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	01/21/2026

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 - Minimal harm or potential for 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** Based on interview and record review the facility failed to protect a resident's right to be free from physical abuse for 1 of 2 residents (Resident 1) reviewed for allegations of abuse. This failure placed residents at risk for further abuse, injury, and diminished quality of life. Findings included.Record review of the facility's policy titled, Abuse Prohibition, dated 10/24/2022, showed the following:- the facility prohibited abuse of residents,- the definition of abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and the definition of willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm,- Physical Abuse included hitting, slapping, pinching and kicking,- the Administrator was responsible for operationalizing policies and procedures that prohibit abuse,- the employee alleged to have committed the act of abuse would be immediately removed from duty, pending investigation.- anyone who witnesses an incident of suspected abuse must also report to outside agencies such as the state survey agency and local law enforcement, Resident 1 Record review showed the resident was admitted to the facility on [DATE] with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), hemiparesis (weakness on one side of the body), dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), bipolar disorder (a disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), and an anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations). Review of the 12/05/2025 comprehensive assessment showed Resident 1 had moderately impaired cognition, was dependent on two staff for bed mobility and toilet hygiene, had an indwelling urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) and was incontinent of bowel. Resident 1 had a Stage 4 pressure ulcer (localized damage to the skin and underlying soft tissue usually over a bony prominence, Stage 4 is full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the ulcer) on their sacrum (area located at the bottom of the spine and ends at the tailbone) that required dressing changes. During a telephone interview on 01/21/2026 at 12:30 PM, Staff D, Nursing Assistant (NA), stated they observed Staff B, Director of Nursing Services, slap Resident 1 on their bare buttock after completing a dressing change to the tailbone. Staff D stated they were being trained by Staff E, NA and Staff F, NA, on day shift on or before 12/23/2025. Staff D stated Resident 1 had a bowel movement that soiled their wound dressing and they notified the cart nurse the dressing needed to be changed. Staff B was working on the medication cart that day and did the dressing change. Staff D stated that they were holding Resident 1 to the right in their bed during the treatment and the other two NAs were standing near the bed. When Staff B was finished, they slapped the resident on their left butt cheek, to which Resident 1 asked what was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that for? and Staff B responded with just to let you know I was done. During an interview on 01/21/2026 at 2:40 PM, Staff E, NA, stated that they did witness Staff B slap Resident 1 on their bare butt cheek after the dressing change was finished. During an interview on 01/21/2026 at 2:50 PM, Staff F, NA, stated they were in the room and saw Staff B slap Resident 1 on the butt cheek after the dressing change was finished. During a telephone interview on 01/21/2026 at 5:03 PM, Staff C, RN Resource Clinician, stated Staff B came to them, told them they tapped Resident 1 on the butt cheek after finishing a dressing and the staff in the room looked at them funny and asked why did you do that? Staff C stated they talked to Resident 1 several hours later and the resident did not seem to be aware of Staff B's actions and they did not interview the staff witnesses. Staff C stated they feel bad for not taking it any further and this incident should have been reported sooner. Reference: WAC 388-97-0640(1), (3)(a)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 4 of 4 staff (Staff C, D, E, F) reviewed for abuse allegations, implemented the facility policy for identifying abuse and reporting to the state agency and administrator of an allegation of abuse involving Resident 1. This failure disallowed the facility administration with the ability to protect residents, report to state survey agency (SSA, State Survey Agency- responsible for oversight of Medicare certified Nursing Homes), investigate, and take corrective action. Further, the failure placed residents at risk for further abuse, injury, and diminished quality of life. Findings included .Record review of the facility's policy titled, Abuse Prohibition, dated 10/24/2022, showed the following:- the facility prohibited abuse of residents,- employees were designated as mandated reporters and were obliged to immediately report any reasonable suspicion of a crime against a resident,- abuse was defined as the willful infliction of injury, willful defined related to abuse means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury, physical abuse- physical abuse included hitting, slapping, pinching and kicking,- anyone who witnesses an incident of suspected abuse, were to tell the abuser to stop immediately and report the incident to their supervisor immediately, regardless of shift worked and the notified supervisor will report the suspected abuse immediately to the Administrator,- the Administrator was responsible for operationalizing policies and procedures that prohibit abuse,- the employee alleged to have committed the act of abuse would be immediately removed from duty, pending investigation,- immediately upon receiving a report of suspected abuse, the Administrator will report, to appropriate SSA and local authorities' allegations within two hours after the allegation was made. Record review showed the resident was admitted to the facility on [DATE] with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), hemiparesis (weakness on one side of the body), dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), bipolar disorder (a disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), and an anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations). Review of the 12/05/2025 comprehensive assessment showed Resident 1 had moderately impaired cognition, was dependent on two staff for bed mobility and toilet hygiene, had an indwelling urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) and was incontinent of bowel. Resident 1 had a Stage 4 pressure ulcer (localized damage to the skin and underlying soft tissue usually over a bony prominence, Stage 4 is full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the ulcer) on their sacrum (area located at the bottom of the spine and ends at the tailbone) that required dressing changes. During a telephone interview on 01/21/2026 at 12:30 PM, Staff D, Nursing Assistant (NA), stated they observed Staff B, Director of Nursing Services, slap Resident 1 on their bare buttock after completing a dressing change to the tailbone. Staff D stated they were being trained by Staff E, NA and Staff F, NA, on day shift on or before 12/23/2025. Staff D stated Resident 1 had a bowel movement that soiled their wound dressing and they notified the cart nurse the dressing needed to be changed. Staff B was working on the medication cart that day and did the dressing change. Staff D stated that they were holding Resident 1 to the right in their bed during the treatment and the other two NAs were standing near the bed. When Staff B was finished, they slapped the resident on their left butt cheek, to which Resident 1 asked what was that for? and Staff B responded with just to let you know I was done. Staff D stated the resident said nothing more. Later that day, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff D stated they told the other two NAs that they were real uncomfortable with what they witnessed and were going to report to the hotline. Staff D stated they did not report the incident until after they had changed employers because they were afraid of what would happen to them. (The report was around 30 days after Staff D witnessed the incident). During an interview on 01/21/2026 at 2:13 PM, Staff A, Administrator, stated there had been no reports that Staff B had been inappropriate with any of the residents. The Administrator was informed of the details of the incident, and they stated they were not aware. Staff A stated that Staff B had called off sick that day and was not at work. On 01/21/2026 at 2:30 PM Resident 1 stated that they did not recall the incident as described and responded with I would be alright with it but did agree that slapping him on the butt was not professional or appropriate interaction between staff and residents. During an interview on 01/21/2026 at 2:40 PM, Staff E, NA, stated they were trained to report suspected abuse to Staff A because they were the abuse coordinator and would decide whether to call the state hotline. They stated that they did witness Staff B slap Resident 1 on their bare butt cheek after the dressing was finished and I did not think it was abuse and [Staff B] was just playful and it did not need to be reported to [Staff A] or the hotline. During an interview on 01/21/2026 at 2:50 PM, Staff F, NA, stated they would report suspected abuse to the head nurse and the Administrator. When asked what the definition of a mandatory reporter was, Staff F stated that if you see something, you say something. Staff F was aware of the state hotline and stated they would call if they (head nurse and Administrator) do nothing. Staff F stated they saw Staff B slap Resident 1 on the butt cheek and did not think it was abuse and did not report it. Another day, Staff D stated they were really uncomfortable with what they witnessed, and they were going to call the state hotline. During an interview on 01/21/2026 at 3:14 PM, Staff A stated that they had informed staff that if they observe abuse to call them right away, anytime day or night. During a telephone interview on 01/21/2026 at 5:03 PM, Staff C, RN Resource Clinician, stated that they were in the facility the day the incident occurred and I feel bad I did not take it any further. They stated Staff B came to them, told them they tapped Resident 1 on the butt cheek after finishing a dressing and the staff in the room looked at them funny and asked why did you do that? Staff C stated they talked to Resident 1 several hours later and the resident did not seem to be aware of Staff B's actions. Staff C stated that the staff had been trained that they were mandated reporters and encouraged them to go to the abuse coordinator/Administrator first and if they still had concerns to call the hotline. Staff C stated this incident should have been reported sooner. Had the resident voiced a concern, suspension and investigation would have occurred. Reference: WAC 388-97-0640(1)(2)(a)(b), (5)(a)(b), (7)(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 4 of 4 staff (staff C, D, E, F) immediately reported suspected abuse to the State Survey Agency (SSA, responsible for oversight of Medicare certified nursing homes) and the facility Administrator according to CFR S483.12(c)(1) for 1 of 2 residents (Resident 1) reviewed for abuse reporting. This failure placed residents at risk for further abuse, potential for harm, and diminished quality of life. Findings included.Record review of the facility's policy titled, Abuse Prohibition, dated 10/24/2022, showed the following:- employees were designated as mandated reporters and were obliged to immediately report any reasonable suspicion of a crime against a resident,- anyone who witnessed an incident of suspected abuse, were to tell the abuser to stop immediately and report the incident to their supervisor immediately, regardless of shift worked and the notified supervisor will report the suspected abuse immediately to the Administrator,- immediately upon receiving a report of suspected abuse, the Administrator will report to the SSA and local authorities' within two hours after the allegation was made. Resident 1Record review showed the resident was admitted to the facility on [DATE] with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), hemiparesis (weakness on one side of the body), dementia (a loss of mental ability severe enough to interfere with normal activities of daily living), bipolar disorder (a disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows), and an anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations). Review of the 12/05/2025 comprehensive assessment showed Resident 1 had moderately impaired cognition, was dependent on two staff for bed mobility, was incontinent of bowel and had one Stage 4 pressure ulcer (localized damage to the skin and underlying soft tissue usually over a bony prominence, Stage 4 is full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the ulcer) on their sacrum (area located at the bottom of the spine and ends at the tailbone) that required dressing changes. During a telephone interview on 01/21/2026 at 12:30 PM, Staff D, Nursing Assistant (NA), stated they observed Staff B, Director of Nursing Services, slap Resident 1 on their bare buttock after completing a dressing change to the tailbone. Staff D stated they were being trained by Staff E, NA and Staff F, NA, on day shift on or before 12/23/2025. Staff D stated Resident 1 had a bowel movement that soiled their wound dressing and they notified the cart nurse the dressing needed to be changed. Staff B was working on the medication cart that day and did the dressing change. Staff D stated that they were holding Resident 1 to the right in their bed during the treatment and the other two NAs were standing near the bed. When Staff B was finished, they slapped the resident on their left butt cheek, to which Resident 1 asked what was that for? and Staff B responded with just to let you know I was done. Staff D stated the resident said nothing more. Later that day, Staff D stated they told the other two NAs that they were real uncomfortable with what they witnessed and were going to report to the hotline. Staff D stated they did not report the incident until after they had changed employers because they were afraid of what would happen to them. (The report was around 30 days after Staff D witnessed the incident). During an interview on 01/21/2026 at 2:13 PM, Staff A, Administrator, stated there had been no reports that Staff B had been inappropriate with any of the residents. The Administrator was informed of the details of the incident, and they stated they were not aware. Staff A stated that Staff B had called off sick that day and was not at work. During an interview on 01/21/2026 at 2:40 PM, Staff E, NA, stated they were trained to report suspected abuse to Staff A because they were the Abuse Coordinator and would decide (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whether to call the state hotline. Staff E stated that they did witness Staff B slap Resident 1 on their bare butt cheek after the dressing was finished. Staff E stated I did not report it because I did not think it was abuse and was just playful behavior between the staff and resident. During an interview on 01/21/2026 at 2:50 PM, Staff F, NA, stated they would report suspected abuse to the head nurse and the Administrator. When asked what the definition of a mandatory reporter was, Staff F stated that if you see something, you say something. Staff F was aware of the state hotline and stated they would call if they do nothing about it. Staff F stated they saw Staff B slap Resident 1 on the butt cheek and did not call the hotline because they were training Staff D and they stated they were going to call. During a telephone interview on 01/21/2026 at 5:03 PM, Staff C, Registered Nurse/ Resource Clinician, stated that they were in the facility the day the incident occurred and I feel bad I did not take it any further. They stated Staff B came to them, told them they tapped Resident 1 on the butt cheek after finishing a dressing and the staff in the room looked at them funny and asked why did you do that? Staff C stated they talked to Resident 1 several hours later and the resident did not seem to be aware of Staff B's actions. Staff C stated that the staff had been trained that they were mandated reporters and encouraged them to go to the Abuse Coordinator/Administrator first and if they still had concerns to call the hotline. Staff C stated this incident should have been reported sooner, I should have reported that day. Reference: WAC 388-97-0640(1)(2)(b), (3)(a), (5)(a)(b), (7)(a)(b)