STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505320	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Crest Center	1100 East Nelson Road Moses Lake, WA 98837

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 11 residents (Resident 35) reviewed for neglect. Resident 35 experienced harm when staff failed to provide Resident 35 water when requested, failed to assess skin excoriation (loss of the top layer of the skin and a portion of the middle layer of the skin due to scratching or an injury) to Resident 35's coccyx (tailbone) and perineum (the area between the thighs that marks the approximate lower boundary of the pelvis and is occupied by the urinary and genital ducts and rectum), and administer pain medications as needed at their end of life per Resident 35's advanced directive (a legal document that outlines preferences for medical care in the event you are unable to communicate your wishes). These failed practices placed the residents at risk for dehydration, additional skin breakdown, and continued pain. Findings included . Review of a policy titled, Abuse Prohibition, dated 10/24/2022, defined neglect as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods, and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes the failure to implement an effective communication system across all shifts for communicating necessary care and information between the Center, patient, practitioners, and patient representatives. <Resident 35> Review of the medical record showed Resident 35 was admitted to the facility on [DATE] with diagnoses of Clostridium Difficile (a bacteria that causes diarrhea and other intestinal issues), malnutrition, and severe sepsis with septic shock (a life-threatening condition that occurs when the body's response to an infection progresses to a dramatic drop in blood pressure). The 11/11/2024 comprehensive assessment showed Resident 35 was dependent on one to two staff members for activities of daily living; touch assistance/supervision for eating. The assessment also showed Resident 35 had a moderately impaired cognition. <Water> (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/13/2024 at 11:38 AM, Resident 35 was lying on their back in bed with their right arm outstretched, reaching towards their water cup on the bedside table. They were calling out ahh and ow. At 11:48 AM, Resident 35 was observed with the back of their hand against the water cup and was calling out water, water. At 11:50 AM, the first observation of staff hearing the resident's request for water, Staff C, Nursing Assistant (NA), walked past the resident's room and did not acknowledge their request for water. At 11:51 AM, Staff E, Director of Rehab/Physical Therapy Assistant (PTA), Staff N, NA, and Resident 52 (a resident that resided in the same hall as Resident 35) were in the hall outside of Resident 35's room, having a conversation. Staff E stated to the resident in the hall, I have a protein cafe latte for (Resident 35) today, I have it in the refrigerator and will give it to them later as Resident 35 was continuously calling out for water. Resident 52 wheeled themselves into Resident 35's room. Staff E told Resident 52 that was not their room, and the resident responded, I am going to check on them, entered Resident 35's room, and was observed talking to Resident 35 and patting their arm. Staff E and Staff N both left the area without responding to Resident 35's requests for water. At 11:55 AM, as Resident 35 was still calling out for water and reaching for their water cup, Staff C and Staff N were observed outside Resident 35's room, donning gown and gloves to enter the room next to Resident 35. Neither Staff C nor Staff N acknowledged Resident 35's requests for water. At 12:03 PM, Resident 52 was observed putting Resident 35's call light on, exited the resident's room, and stated to Staff O, NA, who was walking past Resident 35's room, Resident 35 wants water, needs water, I can't do it for them. At 12:07 PM, Resident 35 was observed still crying out for water. Staff O, again walked past Resident 35's room. They did not acknowledge the activated call light or Resident 35's requests for water. At 12:11 PM, Staff P, Licensed Practical Nurse (LPN), entered Resident 35's room, as they were continuously calling out for water. Staff P turned off the call light and stated, you need a drink of water? and exited the room without giving the resident water. At 12:16 PM, Staff N entered Resident 35's room with their lunch tray. Resident 35 yelled out water. Staff N stated, you need to wait a minute I have to go gown up. At 12:21 PM, Staff N re-entered Resident 35's room and gave the resident a drink of water, 31 minutes after staff first heard Resident 35 calling out for water. During an interview on 11/13/2024 at 12:50 PM, Staff P stated they went into Resident 35's room earlier that day to answer the call light and were going to get Resident 35 a drink of water. They stated they were going to put ice in their cup, left the room, and got sidetracked. Staff P stated the process for answering call lights was to turn them off when entering the room, then take care of the resident's need. They stated they turned the call light off because they did not want other family members or administrative staff to see that call lights were not being answered. During an observation on 11/15/2024 at 9:47 AM, Resident 35 was lying on their back in bed, their eyes and cheeks and were sunken in. Their mouth was open, their tongue and lips were dry and cracking. Their bottom lip was adhered to their bottom teeth and had a white film over it. Resident 35 stated yes when asked if they were thirsty and if they were in pain. Resident 35 was not able to state where their pain was located. <Skin> Record review of a NA assignment sheet, dated 11/10/2024, showed the NA had documented on their sheet that Resident 35 had extreme skin breakdown. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of a nursing progress note, dated 11/10/2024 at 9:29 PM, showed Staff Z, LPN, documented Resident 35 had an excoriated perineum that had an open area on the vulva (external female genital organs) that was bleeding that evening when the NA was providing incontinent care. During an interview on 11/15/2024 at 11:46 AM, Staff C stated they had reported Resident 35's skin maceration (the process of skin softening and breaking down due to prolonged exposure to moisture) to Staff F, Unit Manager (UM), on 11/11/2024. Staff C stated that morning, they were performing personal cares for Resident 35 and their skin was just wiping off. They stated Staff M, Registered Nurse (RN)/Infection Preventionist (IP) had been passing by Resident 35's room during the cares, and they asked Staff M to look at the macerated skin. Staff M advised them to use warm water to remove the thick paste that was covering the wound, but did not assess the wound. During an interview on 11/15/2024 at 12:18 PM, Staff F stated Resident 35 had the maceration from incontinence and sweating. They stated they were informed of the maceration on Tuesday (11/12/204) or Wednesday (11/13/2024). They stated they were informed of redness by maybe an aide but did not assess the areas. During an interview on 11/16/2024 at 9:07 AM, Staff M stated they were asked to look at Resident 35's perineum on either 11/11/2024 or 11/12/2024. They stated they were called into the resident's room by two NAs to assess the areas of concern. Staff M stated there was a thick layer of what looked like powder that had gotten wet, caked on Resident 35's perineum. Staff M stated there was so much powder and wet stool, they were unable to see any of the wound area. Staff M stated they did not assess the wound area. Review of a nursing progress note, dated 11/14/2024 at 7:15 AM, showed Staff B, Senior Director of Nursing, and Staff F assessed Resident 35's perineum and buttocks area, four days after the initial report of skin breakdown. Resident 35 had front peri area that is inflamed and reddened in color with erosion (occurs when the skin's outer layers break down) of skin folds, bilateral (both sides) buttocks have superficial (occurring on the surface) open areas . During an interview on 11/16/2024 at 2:24 PM, Staff Z stated they had reported the perineum concerns to the Registered Nurse that was on duty that night so they could assess Resident 35's condition. <Pain> An observation on 11/15/2024 at 10:01 AM, showed Staff C, Staff Q, NA, Staff O, and Staff R, LPN, outside Resident 35's room, putting on gowns and gloves. The staff entered the room and began to perform incontinent care for Resident 35. Observation of the resident's perineum showed severely macerated (softening and breakdown of the skin due to prolonged exposure to moisture or fluid) tissue that was bright red. As Staff C cleaned the perineum with cleansing wipes, Resident 35 squeezed their eyes shut, cried out in pain, made a fist with their left hand, and repeatedly punched Staff Q in the right forearm. Staff O stated they were training Staff R and stated to Staff R that they kept up on Resident 35's pain medication and were able to administer pain medications every eight hours as needed (provider order showed pain medication was to be given every six hours as needed). Staff O stated they were going to get Resident 35 an oxycodone (a medication used to treat moderate to severe pain) since it was time for their next dose (their last dose had been given at 3:23 AM). Staff O did not administer Resident 35 a pain medication, despite stating they would. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a provider progress note, dated on 11/14/2024 at 9:30 AM, showed Resident 35's provider had assessed them for an acute visit due to decreased activity, worsening pain, and progressive skin changes to their perineum. The provider note showed the resident was unable to feed themselves and had significant pain with repositioning. Resident 35 was observed laying in bed on left side with mouth open, dry mucous membranes. Patient unable to reposition self, due to weakness. The assessment showed their skin was macerated and erythematous (abnormally red skin due to inflammation) rash on buttocks, inner thighs, and bilateral labia (the folds of skin at the outer part of a woman's sexual organs), superficial sloughing (shedding) of dermal (skin) layer on buttocks bilaterally, roughly two to three centimeters (a unit of measurement) in circumference. Resident 35 had a new diagnosis of dermatosis (disease of the skin) of perineum consistent with atopic dermatitis (a condition of the skin that causes inflammation, redness, swelling, and cracking of the skin) reaction from their current conditions of c-diff colitis(inflammation of the large intestine), recurrent diarrhea/watery stools and sweat. Record review of a Nurse Practitioner (NP) provider note, dated 11/15/2024 at 9:30 AM, showed Resident 35 was seen to follow up on concerns of moisture associated skin damage [(MASD) a general term for inflammation of skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, or sweat] of the genital area. The resident was unresponsive and quietly moaning (indicative of discomfort or pain). They were lying in bed, mouth open with dry mucous membranes. Resident 52 was unable to reposition themselves due to weakness and was moaning. Their genitourinary (organs of the urinary and genital system) area was excoriated, and red. New medications were ordered for pain, to be administered every two hours as needed, and anxiety, to be administered every four hours as needed. Review of the November 2024 Medication Administration Record, showed Resident 35 had received one dose of Tylenol (an over the counter medication to treat mild to moderate pain) on 11/15/2024 at 1:41 AM with ineffective results. They received one dose of oxycodone (a prescription pain medication used to treat severe pain) on 11/15/2024 at 3:23 AM, despite Staff O stating they would give a pain medication at 10:01 AM that morning. The facility did not provide Resident 35 any additional medications for pain control prior to them passing away at 9:00 PM, 17.5 hours after their last dose, despite the NP noting Resident 35 had been moaning that morning and had ordered additional medications for pain and anxiety. Record review of Resident 35's Advance Directive dated 12/12/2023, showed it is my desire that pain alleviation or control procedures or medication be administered and continued, and that as long as I live, I be kept as pain-free and comfortable as is reasonably possible. During an interview on 11/19/2024 at 10:27 AM, Staff B stated the process for change in condition did not happen for Resident 35. The new medications for pain and anxiety should have been pulled right away from the Pyxis (a medication dispensing system) and given. Advance Directives were reviewed upon admit by social services and that information should have been communicated to the unit manager. Staff B stated the provider should have been contacted sooner to address those concerns. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/19/2024 at 12:11 PM, Staff A, Administrator, stated they would have expected the staff to administer Resident 35 water, even if we had to have staff sit with (them). They stated the process for any skin change was to report it immediately to the licensed nurse, unit manager, and provider. They stated the process for Advance Directives included a review by Staff B to ensure that all the orders were being followed; that is (their) department and (their) duty. Staff A stated the facility did not follow their processes. Reference: WAC 388-97-0640(1)