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	07/01/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to routinely provide pharmaceutical service that ensured accurate dispensing and administration of medications for 3 of 3 sampled residents (Resident 1, 2, and 3), reviewed for medication administration. This failure placed residents at risk for potential medication errors, misappropriation of opioid medications (also referred to as narcotic, powerful pain medication used to treat severe pain) and diminished quality of life.Findings included.Review of the facility policy titled, Medication Administration, revised September 2025, showed all staff authorized to administer medications must follow the 10 rights of medication administration to ensure resident safety, reduce medication errors, and maintain compliance with federal and state regulations. The policy listed the 10 rights of medication as 1) Right Medication- verify the medication against the provider's order and the Medication Administration Record (MAR), 2) Right Resident- use identifiers such as photo along with verbal confirmation, 3) Right Dose- confirm the dose with the MAR and provider's order, 4) Right Route- confirm the prescribed route of administration, 5) Right Time and Frequency- administer medications as scheduled, 6) Right Documentation- promptly document in the resident's medical record after administration, 7) Right Assessment- assess the resident's condition before administration as applicable, 8) Right to Refuse- respect the resident's right to refuse, 9) Right Evaluation- monitor response and follow-up on as needed medication use for effectiveness, and 10) Right Education- inform the resident about the medication's purpose, expected effects, and possible side effects.<Resident 1>According to the 06/12/2026 quarterly assessment, Resident 1 had diagnoses that included chronic pain. The assessment further showed Resident 1 was frequently in pain and received opioid pain medication.Review of provider orders showed an active order dated 06/09/2026 for Resident 1 to receive hydrocodone (opioid or narcotic pain medication) every six hours as needed for pain.Review of the June 2026 hydrocodone narcotic tracking log showed the pain medication was removed from Resident 1's supply for administration on 06/01/2026 at 7:30 AM, 06/04/2026 at 7:30 AM, 06/05/2026 at 7:15 AM, 06/10/2026 at 8:30 PM, 06/12/2026 at 7:30 AM, 06/13/2026 at 8:00 AM, 06/17/2026 at 7:00 AM, 06/18/2026 at 7:30 AM and 7:30 PM, 06/20/2026 at 9:30 PM, 06/23/2026 at 7:30 AM, 06/26/2026 at 7:30 PM, 06/29/2026 at 8:24 PM, and on 06/30/2026 at 8:35 AM and 6:57 PM.Review of the June 2026 MAR showed no documentation Resident 1 was administered hydrocodone on 06/01/2026 at 7:30 AM, 06/04/2026 at 7:30 AM, 06/05/2026 at 7:15 AM, 06/12/2026 at 7:30 AM, 06/13/2026 at 8:00 AM, 06/17/2026 at 7:00 AM, 06/23/2026 at 7:30 AM, 06/26/2026 at 7:30 PM, 06/29/2026 at 8:24 PM, or on 06/30/2026 at 8:35 AM or 6:57 PM. The MAR further showed Resident 1 was administered hydrocodone on 06/10/2026 at 7:10 PM (one hour and 20 minutes prior to the medication being removed from the resident supply), on 06/18/2026 at 6:56 AM (34 minutes prior to the medication being removed from the resident supply) and 7:05 PM (25 minutes prior to the medication being removed from the resident supply), and on 06/20/2026 at 7:15 PM (two hours and 15 minutes prior to the medication being removed from the resident supply).During observation and interview on 07/01/2026 at 11:44 AM, Resident 1 stated they had no concerns related to their pain management. Resident 1 showed no verbal or non-verbal signs of pain.<Resident 2>According to the (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/21/2026 quarterly assessment, Resident 2 had diagnoses that included toe pain. The assessment further showed Resident 2 was occasionally in pain and received opioid pain medication.Review of provider orders showed an active order dated 05/06/2026 for Resident 2 to receive hydrocodone every six hours as needed for pain.Review of the May 2026 and June 2026 hydrocodone narcotic tracking log showed the pain medication was removed from Resident 2's supply for administration on 05/11/2026 at 1:00 PM, 05/21/2026 at 8:30 AM, 05/27/2026 at 1:50 PM, 06/07/2026 at 8:00 PM, 06/08/2026 at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM, on 06/09/2026 at 6:00 AM, 7:30 AM, 10:15 AM, 1:30 PM, 5:40 PM, and 10:00 PM, on 06/15/2026 at 4:40 PM and 10:55 PM, and on 06/16/2026 at 6:15 AM and 12:30 PM.Review of the May 2026 and June 2026 MAR showed no documentation Resident 2 was administered hydrocodone on 05/11/2026 at 1:00 PM, 05/27/2026 at 1:50 PM, 06/07/2026 at 8:00 PM, 06/08/2026 at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM, on 06/15/2026 at 4:40 PM and 10:55 PM, or on 06/16/2026 at 6:15 AM and 12:30 PM. The MARs further showed Resident 2 was administered hydrocodone on 05/21/2026 at 7:20 AM (one hour and 10 minutes prior to the medication being removed from the resident supply), and on 06/09/2026 at 7:00 AM, 1:00 PM, and 5:13 PM (six doses were removed from the resident supply this day but only three doses documented as administered).During observation and interview on 07/01/2026 at 9:16 AM, Resident 2 denied concerns with their pain management. Resident 2 showed no verbal or non-verbal signs of pain.<Resident 3>According to the 05/29/2026 discharge assessment, Resident 3 had diagnoses that included shoulder and back pain. The assessment further showed Resident 3 was occasionally in pain and received opioid pain medication.Review of provider orders showed an active order dated 05/01/2026 for Resident 3 to receive oxycodone (opioid pain medication) every eight hours as needed for pain.Review of the May 2026 oxycodone narcotic tracking log showed the pain medication was removed from Resident 3's supply for administration on 05/18/2026 at 3:30 PM, 05/20/2026 at 6:30 AM and 11:00 AM, on 05/22/2026 at 5:30 PM, and on 05/28/2026 at 5:40 PM.Review of the May 2026 MAR showed no documentation Resident 3 was administered oxycodone on 05/18/2026 at 3:30 PM, 05/20/2026 at 11:00 AM, 05/22/2026 at 5:30 PM, or on 05/28/2026 at 5:40 PM. The MAR showed Resident 3 was administered oxycodone on 05/20/2026 at 6:06 AM (24 minutes prior to the medication being removed from the resident supply).During an interview on 07/01/2026 at 12:59 PM, Staff E, Nursing Assistant, stated if a resident reported pain, they would notify the nurse on duty so they could follow up.During an interview on 07/01/2026 at 2:20 PM, Staff D, Registered Nurse, stated when a resident voiced pain, the nurse was to assess the source of the pain and provide nonpharmacological interventions. Staff D explained that if a narcotic pain medication was administered, the nurse should follow the rights of medication administration which included verifying the provider order and ensuring the right medication was administered to the right resident at the right dose. Staff D stated narcotic medication needed to be signed out of the narcotic tracking log as well as ensuring the correct date and time the medication was administered was documented in the MAR. Staff D acknowledged if medication administration was not documented accurately, it could result in potential medication errors.During interview and record review on 07/01/2026 at 2:30 PM, Staff C, Resident Care Manager, stated when a resident voiced pain, the nurse was to assess the pain. Staff C explained if a narcotic pain medication was to be administered, the nurse was to follow provider orders and verify the right medication was administered to the right resident at the right dose. Staff C further stated narcotic pain medication needed to be signed out of the narcotic tracking log as well as document the correct date and time the medication was administered in the MAR because it could cause potential medication errors if not documented accurately. Staff C reviewed Resident 1 and 2's medical records. Staff C acknowledged there were numerous discrepancies between the narcotic tracking log and the MAR.During interview and record review on 07/01/2026 at 3:00 PM, Staff B, Director of Nursing, stated nurses were expected to follow the facility medication administration policy when administering medications. Staff B further stated if a narcotic medication was administered, nurses were to sign the medication out of the narcotic (continued on next page)

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