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	11/17/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident rooms and bedside urinals in a sanitary and homelike manner for 2 of 3 residents (Resident 1 and 2) reviewed for environment. This deficient practice placed residents at risk for compromised dignity, diminished quality of life and potential infection control issues.Findings included.Review of the facility policy, Nursing Department Infection Control Guidelines: Care of Patient Care Equipment, dated 02/28/2021 showed Personal Care Equipment such as urinals were for single patient use only, to be cleaned and disinfected after each use, discarded if heavily stained or worn, and to be covered when being stored.Resident 1Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease [(COPD) a group of lung diseases that cause long-term breathing problems], cachexia (condition that causes significant weight loss and muscle loss), and major depressive disorder (a mental health condition where someone feels persistently sad and hopeless). Review of the comprehensive assessment, dated 07/18/2025, showed Resident 1 was cognitively intact and required the assistance of one person for personal hygiene, dressing, toileting, and incontinent care. Further review of the assessment showed Resident 1 was frequently incontinent of bowel and bladder.Review of the medical record showed Resident 1 was transferred to a local hospital for evaluation and treatment on 09/29/2025 at 10:30 PM.During an observation, on 09/30/2025 at 3:45 PM, Resident 1's room (room [ROOM NUMBER]) had multiple pairs of used gloves in the garbage can, the floor had areas of soilage causing footwear to stick while walking, dried pieces of food stuck on the floor near the bed, and the presence of a fly. Resident 1's bathroom had a strong, offensive odor of urine; multiple pieces of personal medical equipment stacked on top of each other including two specialized bedside urinals (a urine bottle with a 47-inch hose attachment and funnel). Both urinal funnels (the part that touches the body) and hoses had a visible, thick layer of a dried sediment substance-brown and white in color.During a concurrent observation and interview, on 09/30/2025 at 4:10 PM, Staff D, Nursing Assistant (NA), stated Resident 1 purchased their specialized urinals online, and would use the urinals for a long time before replacing them. Staff D demonstrated their process for cleaning the specialized urinals by running water through the funnel, the hose, into the bottle, and emptying it into the toilet. Staff D stated they did not use any cleaning or disinfecting solutions because Resident 1 does not like the smell of chemicals.During an interview, on 09/30/2025 at 4:30 PM, Staff E, NA, stated Resident 1's room was difficult to keep clean because Resident 1 did not like the smell of cleaning solutions. Staff E stated Resident 1's room had been deep cleaned that morning by housekeeping. Staff E stated they used water only to clean Resident 1's specialized urinals and they did not think the process was sanitary.Review of Resident 1's care plan on 10/01/2025, last updated on 09/03/2025, showed no documented preferences regarding cleaning solutions, chemical odors, use of personal equipment such as a bedside urinal, or interventions for maintaining and/or storing personal equipment.During an interview, on 10/01/2025 at 10:02 AM, Staff C, Infection Preventionist (IP), stated the process for cleaning bedside urinals was to rinse with water after each use and to discard and replace urinals when they became stained or odorous. Staff C stated they were unaware of Resident 1's specialized urinal and a plan for cleaning, disinfecting, storing, and maintaining would need to be developed. Staff C confirmed the current process for cleaning and maintaining Resident 1's specialized urinals did not meet infection control expectations.During an interview, on 10/01/2025 at 10:10 AM, Staff F, Housekeeping/Laundry Supervisor, stated Resident 1's room was deep cleaned on the morning of 09/30/2025. Staff F stated housekeeping staff used hot water to clean Resident 1's room because Resident 1 did not like the smell of cleaners. Staff F stated the facility had not attempted to use odorless or fragrance-free cleaning solutions for Resident 1's room. Staff F stated housekeeping clean every resident room every day and did a deep clean of every room at least once a month.During an interview, on 10/01/2025 at 10:30, Staff G, Housekeeper, stated their process for daily resident room cleans was to wipe down all surfaces, sweep and mop the floors, clean the toilet, sink and shower, and empty the garbage. Staff G stated multiple residents kept a lot of personal belongings in their rooms making it difficult to move things around to clean surfaces. Resident 2Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus (a chronic condition that affects how the body uses sugar for energy), circulatory complications (blood flow impairment) and a foot ulcer (a wound that does not heal properly) related to DM. Review of the comprehensive assessment, dated 07/12/2025, showed

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement, monitor effectiveness, modify, and supervise interventions meant to reduce the risk of avoidable accidents related to alcohol consumption for 1 of 3 residents (Resident 3) reviewed for accidents and hazards. This deficient practice placed the resident at risk for negative outcomes related to over consumption of alcohol including driving a motor vehicle while under the influence.Findings included.Review of the facility policy Alcoholic Beverages, revised on 02/01/2023, showed an order from a medical provider was needed for alcohol consumption, alcohol supplies were to be stored in a secure location, a specified staff member would dispense the alcohol to the resident, and documentation of consumption would be completed on the Medication Administration Record (MAR) or Treatment Administration Record (TAR).<Resident 3>Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses of alcohol dependence, atherosclerosis (buildup of plaque in the arteries reducing blood flow) of arteries in both legs, and adult failure to thrive (an overall decline in an older adult's health and ability to function, marked by symptoms like unexplained weight loss, decreased appetite, poor nutrition, and reduced physical activity). Review of the comprehensive assessment completed, on 06/16/2025, showed Resident 3 was cognitively intact and was independent with dressing, personal hygiene, toileting, mobility, and bathing.Review of the medical record showed a physician visit progress note (PN), dated 07/24/2025, showed an order for gradual reduction of alcohol starting with 20 beers per day; decreasing by two beers every two weeks, and the plan for maintenance was a goal of four to six beers per day as needed. The PN showed the plan and order was discussed with the Director of Nursing (DON), Social Services Director, and Administrator.Review of the MAR and TAR for July, August, and September 2025 showed no order for alcohol beverage consumption monitoring or the implementation of the gradual reduction order.Review of the medical record showed a physician visit PN, dated 08/20/2025, showed Resident 3 continued with persistent high-risk alcohol use, staff reported Resident 3 stored their alcohol in their room and in their personal vehicle (in the facility parking lot), and the plan was to continue harm reduction approach and the facility protocol was being reviewed.Review of the medical record showed a physician visit PN, dated 08/25/2025, showed Resident 3 was observed with behaviors consistent of alcohol intoxication while in the hallway of the facility and the discussed plan was to implement and monitor the alcohol consumption reduction plan.Review of the medical record showed a physician visit PN, dated 09/04/2025, showed Resident 3 was agreeable to staff dispensing and monitoring amount of alcohol consumed and the plan for reduction of consumption. The PN showed a plan to track and reduce alcohol intake and for facility staff to supervise the dispensing of Resident 3's alcohol.Review of the MAR and TAR for July, August, and September 2025 showed no order for alcohol beverage consumption monitoring or the implementation of the gradual reduction order.Review of the medical record showed a physician's order, dated 10/01/2025, for Resident 3 to have 18 beers per day and for LNs to document the number of beers given per shift.Review of the nursing PN, dated 10/01/2025 at 11:20 AM, showed orders received for Resident 3 to have 18 beers per day from the provider and for LNs to document the number of beers given per shift based on the documented plan outlined in the provider visit PN dated 08/28/2025.Review of the medical record showed Resident 3's care plan for risk of substance use was updated on 10/01/2025 to include interventions of 18 beers per day, beer not to be left at Resident 3's bedside, LNs to document number of beers consumed, and to inform Social Services and LN if Resident 3 had consumed alcohol and left facility by driving their personal vehicle.During an interview, on 10/01/2025 at 12:40 PM, Staff H, Licensed Practical Nurse (LPN), stated Licensed Nurses (LNs) were documenting the number of beers dispensed to Resident 3 in the Controlled Substance Log Book for the past month. Staff H stated it was not their practice to review the total amount of alcohol Resident 3 consumed in a day. Staff H stated they had been instructed to notify local law enforcement if/when Resident 3 appeared intoxicated and chose to leave the facility in their personal vehicle.During an interview, on 10/01/2025 at 12:55 PM, Staff I, NA, stated Resident 3 required assistance in loading their wheelchair into their personal vehicle. Staff I stated Resident 3 did not use the facility sign out sheet when leaving or returning from an outing, and staff were aware of Resident 3's absence through verbal report.During an interview, on 10/01/2025 at 2:30 PM, Staff B, DON, stated Resident 3 had been non-compliant with a lot of the facility's attempts to monitor their safety and confirmed implementation and documentation regarding Resident 3's alcohol consumption should have been