff at risk of not receiving vaccination against COVID-19 if desired, or information to determine the vaccine risks and benefits. Findings included . The facility policy COVID-19 Vaccination for Residents and Staff reviewed 06/02/2025 documented residents, their advocates and staff were educated regarding the benefits, risks and potential side effects associated with the COVID-19 vaccine. The COVID-19 vaccines are offered to residents and staff, and the administration, education, manufacturer and adverse reactions are documented. If residents or staff have previously received the vaccine, the facility requests documentation to confirm vaccination status. A review of records documented Staff F, Director of Maintenance was hired on 06/13/2024, and Staff Q, Registered Nurse, was hired on 04/15/2024. During an interview on 06/13/2025 at 3:41 PM with Staff A, Administrator, documentation of COVID-19 vaccinations or education regarding the vaccine risks and benefits was requested for Staff F and Staff Q. Staff A stated the facility had just started auditing the resident and staff vaccination statuses. They stated that they were unsure if there was a spreadsheet with the information but if one had received the COVID-19 vaccine there would be information in the staff member's employee file. A quick search of employee files failed to find the requested information, and Staff A stated they would keep looking. At 06/13/25 4:04 PM, Staff A stated they were unable to locate COVID-19 vaccination documents for Staff F and Staff Q. They stated Staff F had never received the vaccine, and Staff Q had been called and had not gotten back to them. Reference: WAC 388-97-1320(1)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to maintain a resident call light system that was functionable and audible, as required. This failure placed all facility residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . During observation on 06/09/2025 at 11:21 AM, a call light was visibly lit up above a resident room but not audible in the hallway. Similar observations were made at 11:29 AM and 1:34 PM, on 06/10/2025 at 10:58 AM, 12:53 PM, and 2:36 PM, on 06/11/2025 at 8:48 AM, 8:59 AM, 9:07 AM and 9:32 AM. During an interview on 06/10/2025 at 1:07 PM, the Resident Council stated they experienced excessively long call light wait times, sometimes waiting over an hour. During observation and interview on 06/12/2025 at 12:04 PM, Staff F, Maintenance Director, the call light above room [ROOM NUMBER] was lit up as activated outside the resident room but no sound was heard. The call light above room [ROOM NUMBER] was activated, lit up above the resident room but again no sound was heard. Staff F acknowledged no sound was emitted when the call lights were activated. Staff F explained that the call light system would typically verbally announce what room number had the call light on. Staff F assessed the call light computer system. Staff F acknowledged the call light sound had been turned off by night shift staff to avoid disturbing the residents. Staff F was asked if the call light computer system could be locked to prevent unintended access or adjustments made to the system. Staff F was unsure if the call light computer system had the capability to limit or restrict access. Staff F acknowledged call lights needed to be audible at all times. In a follow-up interview on 06/12/2025 at 12:23 PM, Staff F stated they fixed the call light system, they were now audible. Staff F further stated they locked staff out of the system, and Staff F was now the only staff that could adjust the call light volume. During an interview on 06/12/2025 at 3:46 PM, Staff A, Administrator, stated they expected the call light system to be functionable and audible, as required. During observation and interview on 06/14/2025 at 4:03 AM, with Staff U, Registered Nurse, the call light above room [ROOM NUMBER] was visibly lit up as activated but was again not audible in the hallway. Staff U stated they were unsure why the call light above room [ROOM NUMBER] was not audible. During an interview on 06/14/2025 at 4:13 AM, Resident 195, the only occupant of room [ROOM NUMBER], stated staff turn the call lights down, so they are not audible whenever night shift comes on. During observation and interview on 06/14/2025 at 4:21 AM, Staff V, Nursing Assistant, acknowledged the call lights were audible when they started their shift last night, was unsure when the sound stopped, and acknowledged the call light above room [ROOM NUMBER] was visibly on but not audible. Staff V was asked how they ensured resident safety if and/or when the call lights were not functioning properly or audible. Staff V stated they did not leave the unit often. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and a follow-up interview on 06/14/2025 at 5:51 AM, Staff A, Administrator, a call light was visibly lit up above a resident room but again not audible in the hallway. Staff A acknowledged the call lights were not audible again and maintenance was headed to the facility. Reference WAC 388-97-2280 (1)(a) Refer to F725 for additional information.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, comfortable homelike environment for 3 of 5 sampled residents (Resident 6, 10 and 23), reviewed for environment. Specifically, the facility failed to ensure hazardous chemicals were securely stored in 1 housekeeping closet and 1 shower room accessible to Resident 6. In addition, the facility failed to ensure Resident 23's wheelchair was clean and in good repair, and Resident 10's drywall was repaired when needed. This failure placed residents at risk of potentially avoidable accidents and diminished quality of life. Findings included . <Unsecured Chemicals- Housekeeping Closet> In an observation on 06/09/2025 at 1:46 PM, the housekeeping storage closet on 200-hall was unlocked and able to be opened. The room contained chemicals that were harmful if swallowed or contacted the skin or eyes. No residents were wandering by the room. At 4:08 PM the door was locked. In an interview on 06/09/2025 at 4:10 PM, Staff Q, Registered Nurse, stated the housekeepers were the only people that had keys to that room, and it should always be locked. In an interview on 06/09/2025 at 4:14 PM, Staff F, Maintenance Director, stated the housekeeping storage closet was supposed to be locked for the residents' safety because harmful chemicals were stored there. <Unsecured Chemicals- Shower Room> According to the 05/12/2025 quarterly assessment, Resident 6 had diagnoses including dementia and had moderate cognitive impairment. The assessment further showed Resident 6 was able to perform most activities of daily living independently including walking. Review of the 09/22/2023 care plan showed Resident 6 had cognitive impairment related to dementia and instructed staff to monitor for changes in cognition. During observation on 06/11/2025 at 9:21 AM, Resident 6 walked into the unlocked shower room on 100 hall and walked back out. During observation on 06/11/2025 at 9:25 AM, the surveyor entered the shower room after Resident 6 exited. No staff were in the shower room. A tan metal box was mounted on the wall, upon opening the unlocked box, a spray bottle full of blue solution labeled as multi surface disinfectant and a container of micro kill germicidal wipes were stored inside. During observation and interview on 06/11/2025 at 9:27 AM, Staff Z, NA, the shower room on 100 hall was observed. Staff Z acknowledged the metal box that contained chemicals should be locked to prevent residents accidentally accessing the chemicals. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2025 at 9:52 AM, Staff A, Administrator, stated chemicals should be stored securely and shower rooms locked to prevent residents from entering unaccompanied by staff. <Unclean Wheelchair> The 04/15/2025 quarterly assessment documented Resident 23 had diagnoses which included dementia, anxiety and depression. The resident had severe cognitive impairments and required a wheelchair for mobility. Review of the 08/22/2022 comprehensive care plan documented Resident 23 was wheelchair bound. During an observation on 06/09/2025 at 11:04 AM, Resident 23 was lying in bed. The wheelchair was unclean with thick dirt and debris. The left armrest was torn off and there was an exposed area of padding that was an uncleanable surface. Subsequent observations of the wheelchair being unclean with thick dirt and debris and the armrest being torn off were made on 06/10/2025 at 3:43 PM, 06/11/2025 at 8:45 AM, 12:23 PM, and 2:18 PM, 06/12/2025 at 8:57 AM and 11:24 AM, and on 06/13/2025 at 8:48 AM. In an interview on 06/13/2025 at 10:24 AM, Staff CC, Nursing Assistant, stated the night shift was responsible for cleaning the wheelchairs and was unsure how often it was done. Staff CC stated if a wheelchair needed repairs they reported it to maintenance. In an interview on 06/13/2025 at 10:26 AM, Staff B, Director of Nursing, stated the night shift cleaned the wheelchairs weekly and maintenance addressed any wheelchairs that needed repairs. Staff B stated it was important to keep the wheelchairs clean and in good repair for the residents' safety, good hygiene and infection control. <Drywall in Disrepair> In an observation on 06/09/2025 at 11:49 AM, Resident 10 was sitting in their wheelchair in their room. The resident had large gouges out of their drywall next to their pillow and stated they had been there since they moved in. A subsequent observation of Resident 10's room with large gouges out of their drywall was made on 06/11/2025 at 12:13 PM. In an interview on 06/13/2025 at 10:33 AM, Staff BB, Nursing Assistant, stated they reported rooms in disrepair to maintenance and filled out an order for it to be fixed. Staff BB stated gouges out of a resident's wall could be a safety hazard and a dignity issue. In an interview on 06/13/2025 at 10:37 AM, Staff F, stated when a room needed repairs a paper or an electronic work order was submitted. Staff F stated they had not received any work orders for Resident 10's room and were not aware of the gouges to their drywall. Staff F stated it was important to keep the rooms in good repair, so the residents were more comfortable. Reference WAC 388-97-3220 (1)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to repeatedly ensure nursing assistants received a minimum of 12 hours of in-service training per year, as required to include dementia management, abuse prevention, and caring for individuals with cognitive impairment for 2 of 5 sampled staff (Staff I and L), reviewed for nursing services. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, unmet care needs, and diminished quality of life. <Staff I> Review of Staff I's, Nursing Assistant (NA), personnel file showed they were hired on 07/16/2021. Review of Staff I's training records showed no documentation they received a minimum of 12 hours of in-service training per year as required to include dementia management, abuse prevention, and caring for individuals with cognitive impairment. <Staff L> Review of Staff L's, NA, personnel file showed they were hired on 04/04/2023. Review of Staff L's training records showed no documentation they received a minimum of 12 hours of in-service training per year as required to include dementia management, abuse prevention, and caring for individuals with cognitive impairment. In an interview on 06/12/2025 at 11:54 AM, Staff A, Administrator, acknowledged some staff did not have the minimum required training. Staff A explained the computerized training system did not automatically schedule trainings when due or required. In a follow-up interview on 06/14/2025 at 6:10 AM, Staff A, stated they expected staff to receive adequate training in order to have adequate skills and/or competencies to meet the needs of the facility resident population. Reference WAC 388-97-1680 (2)(a-c) Refer to F726 for additional information.