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	05/29/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on observation, interview, and record review, the facility failed to ensure residents were able to use personal possessions in their room, specifically a personal refrigerator, that did not infringe on the rights of other residents for 1 of 3 residents (Resident 2) reviewed for resident rights. This deficient practice placed residents at risk of feeling emotional distress and retaliated against. Findings included . Review of the facility policy, Refrigerators: Patient In-Room, revised 08/07/2023 showed residents could have a small [two cubic feet (unit of measurement) or less] personal refrigerator in their room, and the document In Room Refrigerator Acknowledgment would be provided to inform the resident of their right to store food in the refrigerator and the process to do so. <Resident 2> Review of the medial record showed Resident 2 admitted to the facility on [DATE] with diagnoses of multiple sclerosis (a disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain and spinal cord) and depression (a common but serious mood disorder that can affect how you feel, think, and act). Review of the comprehensive assessment, dated 03/21/2025, showed Resident 2 was cognitively intact and required the assistance of two people for personal cares, bed mobility, transfers, and toileting. Review of the nursing progress note (PN), dated 05/08/2025 at 4:47 PM, showed Staff A, Administrator, informed Resident 2 they could not have the refrigerator Resident 2 had purchased online and had delivered to the facility. During an interview, on 05/27/2025 at 4:45 PM, Staff B, Affiliated Administrator, stated the facility policy allowed residents to have personal refrigerators in their room and they were unaware of any recent change to the policy. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 05/27/2025 at 5:05 PM, Resident 2 stated they had purchased a refrigerator online and had it delivered to the facility on [DATE], but was told they could not have it in their room. Resident 2 arranged for their family to pick up the refrigerator on 05/11/2025, but staff was unable to locate the refrigerator. Resident 2 stated they had not been updated regarding their missing property. Review of the nursing progress note (PN), dated 05/27/2025 at 9:28 PM, showed Staff C, Director of Nursing, met with Resident 2 regarding their personal refrigerator. Staff C informed Resident 2 their refrigerator was located in Staff C's office and could be picked up at any time. Staff C explained per facility policy, Resident 2 could have a personal refrigerator in their room, but the one Resident 2 had purchased was too big (3.2 cubic feet; equivalent to 18.5 inches by 19.4 inches by 33.3 inches). During an observation, on 05/29/2025 at 10:30 AM, personal refrigerators were noted in rooms [ROOM NUMBERS]. During a concurrent observation and interview, on 05/29/2025 at 10:35 AM, Resident 2 showed they currently had a very small personal refrigerator (0.3 cubic feet) but wanted one with a freezer component. Resident 2 stated Staff C met with them on 05/27/2025 and explained they could have a personal refrigerator that was 2.0 cubic feet or smaller. Resident 2 stated they appreciated the clarification because the conversation with Staff A on 05/08/2025 left them believing they could not have a personal refrigerator at all and overall felt retaliated against. During an interview, on 05/29/2025 at 1:10 PM, Staff C stated the facility policy showed Resident 2 had the right to keep a personal refrigerator in their room, and the policy should have been explained to Resident 2 in a more thorough and clear manner. Reference: WAC 388-97-0560 (1)(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on observation, interview, and record review, the facility failed to provide supervision, monitoring and/or modification of interventions related to safe smoking for 1 of 2 residents (Resident 1) reviewed for accidents and hazards. This deficient practice placed Resident 1 at an increased risk for avoidable smoking accidents, injuries, and unmet care needs. Findings included . Review of the facility policy, titled Smoking, revised 02/24/2025, showed residents who smoked would have a care plan outlining the elements needed for supervision and physical assistance while smoking, and facility leadership would consider special accommodations on an individual basis. <Resident 1> Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of hemiparesis of the right side (paralysis of right side of body) from a stroke and epilepsy (a brain disorder causing repeated seizures). Review of the comprehensive assessment, dated 03/05/2025, showed Resident 1 had moderately impaired cognition, required the assistance of two people for bed mobility, incontinent care, transfers, bathing, and was independent with mobility when up in their manual wheelchair. Review of the medical record showed a Smoking Evaluation, dated 02/05/2025, identified Resident 1 to be unsafe to smoke independently-supervised smoking required, and showed Resident 1's family refused to purchase or provide smoking supplies and/or paraphernalia (items or equipment associated with a particular activity, hobby, or lifestyle). Review of the facility incident log for March 2025, April 2025, and May 2025 showed Resident 1 sustained a self inflicted injury on 03/22/2025 and an unobserved injury on 05/24/2025. Review of the 03/22/2025 incident investigation showed Resident 1 was found to have a small burn hole on the bottom of their shirt and a corresponding circular pink area to their inner left thigh. The investigation showed Resident 1 stated they were smoking independently and had dropped their cigarette on their lap causing the burn. Review of the investigation summary, dated 03/25/2025, showed Resident 1 had been observed attempting to pick-up left-over cigarettes from other residents in the designated smoking area and was the likely cause of the burn hole and pink area to their inner left thigh. The inventions to prevent reoccurrence was to continue to encourage smoking cessation, provide Resident 1 education regarding the smoking policy and the requirement for supervision when smoking, and to encourage Resident 1 to not pick-up left-over cigarettes. Review of the 05/24/2025 incident investigation showed Resident 1 was found with a fluid filled blister to right inner thigh. The investigation showed Resident 1 stated the blister was from smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/2025 at 3:50 PM, Resident 1 stated they were given a cigarette from a friend and was smoking independently when they dropped the cigarette in their lap. Resident 1 stated they did not give permission for facility staff to assess the blister. During an interview on 05/28/2025 at 10:15 AM, Staff E, Licensed Practical Nurse (LPN), stated they tried to monitor Resident 1 when they were outside in the courtyard smoking designation area. Staff E stated Resident 1 was persistent with their desire to smoke and would ask other residents and visitors for cigarettes. Staff E stated Resident 1 was not safe to smoke independently and if they had the means to smoke, Resident 1 would need supervision to be safe. During an interview on 05/28/2025 at 10:55 AM, Staff F, Nursing Assistant (NA), stated the interventions to keep Resident 1 safe was to encourage and try to prevent them from smoking. Staff F stated they did not feel this approach was effective because Resident 1 continued to ask other residents and visitors for cigarettes. Staff F stated they had observed Resident 1 looking for discarded cigarettes in the courtyard and in the front parking lot. During an interview, on 05/28/2025 at 11:15 AM, Staff G, NA, stated Resident 1 was independent with mobility once they were in the wheelchair, and spends most of their time going between the courtyard smoking designation area and the front parking lot area. Staff G stated they checked on Resident 1, but did not stay with them for the duration of their time outside. During an observation on 05/28/2025 at 12:30 PM, Resident 1 was observed self-propelling in their wheelchair in the hallway going toward the front door. Resident 1 was observed going out the front door and was not accompanied by facility staff. During an interview, on 05/28/2025 at 12:50 PM, Staff D, Resident Care Manager (RCM), stated they observed Resident 1 smoking on 05/24/2025 and assessed them to be unsafe in all aspects of smoking, including with the use of a smoking apron (protective covering worn by smokers, especially those who may be prone to dropping cigarettes or ashes, to help prevent burns to their clothing, skin, or surroundings). Staff C stated the previous approach for Resident 1's smoking safety was to encourage Resident 1 to not smoke, and this plan did not appear to be effective. During an interview, on 05/29/2025 at 11:04 AM, Staff B, DNS, stated Resident 1 continued to show determination to smoke and the encouragement to not smoke was not effective in maintaining smoking safety. Staff B stated Resident 1 needed one-on-one supervision while smoking and potentially physical assistance to ensure they were safe. Reference: WAC 388-97-1060 (3)(g)