STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505275	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colville Health and Rehabilitation of Cascadia	1000 East Elep Street Colville, WA 99114

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an allegation of potential abuse was reported as required to the State Survey Agency within two hours after the allegation was made, for 1 of 3 sampled residents (Resident 1), reviewed for abuse and/or neglect. Failure to report an allegation of potential abuse placed Resident 1, and other residents in the facility, at risk for additional abuse. Findings included .The 02/27/2026 annual assessment showed Resident 1 had diagnoses to include kidney disease. The assessment showed Resident 1 had memory impairments and difficulty making their needs known and required substantial to maximum assistance with bed mobility. The facility policy titled Abuse - Reporting and Response dated 08/25/2025, documented allegations involving abuse, neglect .will be promptly reported, investigated, and addressed in accordance with applicable Federal and State regulations. Alleged or suspected incidents involving resident abuse, neglect . must be promptly reported to the Administrator and/or Director of Nursing. Facility staff are required to immediately report any suspicion of resident abuse to their direct supervisor or another designated facility representative. If it involves a facility employee, they will promptly be removed from resident care areas and placed on suspension. Allegations that involve abuse or results in serious bodily injury to a resident, the facility is required to report without delay. The report must be submitted no later than two hours from the time the allegation was made.A facility document titled Annual Acknowledgment of Abuse reporting obligations, dated 10/01/2017, showed all staff had the responsibility to report to the State Survey Agency. The document explained how to report, time frame to report, and retaliation was prohibited to staff who reported. The document was to be read and signed annually. A 03/15/2026 progress note written by Staff A, Licensed Practical Nurse (LPN), showed Staff A heard Resident 1 yell from their room. Staff A entered the room and Staff C, Certified Nursing Assistant (CNA), was in the room and appeared to have finished care for the resident. Resident 1 started to yell keep her away from me! Staff A asked the resident what happened and the resident replied, look at my arms. Staff A observed skin tears on the resident's left and right wrist and back of the right arm. Staff A then asked Staff C what happened to the resident's arms and Staff C replied, they were like that when I got here. After Staff C left the room, the resident stated they were scared to be alone and wanted to leave. A facility investigation dated 03/15/2026, showed Resident 1 reported Staff C had hurt them during care. Staff B, Director of Nursing Services (DNS), documented an investigation was started upon discovery of the incident and the State Requirement for reporting was followed. After the investigation was conducted, it was concluded the resident had an unexpected/unavoidable accident related to mishandling during care and a bed change. All staff were educated on safe handling and how to make an occupied bed. Staff C received the training individually as well as additional training. Review of the State Survey Agency Secure Tracking and Reporting System (STARS), showed Staff B had called in an allegation of injury of unknown source for Resident 1 on 03/15/2026 at 9:07 PM. The alleged abuse occurred at 5:00 AM on 03/15/2026.On 04/07/2026 at 1:55 PM, Staff A was interviewed and stated it was around 5:00 AM on 03/15/2026 when they heard Resident 1 scream. Staff A went into the resident room, and Staff C had just finished care. The resident yelled keep her away from me and was very upset. Staff A asked Staff C what (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened and Staff C stated the skin tears were already there and left the room. After Staff C had left, Resident 1 said they were scared to be alone. Staff A stated the skin tears looked like they had just happened. Staff A was asked if they thought this was potential abuse, Staff A stated yes, and they had called Staff B to report it to them. Staff A went on to say the resident was very lucid (something is clear, easy to understand, or rational) at the time of the incident and was really scared. Staff A was asked if they called the allegation of abuse into the State Survey Agency as a mandatory reporter, Staff A said they hadn't. Staff A stated staff were to report allegations to management and management would call the State.On 04/07/2026 at 2:27 PM, Staff D, Registered Nurse (RN), was asked what they would do if a resident reported an allegation of abuse. Staff D stated they would make sure the resident was safe and remove the staff member away from the resident. Staff D would then let Staff E, Administrator, or Staff B know. When Staff D was asked if they would call the State Survey Agency as a mandatory reporter, Staff D stated they would confer with Staff B or Staff E before they would call the state. On 04/07/2026 at 2:34 PM, Staff F, CNA, was asked what they would do if a resident reported an incident of abuse. Staff F stated management would be told and then management called the state unless it was severe enough of an allegation then they would call. On 04/07/2026 at 2:38 PM, Staff G, CNA, was asked what they would do if a resident reported an incident of abuse. Staff G stated they would report it to their assigned nurse. When asked if they would call the state as a mandatory reporter, Staff G stated they would just report to their assigned nurse and then it would go up the chain of command from there. On 04/07/2026 at 2:40 PM, Staff H, Resident Care Manager (RCM) and Staff I, RCM, were asked what the process of reporting an allegation of abuse and/or neglect was. Staff H stated staff were to immediately report it to Staff E, the Abuse and Neglect Coordinator. When asked if staff were to report it to the State Survey Agency, both Staff H and Staff I stated Staff E was the one that called the state.On 04/07/2026 at 2:54 PM, Staff E and Staff B were interviewed. Staff E was asked what the process was when a staff member suspected potential abuse. Staff E stated staff would make sure the resident was safe, let their assigned nurse know, notify the provider, and an investigation would be started. Staff E would be notified since they were the Abuse and Neglect Coordinator and would call the state if abuse was suspected. Staff E stated Administrative staff were available all hours for staff to call if there was an allegation of abuse and/or neglect. When asked about other staff calling the State Survey Agency, Staff E stated all staff were mandatory reporters and could call the State hotline and that staff received training on mandatory reporting in their yearly training for abuse and neglect. Staff B stated they had received a call from Staff A on 03/15/2026, who reported Resident 1 had new skin tears and requested Staff B come to the facility to look at the resident. Staff B stated they immediately went to the facility and interviewed Staff A, Staff C, and Resident 1. Staff B stated Resident 1's skin tears appeared to be new since they were bright red and had no scabbing. Staff B stated they could not validate if Staff C was the source of the injury, so the skin tears were determined to be an injury of unknown origin, and it was called in within the 24 hours as required. Reference: WAC 388-97-0640(5)(a)