

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Columbia Crest Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on interview and record review, the facility failed to ensure a process was in place to ensure 4 of 6 residents (Resident 62, 26, 49, and 8) reviewed for resident rights, had the opportunity to exercise their constitutional right to vote as a citizen of United States during the 2024 Presidential election. This failure placed the residents at risk for disappointment, frustration, and psychological distress.</p> <p>Findings included .</p> <p>Review of a document titled, [NAME] Voting Rights for Residents, undated, showed individuals residing in long term care facilities retain their right to vote. The long-term care facility must work with the residents to ensure they were able to exercise their constitutional right to vote. The long-term care facility must not interfere with the resident exercising their right to vote or coerce them during the voting process. The facility must assist any resident to vote that has expressed the desire to vote and ensure staff did not make determinations about who was eligible to vote. The facility must help the resident register to vote, obtain ballots, and assist residents with filling out ballots and returning them.</p> <p><Resident 62></p> <p>Review of the medical record showed Resident 62 was admitted to the facility with diagnoses including Parkinson's disease (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns), depression, and muscle weakness. Resident 62 was able to make their needs known.</p> <p>During an interview on 11/18/2024 at 2:39 PM, Resident 62 stated they did not get to vote in this year's Presidential election. Resident 62 stated no one had asked them if they wanted to vote and would have liked to.</p> <p><Resident 26></p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record showed Resident 26 was admitted to the facility with diagnoses of spinal stenosis (a condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerve roots), incomplete quadriplegia (a condition that causes partial paralysis in the arms and legs), and muscle spasms. The 09/23/2024 comprehensive assessment showed Resident 26 was cognitively intact.</p> <p>During an interview on 11/13/2024 at 10:33 AM, Resident 26 stated they did not get to vote this year. They stated they had completed their ballot and had asked the nursing assistants and nursing staff to mail their ballot, but no one had mailed it for them. They stated it was important for them to vote, and they were disappointed that their ballot did not get mailed.</p> <p><Resident 49></p> <p>Review of the medical record showed Resident 49 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), depression, and anxiety. The 10/15/2024 comprehensive assessment showed Resident 49 was cognitively intact.</p> <p>During an interview on 11/18/2024 at 2:23 PM, Resident 49 stated they did not get to vote in the recent Presidential election. They stated they were interested in the election but could not figure out how to vote. They stated no one at the facility had provided information on how to register and vote.</p> <p><Resident 8></p> <p>Review of the medical record showed Resident 8 was admitted to the facility with diagnoses including a stroke, diabetes (a group of diseases that result in too much sugar in the blood), and depression. The 11/07/2024 comprehensive assessment showed Resident 8 had an intact cognition.</p> <p>During an interview on 11/18/2024 at 12:30 PM, Resident 8 stated they were unable to see their ballot, and no one would help them fill it out. Resident 8 stated they tried to get someone to help them. Resident 8 stated they were very upset, mad, disappointed and felt cheated out of their rights.</p> <p>During an interview on 11/18/2024 at 11:52 AM, Staff H, Activities Director, stated the process for voting was to include the website for voter registration on the resident's newsletter. They stated they took ballots to some resident rooms and that was the extent of their involvement. Staff H stated Resident 8 had asked them for assistance reading the ballot since they could not see it. Staff H stated they forgot to assist them and left for vacation. Staff H stated they could not confirm if the residents voted and were not aware of any residents that did not get to vote.</p> <p>During an interview on 11/19/2024 at 12:04 PM, Staff A, Administrator, stated the facility did not have a process to ensure residents retained their right to vote. They stated they had expected Staff H to have a process in place for ensuring residents voted during this election season.</p> <p>Reference: WAC 388-97-0180(1-4)</p> <p>48368</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on observation and interview, the facility failed to provide a homelike dining room experience, including the choice to eat meals in the dining room, for 4 of 9 residents (Resident 9, 14, 51, and 2) reviewed for choices. This failed practice placed residents at risk for unmet care needs, isolation and weight loss.</p> <p>Findings included .</p> <p>Multiple observations of the dining room from 11/13/2024 through 11/19/2024 for all meals including breakfast, lunch, and dinner, showed no residents were provided meals in the dining room.</p> <p><Resident 9></p> <p>Review of the medical record showed the resident was admitted with diagnoses including a stroke (when blood flow to the brain is cut off, damaging brain tissue) and diabetes (a chronic disease in which there is too much sugar in the blood). The 10/21/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and required the assistance of one staff member with set-up for meals.</p> <p>Record review of Resident 9's care plan dated 07/20/2024 showed they preferred to eat in the dining room.</p> <p>During an interview on 11/15/2024 at 2:10 PM, Resident 9 stated they closed the dining room for COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) and have never opened it back up. Resident 9 stated they would like to eat in the dining room, they missed eating with their friends.</p> <p><Resident 14></p> <p>Review of the medical record showed the resident admitted with diagnoses including congestive heart failure (a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs) and dysphagia (difficulty swallowing). The 10/21/2024 comprehensive assessment showed Resident 14's cognition was moderately impaired and required the assistance of one staff member with set-up for meals.</p> <p>During an interview on 11/15/2024 at 12:55 PM, Resident 14 stated they were unsure why no one ate their meals in the dining room and very seldom saw anyone down there. Resident 14 stated they would like to eat in the dining room, but no one was ever there, so they might as well just stay in their room.</p> <p><Resident 51></p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed they were admitted to the facility with diagnoses including, chronic obstructive pulmonary disease (a chronic lung disease that blocks air flow and makes it difficult to breathe) and congestive heart failure (the heart can no longer keep up with the needs of the body). Review of the residents most recent comprehensive assessment dated [DATE] showed the resident was cognitively intact.</p> <p>During multiple observations on 11/12/2024 at 6:40 PM, 11/13/2024 at 9:50 AM, 11/14/2024 at 12:45 PM, and 11/17/2024 at 9:30 AM, showed Resident 52 eating alone in their room.</p> <p>During an interview on 11/13/2024 at 11:05 AM, Resident 52 stated they would like to eat in the dining room and make some new friends; I get so lonely sometimes. The resident further stated they were unable to eat in the dining room because it was always closed.</p> <p><Resident 2></p> <p>Review of the resident's medical record showed the resident was admitted with diagnoses to include multiple sclerosis (a disease in which the immune system eats away the protective covering of the nerves resulting in nerve damage) and diabetes. Review of Resident 2's comprehensive assessment dated [DATE], showed the resident had mild cognitive impairment however was able to make their likes and dislikes known. The assessment showed the resident enjoyed socializing and being around other residents.</p> <p>During multiple observations on 11/12/2024 at 6:45 PM, 11/13/2024 at 1:15 PM, 11/14/2024 at 1:32 PM, and 11/15/2025 at 12:45 PM, showed Resident 2 eating in their room with their tray placed on an over bed table.</p> <p>During an interview on 11/13/2024 12:14 PM, Staff MM, Nursing Assistant (NA), stated the dining rooms had been closed since the last COVID-19 outbreak. They stated the dining room had not reopened related to not having enough staff to assist with eating in both the dining rooms and resident rooms.</p> <p>During an interview on 11/13/2024 at 3:33 PM, Resident 2 stated they would love to eat in the dining room but it was no longer an option since the COVID virus had been active in their building. The resident further stated, I get so tired of being bound to my room to eat.</p> <p>During an interview on 11/15/24 at 11:26 AM, Staff F, Licensed Practical Nurse (LPN), Unit Manager stated the resident dining room had been closed since the COVID outbreak. Staff F stated the facility would like to start having the dining room open again for residents but we just do not have enough staff at this time to make it happen. Staff F stated the dining room had been closed since COVID; we would like to start eating in there again, but we just do not have the staff.</p> <p>During an interview on 11/15/2024 at 3:01 PM, Staff B, Senior Director of Nursing, stated the dining rooms had remained closed due to low staffing. Staff B stated they did not have enough staff to pull NAs off the floor to staff the dining rooms. Staff B further stated it was the residents right to choose to eat in the dining room and they knew it was an issue with their rights.</p> <p>Reference: WAC 388-97-0900(1)(3)(4)</p> <p>39652</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on interview and record review, the facility failed to return the balance of funds to the Office of Financial Recovery [(OFR) responsible for the recovery of financial, medical, social services, and food assistance overpayments from the Department of Social and Health Services clients] for 3 of 4 residents (Resident 232, 60, and 231) reviewed for conveyance (the legal process of transferring property from one owner to another) of personal funds. This failure placed the state department at risk for loss of funds and interest accumulated.</p> <p>Findings included .</p> <p>Review of a policy titled, Resident Funds, dated [DATE], showed when a resident expired and had funds remaining in their trust account, refunds must be made via check and include a final accounting of those funds within 30 days of death. Timely processing of the refund check or in the case of death, the individual or probate jurisdiction administering the resident's estate in accordance with state regulations.</p> <p><Resident 232></p> <p>Review of the medical record showed Resident 232 was admitted to the facility on [DATE] and expired on [DATE]. Resident 232's trust account showed a balance of \$781.02, that was sent to the Genesis Healthcare Abandoned/Unclaimed Property account (a bank account owned by the facility that is used when there is money and no next of kin to send it to) on [DATE] (greater than 30 days after their discharge from the facility), not the OFR as required.</p> <p><Resident 60></p> <p>Review of the medical record showed Resident 60 was admitted to the facility on [DATE] and expired on [DATE]. Resident 60's trust account showed a balance of \$282.96 that was sent to the Genesis Healthcare Abandoned/Unclaimed Property account on [DATE] (greater than 30 days after their discharge from the facility), not the OFR as required.</p> <p><Resident 231></p> <p>Review of the medical record showed Resident 231 was admitted to the facility on [DATE] and expired on [DATE]. Resident 231's trust account showed a balance of \$368.61. A check had been made out to Resident 231 with the facility address on the check dated [DATE], greater than 30 days after their discharge from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:02 AM, Staff GG, Business Office Manager (BOM), stated the process for returning funds when a resident expired, and they had funds remaining in their trust account, included waiting 30 days to see if the facility received a State Recovery letter from the Department of Social and Health Services [(DSHS) a government agency that provides services and benefits to Washington State residents that need support to be safe and healthy) requesting return of the funds. They stated if they did not receive the letter within 30 days, they would place a call to DSHS to verify that funds did not need to be returned. They stated if the funds did not need to be returned to DSHS, they would send the remaining funds to the next of kin or Power of Attorney [(POA)a person legally able to act on your behalf], as that was their right to have the remaining funds. Staff GG stated if they did not have to return the funds to DSHS and there was no next of kin/POA, they would send the funds to the Genesis Healthcare Abandoned/Unclaimed Property account. Staff GG stated the Genesis Healthcare Abandoned/Unclaimed Property account would hold the money until a next of kin/POA was located. Staff GG stated they had read the Washington State Administrative Codes and understood that the money only went back to OFR if they had received the State Recovery letter.</p> <p>During an interview on [DATE] at 12:07 PM, Staff A, Administrator, stated the process for disposition of resident funds, if a Medicaid resident, would be to follow the state recovery process. They stated the money would need to be returned to the OFR within 30 days of a resident expiring. Staff A stated their expectation was for the return of money to the OFR be completed immediately upon the resident's expiration and the process for this had not been followed.</p> <p>Reference: WAC [DATE](4)(5)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>45117</p> <p>Based on observation, interview, and record review, the facility failed to ensure the State Long-Term Care Ombudsman [(ombudsman) an advocate for resident's rights in long term care) program was reviewed with residents and information was discussed on how to contact the ombudsman for 5 of 5 residents (Resident 31, 9, 11, 8, and 2) reviewed for required notices and contact information. The failure to not provide accessible ombudsman information left residents at risk for not having rightful resources and advocate available to them.</p> <p>Findings included .</p> <p><Resident 31></p> <p>Review of the medical record showed Resident 31 was admitted to the facility with diagnoses of dementia (a progressive disease that destroys memory and other important mental functions), depression, and anxiety. The 09/05/2024 comprehensive assessment showed Resident 31 was cognitively intact.</p> <p><Resident 9></p> <p>Review of the medical record showed Resident 9 was admitted to the facility with diagnoses including a stroke and heart disease. The 10/21/2024 comprehensive assessment had a moderately impaired cognition. Resident 9 was able to make their needs known.</p> <p><Resident 11></p> <p>Review of the medical record showed Resident 11 was admitted to the facility with diagnoses including Multiple Sclerosis (a chronic neurological disorder that affects the brain and spinal cord) and diseases of the urinary tract. The 11/08/2024 comprehensive assessment showed Resident 11 was cognitively intact.</p> <p><Resident 8></p> <p>Review of the medical record showed Resident 8 was admitted to the facility with diagnoses including a stroke, diabetes (a group of diseases that result in too much sugar in the blood), and depression. The 11/07/2024 comprehensive assessment showed Resident 8 was cognitively intact.</p> <p><Resident 2></p> <p>Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including multiple sclerosis, diseases of the urinary tract, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The 10/11/2024 comprehensive assessment showed Resident 2 had a moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility Resident Council (a gathering of residents in a community where they can discuss concerns, suggest improvements, and make decisions that affect their lives) meeting minutes dated 06/10/2024, 07/08/2024, 08/12/2024, 09/09/2024, 10/14/2024, and 11/12/2024, showed no documentation that information was provided to the residents on who their Ombudsman was, what their purpose was, and what the program entailed.</p> <p>During a Resident Council meeting (federally mandated task conducted by the survey team) on 11/14/2024 at 10:00 AM, Residents 31, 9, 11, 8, and 2 stated they did not know what an ombudsman was or what services they would provide for the residents. Residents 31, 9, 11, 8, and 2 stated they did not know where the contact information was located or why they would need to speak with an ombudsman.</p> <p>During an interview on 11/18/2024 at 11:57 AM, Staff H, Activities Director, stated they did not review any information regarding the ombudsman with the residents during the Resident Council meetings. Staff H stated they did not know what an ombudsman was. Staff H stated they would do some research and find out what they (ombudsman) do.</p> <p>During an interview on 11/19/2024 at 12:09 PM, Staff A, Administrator, stated all staff were required to know what an ombudsman was and how to contact them so staff could direct the residents to their advocate.</p> <p>Reference: WAC 388-97-0300(7)(c)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>46722</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's right to privacy, security, and confidentiality, when a video/audio camera was placed in their room, for 1 of 2 residents (Resident 55) reviewed for privacy and confidentiality. This failed practice placed residents at risk for the loss of personal privacy.</p> <p>Findings included .</p> <p>Review of the policy titled Use of Audio/Video Devices (Cameras, Recording and/or Broadcasting), revised 05/01/2022, showed the Administrator would review the request for placement of an audio and/or video device for the needs of the resident. The policy further showed after the completed review, the Administrator could authorize use in accordance with state and federal laws.</p> <p><Resident 55></p> <p>Review of the medical record showed Resident 55 was admitted with diagnoses including chronic obstructive pulmonary disease [(COPD) a group of lung diseases that block airflow and make it difficult to breathe] with exacerbation (a sudden worsening) and anxiety. The 08/28/2024 comprehensive assessment showed Resident 55 required substantial/maximal assistance of one to two staff members for activities of daily living and was dependent on staff for transfers. The assessment also showed Resident 55 had a moderately impaired cognition.</p> <p>Review of the medical record showed a patient consent form titled, Use of Audio and/or Video Recordings, dated 10/11/2024, signed by Resident 55's representative (RR). The consent showed the authorized device was a web camera (video live stream and/or audio and visual recording transmitted over the internet).</p> <p>An observation and interview on 11/14/2024 at 9:45 AM, showed, upon entrance to Resident 55's room, a sign that showed video/audio monitoring in progress. Resident 55's room had a video camera on a nightstand, aimed at the resident, with a blinking red light. Resident 55's room was directly in front of the nursing station and their door remained open for staff visual observations. Resident 55 stated they were unaware there was a video camera in their room until asked.</p> <p>During an interview on 11/14/2024 at 9:59 AM, Staff BB, Unit Manager, stated Resident 55's representative had placed the video/audio camera in their room. Staff BB stated the RR was approved by Staff A, Administrator.</p> <p>During an interview on 11/14/2024 at 10:44 AM, Resident 55's RR stated the resident had a video camera in their room and was placed there by their family member five weeks ago. The RR stated they had the video camera placed in Resident 55's room as they felt they were not being cared for properly. The RR stated Resident 55 had continued to yell and scream and the staff would not attend to their needs. Resident 55's RR stated they were able to monitor the resident whenever they wanted from their personal phone and home computer. They stated the video camera was live stream (ability to present in real time an event over the internet), had audio, and the ability to record.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/2024 at 10:08 AM, Staff G, Nursing Assistant (NA), stated Resident 55's family had placed the video camera in their room and was unsure of the exact reason. Staff G stated they were concerned for Resident 55's privacy and other residents, as the video camera also had audio, recording, and live streaming capability. Staff G stated they were informed by the Staff A, Administrator, the RR was allowed to have the video camera.</p> <p>During an interview on 11/15/2024 at 1:49 PM, Staff C, NA, stated the video camera in Resident 55's room was for their family to view the resident anytime they wanted, as the family felt cares were not provided for the resident. Staff C stated they were informed by Staff A the RR was allowed to have the video camera.</p> <p>During a concurrent interview on 11/15/2024 at 3:01 PM, Staff CC, NA, and Staff DD, Licensed Practical Nurse (LPN), stated they were not informed there was a video/audio camera in Resident 55's room. Staff CC and Staff DD stated when they performed cares for Resident 55, they either turned the camera away or covered it to allow for privacy for the Resident.</p> <p>An observation on 11/16/2024 at 8:22 AM, showed Resident 55's door was completely open, and Resident 55 was laying in their bed with oxygen on. Resident 55 yelled for assistance and staff members immediately entered their room and attended to their needs.</p> <p>During an interview on 11/17/2024 at 3:18 PM, Staff A, Administrator, stated they were not informed when the video camera was installed in Resident 55's room on 10/11/2024. Staff A stated the RR wanted the video camera to monitor the resident to ensure they were receiving timely appropriate care. Staff A stated the camera was a security camera with video and audio that allowed the RR to monitor the resident on their personal cell phone and was unsure if the security camera had the ability to live stream and/or record. Staff A stated they did not ask Resident 55 for consent for the video camera. Staff A stated the resident had moments of clarity and should have asked the resident for consent or acknowledgement of the video camera prior to its use. Staff A stated they probably did not protect Resident 55's privacy.</p> <p>Reference WAC: 388-97-0400</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on observation and interview, the facility failed to ensure a sanitary and homelike environment for 3 of 3 shower rooms (North Hall, [NAME] Hall, and East Hall), 1 of 3 hall kitchenettes (East Hall), and 3 of 6 resident rooms (rooms [ROOM NUMBER]) reviewed for environment. These failures place the residents at risk of unpleasant living conditions and diminished self-worth.</p> <p>Findings included .</p> <p>Review of the policy titled, Resident Rights Under Federal Law, revised 02/01/2023, showed residents had the right to a safe, clean, comfortable and homelike environment and the facility would provide housekeeping and maintenance services to maintain a sanitary and comfortable environment.</p> <p><Shower room></p> <p><North hall></p> <p>An observation on 11/12/2024 at 7:02 PM, showed the North Hall shower room had a trash can that was overflowing with soiled resident briefs. The shower stall had a six inch (unit of measure), by three-inch mound of hard substance along the shower floor and wall. The mound had exposed grey, brown, and reddish substance around the base of the mound and shower seam of the floor. The shower stall had four holes that were waist high on the shower wall. The holes were reddish brown with screws holes inset into the wall tiles. The area that surrounded the four screw holes had a four-inch circular imprinted gouge (deep scratch) with white and reddish-brown substance. The shower stall had three silver grab bars, two shower knobs, and a faucet, that showed a white film that covered the surfaces. The hand washing sink base, knobs, and faucet showed a white film, and reddish-brown substance coating the surfaces.</p> <p><West hall></p> <p>An observation on 11/15/2024 at 9:36 AM, showed the [NAME] Hall shower room wall divider had a rubber base board running along the floor seam. The base board had torn rubber with a one-inch gap that exposed broken, black-brown and yellow wall debris. The toilet base had black, yellow, and reddish-brown dried, cracked, and missing caulk (a waterproof sealer or sealant). The toilet also contained fecal matter on the toilet seat. The handwashing sink showed a black-brown crust and yellow substance on the handles and base of the faucet.</p> <p><East hall></p> <p>An observation on 11/18/2024 at 4:30 PM, showed the East Hall shower room wall rubber base board that was peeled back from the wall. The paint on the wall had bubbled and exposed a reddish-brown substance. The shower divider wall showed a 12-inch, white, unfinished wall patch with torn, exposed drywall. The shower divider wall corner was unpainted and chipped. The shower divider rubber base board was not attached the wall and showed black-brown thick debris.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><East Hall Kitchenette></p> <p>An observation on 11/16/2024 at 2:53 PM, showed the East Hall kitchenette sink had three inches of standing water with food debris and not draining. The kitchenette also had food debris scattered on the countertop. The cabinet below the sink showed the entire cabinet bottom was covered in black-brown sludge with variations in darkness and shape, with chunks and gouges of missing cabinet base. The cabinet base showed the laminated edge was peeled up from the opening of the cupboard and exposed the absorbent wood product.</p> <p><Resident rooms></p> <p><room [ROOM NUMBER]></p> <p>An observation on 11/13/2024 at 9:24 AM, showed the bathroom in resident room [ROOM NUMBER] had an overflowed trash can that contained opened, soiled resident briefs. The resident's toilet seat had fecal matter on the toilet seat and the rim of the toilet. The shower divider wall between the toilet and shower stall had both corners from the floor to the divider wall had deep gouges and broken tiles with exposed black-brown debris and when touched crumbled to the floor. The bathroom had three ceiling tiles that were warped and bowed, had dark stains and exposed the area above the bathroom. The bathroom wall, to the left of the door, had multiple paint gouges and scrapes on the wall. The bathroom also showed soiled wet towels on the floor near the toilet.</p> <p>Observations on 11/15/2024 at 10:02 AM and 11/18/2024 at 11:45 AM, showed resident room [ROOM NUMBER]'s bathroom had fecal matter on the toilet seat and rim of the toilet, the shower divider wall had broken tiles, ceiling tiles that had black-brown debris, warped, and bowed. There were multiple paint gouges and scrapes on the wall.</p> <p><room [ROOM NUMBER]></p> <p>An observation on 11/13/2024 at 2:53 PM, showed resident room [ROOM NUMBER]'s wall behind their bed contained an area four feet [(ft) unit of measure] by four ft with multiple deep gouges and paint scrapes that exposed the drywall. The wall also showed an area of white wall patching material that was unpainted.</p> <p>During an interview on 11/14/2024 at 10:28 AM, the Resident Representative for the resident that resided in room [ROOM NUMBER] stated the walls were terrible and they should not have to live in an environment like that.</p> <p><room [ROOM NUMBER]></p> <p>An observation on 11/14/2024 at 10:04 AM, showed resident room [ROOM NUMBER]'s bathroom had four holes in the bathroom door. Two holes measured two inches by two inches, and the other holes measured one inch by one and a half inches. The toilet tank lid was not fitted to the toilet and had a three-inch gap that exposed the toilet tank water and flushing equipment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/18/2024 at 4:11 PM, Staff K, Maintenance Director, stated they had not repaired or been asked to repair any of the reported issues in the three shower rooms. Staff K stated the identified faucets, grab bars, tiles, walls, and rubber base boards were stained, broken, and were covered in hard water and build-up. They did not look clean and needed to either be replaced or repaired. Staff K stated the toilet caulking in the [NAME] Hall needed to be replaced. Staff K stated resident room [ROOM NUMBER]'s bathroom had broken tile, hard water build-up on the grab bars and faucet, and the ceiling tiles appeared to have had water damage and needed to be replaced. Staff K stated they were unaware of resident room [ROOM NUMBER]'s bathroom having holes in their door and the unfitted toilet lid, and these items needed to be replaced and repaired. They stated they were aware of previous issues with the East Hall kitchenette having slow drainage in the sink and had repaired it before. Staff K stated they did not know that the slow drainage had returned and did not know the sink cabinet was covered in the black-brown sludge. Staff K stated these identified areas were not homelike and needed repaired or replaced.</p> <p>During an interview on 11/19/2024 at 8:21 AM, Staff M, Registered Nurse/Infection Preventionist, stated they were unaware of the sludge under the East Hall kitchenette sink. Staff M stated the sink cabinet should not be in that condition. They stated the area should have been cleaned and maintenance notified to repair the issue.</p> <p>During an interview on 11/19/2024 at 11:28 AM, Staff A, Administrator, stated the identified shower rooms, resident rooms, and kitchenette were not homelike and in good condition and needed to be repaired.</p> <p>Reference WAC: 388-97-0880(1)(2)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>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.</p> <p>Findings included .</p> <p>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.</p> <p><Resident 35></p> <p>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.</p> <p><Water></p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p><Skin></p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 (11/12/2024) or Wednesday (11/13/2024). They stated they were informed of redness by maybe an aide but did not assess the areas.</p> <p>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.</p> <p>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 .</p> <p>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.</p> <p><Pain></p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p data-bbox="477 632 1503 762">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.</p> <p data-bbox="477 787 792 812">Reference: WAC 388-97-0640(1)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652</p> <p>Based on interview and record review the facility failed to implement their abuse/neglect policies and procedures to identify, prevent, protect, investigate, and report abuse/neglect allegations for 3 of 3 residents (Residents 2, 38, and 62) who had reported allegations of abuse and neglect by filing out grievance forms. Review of the facility's Grievance/Concern forms, dated 06/01/2024 to 11/14/2024, showed 10 additional allegations of abuse/neglect involving 7 of 7 residents (Residents 226, 228, 227, 2, 54, 11, and 40) reviewed for abuse/neglect. The facility did not have a process to identify allegations of abuse/neglect, that were written as grievances and required thorough and timely investigations. The facility also failed to report the allegations to the State Complaint Resolution Unit (the section of the Department of Social and Health Services that is responsible for processing and initiating an electronic recording of all resident received reports) as required. This failed practice placed other residents at risk for abuse and neglect. The lack of recognizing allegations of abuse and neglect and taking any needed action constituted an immediate jeopardy (IJ).</p> <p>On 11/14/2024 the facility was notified of an IJ at, F607 42 CFR 483.12(b)(1)-(4) Develop/Implement Abuse/Neglect Policies when resident allegations of abuse and neglect in the form of grievances were not appropriately followed up on by identifying the allegations of abuse and neglect, protecting the resident, and conducting a thorough and timely investigation to determine if abuse or neglect had occurred. It was determined the IJ began on 11/14/2024 and the immediacy was removed on 11/15/2024 with an onsite investigation from surveyors. The facility removed the immediacy by conducting facility wide interviews with residents and/or families specific to abuse or neglect to identify if any additional allegations were made to provide the necessary follow up. Education was provided to staff on the grievance process and how to immediately identify and report abuse or neglect allegations to include protection of the resident during the investigation. Education was to be completed with all staff prior to their next scheduled shift. The measures put into place by the facility ensured that all staff were trained on identifying and reporting abuse.</p> <p>Findings included .</p> <p>Record review of a facility policy titled Abuse Prohibition revised of 10/24/2022 showed; The center will implement an abuse prohibition program through the following:</p> <ul style="list-style-type: none"> * Screening of potential hires * Training of employees * Prevention of occurrence * Identification of possible incidents or allegations which need investigation * Investigation of incidents and allegations * Protection of patients during investigation * Reporting of incidents. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Columbia Crest Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 East Nelson Road Moses Lake, WA 98837	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><Resident 2></p> <p>Review of the resident's medical record showed they were admitted with diagnoses including multiple sclerosis (a disease in which the immune system destroys the protective covering of the nerves) and diabetes (a chronic disease that causes too much sugar in the blood). Review of the comprehensive assessment dated [DATE] showed the resident's had mild cognitive impairment and experienced pain during the assessment period.</p> <p>During an interview on 11/13/2024 at 2:56 PM, Resident 2 stated Staff D, Licensed Practical Nurse (LPN), had refused to give them pain medication alleging Staff D was rude and verbally abusive. The resident stated Staff D often told them their medication was unavailable as well, so they had filed a grievance as they felt Staff D was purposely withholding their pain medication to be mean to me.</p> <p>Review of a Grievance/Concern Form dated 10/09/2024 showed Resident 2 had alleged Staff D would not give them pain medication and was picking on me. The grievance was signed by Staff A, Administrator, but not dated. Record review of the facility incident reporting log showed there had been no investigation into Resident 2's allegation against Staff D's treatment of them.</p> <p><Resident 38></p> <p>Review of the resident's medical record showed the resident was admitted to the facility with diagnoses including multiple sclerosis and chronic pain. Review of the resident's comprehensive assessment dated [DATE] showed the resident was cognitively intact with no memory deficits and suffered from frequent pain.</p> <p>During an interview on 11/13/2024 at 11:13 AM, Resident 38 stated they had filed a grievance about three weeks ago related to a nurse being rude, belittling and had refused to give them pain medications when they had requested. The resident identified the nurse as Staff D. Resident 38 stated Staff D was not allowed to pass their medications anymore, but had remained on the unit and they felt Staff D was able to retaliate against them as they would not report to the other nurse taking care of them when they wanted a pain pill Resident 38 stated I feel like (Staff D) was purposely ignoring my requests it was very uncomfortable with (Staff D) still on my unit. Resident 38 stated they would have to wait until Staff D left to get their pain medications.</p> <p>Review of Resident 38's Grievance/Concern Form dated 10/22/2024 showed the resident alleged Staff D was frequently rude and refused to listen to them. Further review of the allegation showed Staff D often refused the residents request for pain medication and was disapproving when they asked for pain medication. Staff D would blatantly refuse or tell them it was unavailable. The grievance was signed by Staff F, Unit Manager but did not include the date it was reviewed. Review of the facility incident reporting log showed no investigation had been completed into Resident 38's allegations of abuse/neglect made against Staff D.</p> <p><Resident 62></p> <p>Review of the resident's medical record showed the resident was admitted to the facility with a diagnosis of Parkinson's disease (a disease of the nervous system that affects movement and causes tremors). Review of the comprehensive assessment dated [DATE] showed the resident was able to make their needs known.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/13/2024 at 10:08 AM, Resident 62 stated they had missed their medication for tremors Carbidopa-Levodopa (a medication used to treat the symptoms of Parkinson's disease such as tremors) several days earlier. Resident 62 stated Staff D had told them they were out of the medication, and it was not available. The resident informed Staff D they needed their medication on time otherwise they would suffer from tremors.</p> <p>Record review of a Grievance/Concern form dated 11/08/2024 showed Resident 62 had notified the facility of the missed medication and had reported they had experienced intense shaking and tremors after the missed dose. The grievance was undated and signed by Staff F, Unit Manager and showed the medication had been found located in the medication cart.</p> <p>Review of the incident reporting log showed the facility had not recognized Staff D's frequency of allegations of abuse/neglect and a pattern of alleged medication errors as indicated by grievances filed on 10/09/2024 by Resident 2, 10/22/2024 by Resident 38 and 11/09/2024 filed by Resident 62.</p> <p>Review of the nurse's schedule dated 10/01/2024 to 11/14/2024 showed Staff D had continued to work with unsupervised access to residents and without a thorough and timely investigation into the allegations.</p> <p>During a concurrent interview on 11/14/2024 at 04:56 PM, Staff A, Administrator and Staff B, Senior Director of Nursing, stated there were no incident investigations that had been completed related to the allegations against Staff D filed by Residents 2, 38 and 62.</p> <p>Record review of the facility Grievance/Concerns forms dated 06/01/2024 to 11/14/2024 showed 10 additional allegations involving seven dependent residents (Resident's 226, 228, 227, 2, 54, 11, and 40) alleging abuse/neglect as follows;</p> <ul style="list-style-type: none"> * 06/04/2024 Resident 226 allegation - the resident was left in their wheelchair without any care from 9:00 AM to 3:00 PM. * 06/20/2024 Resident 228 allegation - the resident had not been changed or turned and re-positioned on several occasions. * 06/14/2024 Resident 227 allegation - the nurse refused to let them keep their door open when they suffer from claustrophobia. * 07/18/2024 filed Resident 228 allegation - the resident was neglected and not changed two nights in a row. * 08/26/2024 Resident 2 - allegation their post-surgical bandage was not being changed by the evening nurses. * 09/26/2024 Resident 54 - alleged evening shift was rough with them. * 10/12/2024 Resident 54 - alleged staff were super rough with them. * 10/22/2024 Resident 11 - stated they did not like the way a nurse treated their wife. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>* 11/10/2024 Resident 40 - alleged a nurse used excessive force to clean their wound and they almost cried from the pain.</p> <p>Record review of the facility incident reporting log from 06/01/2024 to 11/14/2024 showed the facility had not recognized the above listed allegations as abuse or neglect therefore no thorough or timely investigations had been completed into the above allegations filed as grievances.</p> <p>During an interview on 11/15/2024 at 8:08 AM, Staff A, Administrator stated it's a very broken system for reporting allegations related to abuse and neglect. Staff A stated they had not been aware of some of the grievances alleging abuse/neglect filed as they had not been presented to them. Staff A further stated even though they did not see all the grievances I am the administrator so it's on me.</p> <p>Reference WAC-388-97-0640(2)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>45117</p> <p>Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse/neglect for 6 of 11 residents (Resident 2, 62, 38, 4, 52, and 49) reviewed for allegations of abuse/neglect. Failure to thoroughly investigate the allegations of abuse/neglect placed the residents at risk for further abuse/neglect.</p> <p>Findings included .</p> <p>According to the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), all incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. A thorough investigation is a systematic collection of review of evidence/information that describes and explains an event or a series of events to determine what occurred and make necessary changes to resident's plan of care and services to prevent reoccurrence. The investigation should include the who, what, when, where, why and how, of the incident and establish a reasonable cause within 24 hours of the incident.</p> <p><Resident 2></p> <p>Review of the resident's medical record showed they were admitted to the facility with diagnoses including Multiple Sclerosis (a disease in which the immune system destroys the protective covering of the nerves) and diabetes (a chronic disease that causes too much sugar in the blood). Review of the comprehensive assessment, dated 10/04/2024, showed Resident 2 had mild cognitive impairment.</p> <p>During an interview on 11/13/2024 at 2:56 PM, Resident 2 stated Staff D, Licensed Practical Nurse (LPN), had refused to give them pain medication, alleging Staff D was rude and verbally abusive. The resident stated Staff D was often mean to me.</p> <p>Record review of a facility investigation, dated 11/13/2024, signed by Staff B, Senior Director of Nursing, showed the investigation was incomplete. The investigation included an abuse questionnaire completed with only Resident 2 and their spouse, who made a statement that Resident 2 was afraid Staff D would come and hurt them. There were no interviews with other residents or staff to rule out a pattern of abuse or neglect involving Staff D.</p> <p><Resident 62></p> <p>Review of the medical record showed Resident 62 was admitted to the facility with diagnoses including Parkinson's Disease (a degenerative disease that causes movement problems) with dyskinesia (a side effect of Parkinson's disease medications that causes involuntary, erratic, writhing movements of the face, arms, legs, or trunk). The 09/26/2024 comprehensive assessment showed Resident 62 required substantial assistance of one staff member for activities of daily living (ADLs). Resident 62 was able to make their needs known.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility investigation, dated 11/14/2024, showed Staff B reviewed a grievance form, dated 11/08/2024, that showed Resident 62 did not receive an evening dose of medication, resulting in the resident having increased tremors and anxiety. There was no interview with the resident regarding their concerns. Staff B and Staff F, Unit Manager, interviewed Staff D regarding the missed medication. Staff F did a follow-up interview (despite there being no initial interview) with Resident 62, who stated they had received all of their medications with exception of the one time. Staff D was suspended pending investigation. Staff B documented abuse/neglect is unsubstantiated without initialing interviewing Resident 62, other residents, or staff.</p> <p><Resident 38></p> <p>Review of the resident's medical record showed the resident was admitted to the facility with diagnoses including Multiple Sclerosis and chronic pain. Review of the resident's comprehensive assessment, dated 10/14/2024, showed the resident was cognitively intact with no memory deficits and suffered from frequent pain.</p> <p>During an interview on 11/13/2024 at 11:13 AM, Resident 38 stated they had filed a grievance against Staff D as they were rude and belittling to them and often refused to give them their pain medications.</p> <p>Review of a facility incident investigation, dated 11/18/2024, showed Staff B's signature as completing the investigation. The investigation did not include other resident or staff interviews to rule out abuse or neglect involving Staff D and was not complete.</p> <p>Staff D had been named by three residents (Residents 2, 62 and 38) with concerns related to abuse/neglect, however the facility did not recognize the pattern involving Staff D or interview other residents and staff to ensure a thorough investigation had been completed.</p> <p><Resident 4></p> <p>Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including diverticulitis (inflammation of pouches in the colon that can cause abdominal pain, fever, nausea, vomiting, and sometimes bleeding), epilepsy (a brain disorder that causes people to have repeated seizures), and anxiety. The 10/24/2024 comprehensive assessment showed Resident 4 required substantial/maximal assistance of one staff member for ADLs, including transfers and mobility. Resident 4 was able to make their needs known.</p> <p>During an interview on 11/13/2024 at 3:21 PM, Resident 4 stated they were afraid of Staff E, Director of Rehab (DOR)/Physical Therapy Assistant (PTA). They stated Staff E took my mail and I never got it back. Additionally, Resident 4 stated about a week ago, a staff member working the night shift had picked them up off the bed to put them in their wheelchair and had dropped them on their bed, with the staff member falling on top of them. Resident 4 stated their left foot had twisted all the way around and their left foot and ankle hurt. Resident 4 reported their little toe on their right foot was injured when a staff member was assisting them to the restroom. They stated the staff member was pushing them in their wheelchair and had bumped their foot on their roommate's bed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a facility investigation, dated 11/13/2024, showed Resident 4 stated they were afraid of Staff E. Resident 4 stated Staff E had taken a letter from their room and had not returned it. The investigation showed Staff E had been placed on administrative leave pending the investigation. Staff A, Administrator, completed the investigation after speaking with Resident 4 and Staff E, and stated they were unable to substantiate abuse/neglect. There were no interviews from other residents or staff to assist in ruling out abuse/neglect.</p> <p>Record review of a second facility investigation, dated 11/13/2024, showed Resident 4 stated a staff member working the night shift had picked them up and fell on top of them. The facility identified the staff member and placed them on administrative leave pending investigation. The investigation showed interviews were completed with the resident and alleged perpetrator, however there were no additional interviews with other staff or residents to rule out abuse/neglect. Staff A's documentation showed abuse/neglect was unsubstantiated.</p> <p>Review of a third facility investigation, dated 11/13/2024, showed Resident 4 stated they received an injury to their right outer toe while being transported in a wheelchair. The investigation showed Staff A was unable to identify staff that may have been involved in the incident and ruled out abuse/neglect. There were no interviews with staff or other residents to rule out abuse/neglect.</p> <p><Resident 52></p> <p>Review of the medical record showed Resident 52 was admitted to the facility with diagnoses including a fracture of the right lower leg. The 11/03/2024 comprehensive assessment showed Resident 52 required assistance of one staff member for ADLs. The assessment also showed Resident 52 had a moderately impaired cognition.</p> <p>During an interview on 11/13/2024 at 9:34 AM, Resident 52 stated staff had left them to lay in their urine and feces. They stated, this morning, they man handled (rough with cares) me and acted disgusted with me when cleaning me. Resident 52 stated the staff were rough and did not treat them like a human.</p> <p>Record review of a facility investigation, dated 11/13/2024, showed Staff A had interviewed Resident 52. The investigation interview showed Resident 52 identified two staff members as alleged perpetrators. The investigation showed the identified staff members were placed on administrative leave pending the investigation. Staff A completed phone interviews with the alleged perpetrators, who denied any issues related to caring for their residents. Staff A was unable to substantiate abuse/neglect, without interviewing other residents or staff.</p> <p><Resident 49></p> <p>Review of the medical record showed Resident 49 had diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), anxiety and major depressive disorder (MDD - a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves). The 10/15/2024 comprehensive assessment showed Resident 49 required supervision/partial assistance of one staff member for activities of daily living and had an intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the 11/17/2024 facility investigation report showed Resident 49 could not remember the date of the incident but was able to recall the staff member for the incident and did not want them to provide any further cares for them. The investigation report showed Resident 49 felt Staff EE, Nursing Assistant (NA), was rough during their care but not deliberate when they were smacked on their bottom, they felt safe, and this had not happened again. The investigation report showed Staff EE was on administrative leave and the facility was unable to substantiate abuse. The investigation report did not contain any interviews from other residents, the alleged perpetrator, or staff.</p> <p>During an interview on 11/13/2024 at 3:46 PM, Resident 49 stated Staff EE, was rude and rough with their personal care during a brief change. Resident 49 stated the incident had occurred a few months prior and was unsure of the date. Resident 49 stated they did not report the incident.</p> <p>During an interview on 11/18/2024 at 10:58 AM, Resident 49 stated Staff F, Unit Manager, interviewed them on 11/17/2024 about the incident. Resident 49 stated the only question they were asked was if Staff EE hit me. Resident 49 stated they explained that Staff EE had been rough and rude with their brief change, and they did not want Staff EE to touch them again. Resident 49 stated they felt Staff EE was disgusted, as they had to perform their personal cares after they could not hold their urine. Resident 49 stated Staff EE had told them to turn onto their side, but they needed assistance and that was when they rolled them roughly onto their right side and smacked their bottom during the process.</p> <p>During an interview on 11/19/2024 at 10:19 AM, Staff B stated they were from out of state and did not understand the Washington State rules in the The Purple Book.</p> <p>During an interview on 11/19/2024 at 10:43 AM, Staff A stated the investigations should include interviews with other residents and staff for a complete investigation. During a follow-up interview at 11:05 AM, Staff A stated the facility investigation reports were not thorough, there were no interviews from the alleged perpetrator, other residents, or staff.</p> <p>Reference: WAC 388-97-0640(6)(c)</p> <p>39652</p> <p>46722</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review [(PASARR) a federally required form that is used to help ensure individuals were not inappropriately placed in nursing homes for long term care] Level II comprehensive evaluation was obtained for 1 of 3 residents (Resident 41) reviewed for PASARR. This failure placed residents at risk for not receiving necessary mental health care and services.</p> <p>Findings included .</p> <p>Review of the policy titled Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients, revised 02/16/2024, showed the social worker or designated staff would review resident ' s PASARRs, update per state requirements, and refer to the appropriate state designated authority.</p> <p><Resident 41></p> <p>Review of the medical record showed Resident 41 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), major depressive disorder (MDD - a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves), and Post Traumatic Stress Disorder [(PTSD) a mental health condition caused by an extreme stressful or terrifying event]. The 11/08/2024 comprehensive assessment showed Resident 41 required substantial/maximal assistance of one to two staff members for activities of daily living and had a moderately impaired cognition.</p> <p>Record review of Resident 41's PASARR, updated 08/08/2024, showed the resident had serious mental disorder indicators of MDD and PTSD. The form showed a Level II evaluation was required and was to be forwarded to the Behavioral Health Administration PASARR contractor immediately.</p> <p>During an interview on 11/19/2024 at 11:11 AM, Staff A, Administrator, stated they were unsure if Resident 41's Level II PASARR screening form was referred for the required evaluation as there was no determination from the evaluation found in the medical record.</p> <p>Reference WAC: 388-97-1975(1)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan, within 48 hours of admission, that documented resident-specific goals and treatment plans for 4 of 7 residents (Resident 62, 35, 26, and 55) reviewed for baseline care plans. Failure to develop a baseline care plan placed the residents at risk for unmet care needs and possible complications.</p> <p>Findings included .</p> <p>Review of a policy titled, Person-Centered Care Plan, revised 10/24/2022, showed a baseline care plan must be developed and implemented within 48 hours of admission/readmission. The baseline care plan must include the instruction needed to provide effective and person-centered care that met professional standards of care. The baseline care plan must include the minimum healthcare information necessary to properly care for a resident that included initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and Pre-admission Screening and Resident Review [(PASARR) a federal requirement to help ensure that individuals were not inappropriately placed in nursing homes for long term care] recommendations. The center must provide the resident/representative with a summary of the baseline care plan that included initial goals of the resident, medications and dietary instructions, any services/treatments to be administered by the facility, and contain evidence that the summary was given to the resident/representative.</p> <p><Resident 62></p> <p>Review of the medical record showed Resident 62 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a degenerative disease that causes movement problems) with dyskinesia (a side effect of Parkinson's disease medications that causes involuntary, erratic, writhing movements of the face, arms, legs, or trunk), kidney failure, and pneumonia (a lung infection). The 09/26/2024 comprehensive assessment showed Resident 62 required substantial/maximum assistance of one staff member for activities of daily living (ADLs). The assessment also showed the resident had a severely impaired cognition. Resident 62 was able to make their needs known.</p> <p>Review of the Resident 62's medical record showed a baseline care plan had not been completed. The comprehensive care plan showed focus areas, goals, and interventions related to ADLs were added to the care plan on 10/07/2024, 13 days after their admission to the facility. The focus areas, goals, and interventions related to social services were not added to the care plan until 10/10/2024, 16 days after admission. The use of psychotropic medication, goals, and interventions were not added to the care plan until 09/24/2024, five days after admission. PASARR evaluation and/or recommendations were not added to the care plan until 11/13/2024, 49 days after admission. Additionally, the care plan did not reflect dietary or therapy orders.</p> <p><Resident 35></p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 ADLs; touch assistance/supervision for eating. The assessment also showed Resident 35 had a moderately impaired cognition.</p> <p>Record review of Resident 35's care plan showed there were no documented focus areas, goals, or interventions related to social services until 11/05/2024, six days after admission to the facility.</p> <p><Resident 26 ></p> <p>Review of the medical record showed Resident 26 was admitted to the facility on [DATE] with diagnoses including heart failure, a seizure disorder, diabetes (a group of diseases that result in too much sugar in the blood), and incomplete quadriplegia (a condition that causes partial weakness or paralysis in the arms and legs). The 09/23/2024 comprehensive assessment showed Resident 26 required supervision from one staff member for eating and was dependent on one to two staff members for all ADLs. Resident 26 had an intact cognition.</p> <p>Review of Resident 26's medical record showed no documentation on the baseline care plan that addressed their dietary orders.</p> <p><Resident 55></p> <p>Review of the medical record showed Resident 55 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease [(COPD) a group of lung diseases that block airflow and make it difficult to breathe] with exacerbation (a sudden worsening), coronary artery aneurysm [a section of a large heart vessel was widened with increased risk of heart attack or rupture (burst) that may lead to death], and high blood pressure. The 08/28/2024 comprehensive assessment showed Resident 55 required substantial/maximal assistance on one to two staff for ADLs and was dependent on staff for transfers. The assessment also showed Resident 55 had a moderately impaired cognition.</p> <p>Review of Resident 55's baseline care plan showed there was no documentation that addressed their physician orders for their admission diagnoses until 08/29/2024, 15 days after they were admitted . Additionally, their dietary orders were not addressed until 08/23/2024, nine days after they were admitted .</p> <p>During an interview on 11/19/2024 at 12:23 PM, Staff A, Administrator, stated the baseline care plan needed to be completed within 24-48 hours. They stated the baseline care plan should have the basic required information to ensure appropriate care and services were provided to the resident upon admission to the facility. Staff A stated there needed to be evidence in the record that proof of the baseline care plan was presented to the resident/representative. Staff A stated the process had not been followed for baseline care plans.</p> <p>Reference: WAC 388-97-1020(3)</p> <p>46722</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on interview and record review, the facility failed to ensure policies were implemented to ensure staff responsible for providing cardiopulmonary resuscitation [(CPR) an emergency procedure consisting of chest compressions combined with giving breaths of air] had current CPR certification for 2 of 9 staff (Staff C and G), reviewed for CPR. Additionally, the documentation on the CPR/automated external defibrillator (AED) - a medical device that can help restore a normal heart rhythm in someone experiencing sudden cardiac arrest) Flow Sheet was incomplete/inaccurate. The facility lacked current records of CPR certification status for all staff that responded to an emergent situation requiring CPR. This failure had the potential to result in a lack of staff that were properly trained in CPR, readily available to respond in an emergency.</p> <p>Findings included .</p> <p>Review of a policy titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], showed CPR certified staff would be on duty at all times. Licensed nursing staff must maintain current CPR certification for healthcare providers. CPR certified staff would initiate CPR and emergency medical services (EMS) would be activated for residents that did not have a do not resuscitate order.</p> <p>Review of a policy titled, Procedure: Cardiac and/or Respiratory Arrest, revised [DATE], showed an individual would be designated to record events on the CPR/AED Flow Sheet.</p> <p><Resident 69></p> <p>Review of the medical record showed Resident 69 was admitted to the facility with diagnoses including kidney failure, diabetes (a group of diseases that result in too much sugar in the blood), and a stroke. The [DATE] comprehensive assessment showed Resident 69 required partial/moderate assistance for activities of daily living. The assessment also showed Resident 69 had a moderately impaired cognition.</p> <p>Record review of Resident 69's Portable Orders for Life-Sustaining Treatment (POLST) form, dated [DATE], showed the resident's wishes included the use of CPR when they had no pulse and were not breathing.</p> <p>Review of a CPR/AED flow sheet, dated [DATE], showed Staff C, Nursing Assistant (NA), found Resident 69 on their bed, gray in color. They were unresponsive. At 12:17 PM, the documentation showed Staff G, NA, initiated ventilations (artificial breaths given to a person during CPR to provide oxygen to their lungs when their heart has stopped beating) and Staff HH, Registered Nurse (RN), initiated compressions (repeatedly pressing down on the center of the chest with the hands to help circulated oxygen-rich blood to the brain and restart breathing). At 12:19 PM, the provider and family were notified by Staff II, RN. EMS arrived at 12:20 PM and an intravenous line[(IV) a flexible tube that's inserted into a vein to deliver fluids or medicine) was inserted by EMS at 12:27 PM. Resuscitation outcome was documented as deceased at 12:37 PM. The form was signed by Staff C and Staff GG, as Person(s) Performing CPR/AED.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a second undated CPR/AED flow sheet showed ventilations were initiated by Staff GG and compressions by Staff C at 12:17 PM. The provider was notified at 12:18 PM by Staff II. EMS inserted the IV line at 12:21 PM. Resident 69 received oral and tracheal suctioning [the use of a suction device to remove mucus and secretions from the mouth or trachea (windpipe)] at 12:22 PM. Staff II notified the family at 12:45 PM, and the resident had expired at 12:44 PM. The form was signed by Staff JJ, RN, as the recorder, and Staff KK, NA, and Staff M as the person(s) that performed CPR/AED.</p> <p>During an interview on [DATE] at 11:46 AM, Staff C stated they had found the resident in their room, sprawled on the bed, unresponsive. They stated they ran to the end of the hall to get the licensed nurse. They stated Staff HH and Staff II were at the nurse's station. Staff C stated Staff HH and Staff II told them to go get your unit manager (Staff F, LPN). Staff C stated they ran back down the hall, through two sets of double doors to the unit manager's office and told them the resident was unresponsive. They stated they ran back to the resident's room and began CPR with Staff HH. Staff C stated Staff G came in to assist. Staff C stated it was probably five minutes from when I found him until we started CPR. Staff C stated there was no process in place to alert the staff as to who was a full code.</p> <p>During an interview on [DATE] at 12:27 PM, Staff F stated Staff C came to their office just before lunch and stated Resident 69 was coding. They stated the normal process was to call a code blue (an announcement stating a person was having a medical emergency) overhead and all staff would respond. They stated they would not be able to hear an overhead page because there was no speaker in their office. Staff F stated there was no post-code meeting to discuss the process.</p> <p>During an interview on [DATE] at 1:25 PM, Staff JJ stated they arrived at the end of the code. They stated they filled out the flow sheet based off the times someone else told me. They stated that was not the normal process. Staff JJ stated the normal process for a code included an overhead page to alert all staff. They stated they did not recall hearing a page that day. They stated one nurse should be the recorder and complete the entire flow sheet as it was happening. They stated they did not know why that did not happen. Staff JJ stated they signed the flow sheet, despite not witnessing the entire code.</p> <p>During an interview on [DATE] at 1:32 PM, Staff M, RN/IP, stated when they arrived at Resident 69's room, the code was already in process. They stated they got in line to do compressions. Staff M stated the process for a code was for someone to check the POLST, notify the nurse, call the code overhead, and call EMS. They stated they should have heard an overhead page but did not that day.</p> <p>During an interview on [DATE] at 3:19 PM, Staff HH stated during the code, there was no one recording. They stated they came up with a time frame after the event. They stated they had never been part of any code drills at the facility.</p> <p>Record review of CPR certification cards showed Staff C and Staff G did not have current CPR certification on file.</p> <p>Review of the reporting log showed no documentation that Resident 69 had an unexpected death and there was no investigation completed.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:11 PM, Staff B, Senior Director of Nursing, stated the normal process should be yelling out for help, someone else grab the crash cart, someone call EMS and the provider, and hopefully EMS arrives and takes over.</p> <p>During an interview on [DATE] at 12:26 PM, Staff A, Administrator, stated the process for initiating CPR included verifying code stated and to call the code by an overhead page. They stated CPR certification cards needed to be kept up to date and code drills should be done. Staff A the unexpected death should have been on the reporting log and an investigation completed according to regulations. They stated the process was not followed.</p> <p>Reference: WAC [DATE](1)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on observation, interview, and record review, the facility failed to provide, individualized, meaningful activities for 5 of 6 residents (Resident 5, 14, 26 ,41, and 51) reviewed for activity participation. This failure placed the residents at risk for boredom, social isolation, and depression.</p> <p>Findings included .</p> <p>Review of a policy titled, Rec202 Program Design, dated 08/07/2023, showed the facility ' s recreation (activities) program must provide, based on the comprehensive assessment and care plan of each resident, an ongoing program to support activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident.</p> <p><Resident 5></p> <p>Review of the medical record showed the resident admitted with diagnoses to include Multiple Sclerosis (a chronic often disabling disease that attacks the central nervous system), and cerebellar ataxia (a condition that causes a loss of muscle coordination especially in the hands and legs). The 08/12/2024 comprehensive assessment showed Resident 5's cognition was moderately impaired and required one to two person staff assistance with activities of daily living (ADLs). Further review of the comprehensive assessment showed it was important for Resident 5 to have books, newspapers, and magazines to read.</p> <p>Record review of Resident 5's care plan, dated 10/12/2023, showed they enjoyed playing cribbage (a card game for two people) and would have visits from activity staff for socialization one time weekly.</p> <p>During an interview on 11/13/2024 at 1:04 PM, Resident 5 stated they only watched television (TV), and they were bored. Resident 5's representative (RR) stated they came to visit Resident 5 daily. The RR stated Resident 5 was always in bed with the TV on. The RR stated Resident 5 gets so bored just watching TV; they (staff) do nothing else for them.</p> <p>During a concurrent observation and interview on 11/16/2024 at 3:34 PM, Resident 5 was lying in bed watching football. Resident 5 had no activity supplies in their room. Resident 5 nodded their head yes when asked if they wanted to get up and maybe go outside or visit other residents. Resident 5 stated staff did not visit them weekly; they stayed in bed all the time, just watching TV. Resident 5 stated they liked to watch/play card games, but no one took them to activities to do those things</p> <p>During an observation on 11/17/2024 at 10:46 AM, Resident 5 was lying in bed watching TV, no activity items in the room.</p> <p>During an interview on 11/15/2024 at 9:23 AM, Staff H, Activities Director (AD) stated they were unsure why Resident 5 was never out of bed and at activities. Staff H stated they had not talked with Resident 5, staff, or their RR about them getting up for activities and that was something they should maybe do.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Resident 14></p> <p>Review of the medical record showed the resident admitted with diagnoses to include congestive heart failure (a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs). The 10/21/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and required the assistance of one to two staff members for ADLs. Further review of the comprehensive assessment showed it was important for Resident 14 to be with groups of people to do their favorite activities.</p> <p>Record review of Resident 14's care plan, dated 10/17/2024, showed they liked to participate in bingo, crafts, and country music performances with groups of people.</p> <p>During an interview on 11/17/2024 at 3:13 PM, Resident 14 stated they get bored a lot and would like to go to activities with other people. Resident 14 stated they did have some activities in the activity room, but they (the staff) never came to get them or remind them of activity times. Resident 14 stated they had asked staff to remind them of the scheduled activities and they had only been reminded once. Resident 14 pointed to their activities schedule on the wall and stated it was too small of a print for them to even read; they had no idea what activities were scheduled and when.</p> <p>During a follow-up interview on 11/18/2024 at 12:29 PM, Resident 14 stated no one from the facility had interviewed them about the activities they enjoyed. Resident 14 stated they really enjoy playing computer games and bingo.</p> <p><Resident 51></p> <p>Review of the medical record showed the resident was admitted to the facility with diagnoses of congestive heart failure and chronic obstructive pulmonary disease (a lung disease that causes restricted air flow and breathing problems). Review of the most recent comprehensive assessment, dated 10/23/2024, showed the resident was cognitively intact.</p> <p>During multiple observations on 11/13/2024 at 9:34 AM, 11/14/2024 at 4:46 PM, 11/15/2024 at 10:36 AM, and 11/16/2024 at 2:10 PM, showed Resident 51 sitting in their room alone, in the dark, at the side of the bed.</p> <p>During an observation and concurrent interview on 11/17/2024 at 10:21 AM, Resident 51 was sitting in their room alone in the dark, as their curtains were pulled, and no lights were on. Resident 51 stated I just do not have anything to do here but sit in my room. The resident stated, I miss going outside and I get so lonely.</p> <p><Resident 41></p> <p>Review of the medical record showed Resident 41 was admitted to the facility with diagnoses including heart disease, dementia (a progressive disease that destroys memory and other important mental functions), and depression. The 11/08/2024 comprehensive assessment showed Resident 41 required substantial/maximal assistance of one to two staff members for ADLs and had a moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/14/2024 at 10:29 AM, Resident 41's representative (RR), stated Resident 41 had no activities provided by the facility. The RR stated Resident 41 should be involved in activities. Resident 41's representative stated most of the days they visited, Resident 41 was either in their bed watching tv or sitting in their wheelchair by the nurse's station.</p> <p>An observation on 11/15/2024 at 10:04 AM, showed Resident 41 lying in their bed, resting with the television on.</p> <p>During an observation and interview on 11/15/2024 at 1:35 PM, showed Resident 41 lying in their bed, awake, with the television on. Resident 41 stated they had not been out of bed yet and was waiting for staff to help them get up for the day. Resident 41 stated they enjoyed basketball, football, and country music. Resident 41 stated they had not been to activities at the facility and was only able to sit in their wheelchair by the nurses. Resident 41 stated they were not informed when activities were happening at the facility, but when there was music happening, they would like to go.</p> <p>An observation on 11/15/2024 at 2:31 PM, showed Resident 41 lying in their bed while a live musician was performing in the activities room.</p> <p>During an interview on 11/15/2024 at 2:32 PM, Staff CC, Nursing Assistant (NA), stated they did not know what activities were happening in the facility, as they did not review the activity schedule. Staff CC stated they did not ask Resident 41 or any other residents if they would like to attend any activities.</p> <p><Resident 26></p> <p>Review of the medical record showed Resident 26 was admitted to the facility on [DATE] with diagnoses including heart failure, a seizure disorder, diabetes (a group of diseases that result in too much sugar in the blood), and incomplete quadriplegia (a condition that causes partial weakness or paralysis in the arms and legs). The 09/23/2024 comprehensive assessment showed Resident 26 required supervision from one staff member for eating and was dependent on one to two staff members for all ADLs. Resident 26 had an intact cognition.</p> <p>During a concurrent observation and interview on 11/13/2024 at 10:37 AM, Resident 26 was lying in bed, flat on their back, with the TV on. Resident 26 stated no one helped them to get out of bed and TV is the only activity they had.</p> <p>During an observation and interview on 11/17/2024 at 1:21 PM, Resident 26 was again lying in bed, flat on their back. They stated, all I do is watch TV all day. They stated no one came in to visit them or do activities with them.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/18/2024 at 11:52 AM, Staff H, Activities Director, stated the process for involving residents in activities included completing an assessment on admission. They stated they asked the resident if they wanted to attend group activities. If not, they gave them the weekly newsletter and the monthly calendar, with the activities highlighted on the calendar. They stated they did room visits for those residents that did not like to leave their room. Staff H stated room visits were once a week for 15-minute sessions. Staff H stated there were currently 14 residents on the scheduled room visits and five residents attended group activities, for a total of 19 residents receiving activities (current census was 72). They stated they did stop in to visit other residents when delivering the weekly newsletter but did not put them on the room visit schedule, because they would have to schedule them and it could just as easily be an informal visit if not scheduled. Staff H stated they were unable to find any resources for activities on their corporate website. They stated, I should probably reach out to someone at the corporate level to assist with activities; I assumed they would reach out to me.</p> <p>During an interview on 11/19/2024 at 10:00 AM, Staff B, Senior Director of Nursing, stated the process for ensuring residents and staff knew when and where activities occurred, included passing out a monthly activity calendar. They stated Staff H asked the residents to attend activities but was told they consistently refused to go. They stated they thought Staff H did one on one visits with the residents that did not attend group activities. Staff B stated their expectation was for the NAs to bring the residents to activities but I don't see it happening.</p> <p>During an interview on 11/19/2024 at 12:30 PM, Staff A, Administrator, stated the process began with getting the resident's out of bed and involved in the facility activities. They stated there should be smaller group activities that were of interest to the residents. Staff A stated Staff H should talk with the residents about their interests, interact with them, and create that environment for them. Staff A stated the process for activities was a broken system.</p> <p>Reference: WAC 388-97-0940(1)</p> <p>48368</p> <p>39652</p> <p>46722</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>48368</p> <p>Based on observation, interview, and record review, the facility failed to ensure restorative nursing services programs were implemented for 4 of 6 residents (Resident 5, 9, 19, and 50), reviewed for restorative nursing and limited range of motion [(ROM) the extent the joint can move within the expected (normal) range of values]. This failure placed the residents at risk for loss of ROM, deconditioning, pain, and contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen).</p> <p>Findings included .</p> <p>Record review of the facility policy titled, Restorative Nursing, dated 08/07/2023, showed the facility would provide restorative nursing programs for residents who .have restorative needs arise during the course of a longer-term stay .will benefit from restorative programs .to help the patient obtain and maintain optimal physical, mental, and psychosocial functioning . Further review of the policy showed restorative programs were coordinated by nursing and were resident specific based on individual needs. A licensed nurse must oversee the program.</p> <p><Resident 5></p> <p>Review of the medical record showed the resident admitted with diagnoses including Multiple Sclerosis (a chronic often disabling disease that attacks the central nervous system) and cerebellar ataxia (a condition that causes a loss of muscle coordination especially in the hands and legs). The 08/12/2024 comprehensive assessment showed Resident 5's cognition was moderately impaired and required the assistance of one to two staff members with activities of daily living (ADLs) and had impairment to both their upper and lower extremities. The assessment further showed Resident 5 had no restorative nursing programs in place.</p> <p>Record review of Resident 5' care plan, dated 11/29/2023, showed no restorative nursing programs were in place.</p> <p>During an interview on 11/13/2024 at 1:18 PM, Resident 5 stated they had not had anyone working with them from therapy or providing any exercises for their ROM and they would like to exercise. Resident 5's representative stated the facility did not provide any programs or exercises for Resident 5 and they would really like for them to have some form of therapy, they just lay in bed all day.</p> <p><Resident 9></p> <p>Review of the medical record showed the resident admitted with diagnoses to include a stroke (when blood flow to the brain is cut off, damaging brain tissue) and diabetes [the body cannot use glucose (a type of sugar) normally]. The 10/21/2024 comprehensive assessment showed Resident 9's cognition was moderately impaired and required the assistance of one staff member for ADLs. Resident 9 had impairment to one side of upper extremities and impairment to both sides of lower extremities. The assessment further showed no restorative nursing programs in place.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 9's care plan, dated 07/20/2024, showed a focus area that Resident 9 was at risk for changes in functional ability related to contractures and required preventative measures and treatment to right hand, shoulder, and wrist. Further review of the care plan showed no restorative nursing programs were in place.</p> <p>During an interview on 11/15/2024 at 12:26 PM, Resident 9 stated they did not have any ROM or exercise programs. Resident 9 stated the Nursing Assistants (NA) placed their splint to their right hand but did not do any stretching of their right upper extremity.</p> <p><Resident 19></p> <p>Review of the medical record showed the resident admitted with diagnoses to include a traumatic brain injury (an injury to the brain that occurs when an external force impacts the head) and stroke. The 08/14/2024 comprehensive showed Resident 19 required the assistance of two staff members with ADLs and had impairment to both their upper and lower extremities. The assessment showed Resident 19 had an intact cognition and there were no restorative nursing programs in place.</p> <p>Record review of Resident 19's care plan, dated 04/17/2022, showed a focus area that Resident 19 was at risk for changes in functional ability related to contractures to the left arm, elbow, and shoulder. Further review of the care plan showed the NAs were to provide ROM to their left upper extremity during dressing and bathing.</p> <p>During an interview on 11/15/2024 at 12:18 PM, Staff MM, NA, stated they did not have any residents on a restorative program related to staffing issues. Staff MM stated they did not have any training on how to do ROM exercises for Resident 19, so they did not do them. Staff MM stated the residents did not get the attention they needed without the programs.</p> <p>During an interview on 11/18/2024 at 4:17 PM, Staff QQ, NA, stated they did not receive training on how to perform ROM on residents. Staff QQ stated they did some stretching on Resident 19's left arm when getting them dressed but were unsure if there was a program for that.</p> <p><Resident 50></p> <p>Review of the medical record showed the resident admitted with diagnoses to include diabetes, diabetic neuropathy (a type of nerve damage that occurs in people with diabetes most common in the feet and legs), and heart disease. The 10/16/2024 comprehensive assessment showed Resident 50's cognition was intact and required the assistance of one staff member with ADLs.</p> <p>During an interview 11/13/2024 at 10:47 AM, Resident 50 stated when they were discharged from skilled therapy services, they were given a paper with instructions on how to do exercises on their own, in their bed. Resident 50 stated staff did not help them with their exercises.</p> <p>An observation and concurrent interview on 11/17/2024 at 1:29 PM, showed a printed-out paper on Resident 50's bedside table labeled home exercise program, with instructions to perform bed exercises two times daily. Resident 50 stated it was a challenge for them to do the exercises themselves, they got pretty tired and were only able to do them once daily. Resident 50 stated no one checked on them, I guess they just trust that I can do it.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024 at 9:36 AM, Staff G, NA, stated they did not have a restorative nursing program; they took away the restorative aide position related to being short staffed. Staff G further stated they were not aware of any residents that were on a restorative program.</p> <p>During an interview on 11/15/2024 at 11:17 AM, Staff E, Director of Rehab/Physical Therapy Assistant, stated they were aware they did not have a restorative nursing program due to staffing issues. Staff E stated it was something they would look into moving forward.</p> <p>During an interview on 11/18/2024 at 3:40 PM, Staff JJ, Registered Nurse, stated they did not have enough NAs to work the floor, so they had to pull the restorative nursing program. Staff JJ stated they did not have a process in place at this time and they needed to do more education and training.</p> <p>During a follow-up interview on 11/18/2024 at 3:28 PM, Staff E stated they had only worked at the facility for two weeks and did not have answers as to why there was no program for the residents.</p> <p>Reference: WAC 338-97-1060 (3)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment that was free from avoidable accident hazards for 1 of 5 residents (Resident 4) reviewed for accidents with injury. This failed practice placed the residents at risk for avoidable accidents when Resident 4 experienced actual harm when their fifth toe on their right foot was broken while being pushed in their wheelchair. Additionally, the facility failed to ensure a safe smoking area and storage of smoking paraphernalia (items or equipment associated with a particular activity, hobby, or lifestyle) for 3 of 3 residents (Residents 13, 27, and 45) reviewed for safe smoking. The failure to ensure a safe smoking environment and storage of smoking paraphernalia placed the residents at risk for dissatisfaction with their smoking activity experience and injury.</p> <p>Findings included .</p> <p>Review of a policy titled, Accidents/Incidents, revised 03/01/2024, showed an accident was defined as any unexpected or unintentional incident that may result in injury or illness to a resident. After an accident occurred, the licensed nurse (LN) would report the accident and assist with a timely investigation to determine the cause. They would take immediate post-accident measures, implement appropriate interventions, update the care plan and communicate with the resident/representative, and complete nursing documentation and change of condition. Any incident that would be considered an allegation of abuse/neglect would be managed according to facility abuse prohibition policy. The LN would evaluate the resident, notify the physician, report the physical findings/extent of injuries, and obtain orders if necessary. The LN would create an event report in the medical record and document the accident in the resident's chart. All accidents would be reported to the supervisor. All accidents would be investigated to determine if the accident had been reported timely, investigated, and interventions were implemented.</p> <p><Injury></p> <p><Resident 4></p> <p>Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including diverticulitis (inflammation of pouches in the colon that can cause abdominal pain, fever, nausea, vomiting, and sometimes bleeding), epilepsy (a brain disorder that causes people to have repeated seizures), and anxiety. The 10/24/2024 comprehensive assessment showed Resident 4 required substantial/maximal assistance of one staff member for activities of daily living (ADLs), including transfers and mobility. Resident 4 was able to make their needs known.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 11/13/2024 at 3:21 PM, Resident 4 stated their right foot little toe was hurt from the accident that occurred two or three days ago, maybe Sunday. Resident 4 stated they were in their wheelchair that morning and someone had pushed them to the bathroom. Resident 4 stated they hit their foot on their roommate's bed. They stated their foot hurt and no one had looked at it. At 3:50 PM, Staff E, Director of Rehab/Physical Therapy Assistant (PTA) was attending to Resident 4's roommate. They came to Resident 4's bedside and removed Resident 4's right sock. The fifth toe showed blue/purple discoloration at the base of the toe that was one inch in length. The bruising was on both the top and side of the foot. Resident 4 stated to Staff E, I asked you to look at my foot earlier because it hurt and was bumped on their roommate's bed. Staff E responded, you asked me to remove your shoe.</p> <p>During an interview on 11/18/2024 at 8:49 AM, Staff E stated Resident 4 had told them that morning (11/13/2024) that their foot was sore. They stated they removed Resident 4's shoe, did not remove their sock, and asked the resident to wiggle their toes. Staff E stated Resident 4 was able to wiggle their toes and told the resident they were fine.</p> <p>During an interview on 11/18/2024 at 2:33 PM, Staff L, Registered Nurse (RN), stated the injury to Resident 4's foot was reported to them the same day the State Surveyor had reported it to the Administrator (11/13/2024). Staff L stated when they received the report, they assessed the foot and noted purple bruising on the outer side of the fifth toe. Resident 4 reported they had pain with palpation (the process of using one's hands to check the body). Staff L stated they administered pain medication, completed a risk management form, and reported it to the administrative staff. Staff L stated they notified the provider and an order for an X-ray had been placed. Staff L stated they were not notified of any accident or injury until after the State Surveyor had reported it.</p> <p>During an interview on 11/19/2024 at 8:43 AM, Staff F, Unit Manager, stated they were informed of the injury by Staff L. They stated the process was for staff to inform the nurse when an accident/injury had occurred. The licensed nurse would complete a change in condition form to notify the provider of the injury. Staff F stated Staff L completed the form and notified the provider electronically with a change in condition form the night they were told of the injury.</p> <p>Review of the medical record showed an x-ray had been obtained on 11/14/2024, one day after the Resident 4 reported the injury. The x-ray report showed a fracture of the fifth proximal phalanx (smallest toe).</p> <p>During an interview on 11/19/2024 at 10:19 AM, Staff B stated they were unable to determine who injured Resident 4's toe. They stated Staff F had assessed the resident's injury by removing both socks and comparing the feet but was unsure what day that occurred. Staff B stated Staff F reported no concerns at that time. Staff B stated it took a few days for the bruising to show. They stated they assessed the resident on 11/14/2024, saw the bruising, and ordered an x-ray. Staff B stated the process was for staff to report accidents, injuries, and pain to ensure those concerns were followed up on. Staff B stated the process was not followed.</p> <p>During an interview on 11/19/2024 at 12:34 PM, Staff A, Administrator, stated the process should have been for Staff E to report the injury as soon as Resident 4 informed them of the incident. Staff A stated Staff E should not have assessed the resident's injury, as that was not the process, nor their role. Staff A stated any injury should also be immediately reported to the provider, especially if there was pain and/or swelling. Staff A stated the process was not followed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><Smoking></p> <p>Review of the policy titled Smoking, revised on 05/01/2024, showed smoking would be permitted in the designated area only, have a non-combustible container for cigarette disposal, and the outdoor smoking area would protect residents from weather conditions. The policy further showed smoking supplies to include tobacco, and lighters would be stored at the nursing station.</p> <p><Resident 13></p> <p>Review of the medical record showed Resident 13 with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), heart disease and absence of left lower leg. The 09/18/2024 comprehensive assessment showed Resident 13 was independent for ADLs, able to use a manual wheelchair for mobility, and had an intact cognition.</p> <p>Review of the Resident 13's smoking evaluation, dated 08/29/2024, showed they were allowed to smoke independently. The evaluation also showed they were aware of the designated smoking area, reviewed the smoking policy, and their smoking supplies would be maintained by staff and stored at the nursing station.</p> <p>During an interview on 11/13/2024 at 9:53 AM, Staff J, RN, stated Resident 13 would go outside to smoke multiple times per day.</p> <p>During an interview on 11/13/2024 at 9:55 AM, Resident 13 stated they were a current smoker and went outside to smoke five times a day. Resident 13 stated when the weather was good, they would smoke in the designated smoking area, however when the weather was raining, snowing, or hot sun, they would not smoke in the designated smoking area as there was no protection from the elements. Resident 13 stated they always kept their cigarettes and lighter in their room or with them at all times. Resident 13 stated they disposed of their used cigarettes in their empty cigarette pack and put them into their trash can in their room.</p> <p>An observation on 11/13/2024 at 11:31 AM, showed the designated smoking area was an uncovered cement area in the back of the facility. The current weather condition was heavy rain, and the area contained standing water on the pathway from the building to the cement area for smoking.</p> <p>An observation on 11/13/2024 at 1:12 PM, showed Resident 13's trash can in their room had an empty cigarette box with six smoked/used cigarettes in the box.</p> <p>An observation on 11/15/2024 at 10:50 AM, showed Resident 13 in front of the facility under the covered entrance smoking as it was raining.</p> <p>During an interview on 11/18/2024 at 3:04 PM, Resident 13 stated they would continue to go to the front of the facility under the covered entrance to smoke when the weather was bad, as the facility had not provided a covered area in the designated smoking area. Resident 13 stated they had continued to put their used cigarettes in their empty cigarette box and brought to their room to dispose of in their trash can. Resident 13 further stated the nurses were supposed to keep their cigarettes and lighter until they asked for them. Resident 13 stated the nurses had never stored their smoking supplies as they kept the supplies with them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 11/19/2024 at 12:47 PM, Resident 13 was smoking in front of the facility under the covered entrance.</p> <p><Resident 45></p> <p>Review of the medical record showed Resident 45 with diagnoses including stroke with left sided weakness and depression. The 10/25/2024 comprehensive assessment showed Resident 45 required supervision of one staff member for ADLs, independent for use of manual wheelchair for mobility, had a moderately impaired cognition, and was able to make their needs known.</p> <p>Review of Resident 45's smoking evaluation, dated 11/11/2024, showed they were allowed to smoke independently. The evaluation also showed they were aware of the designated smoking area, reviewed the smoking policy, and their smoking supplies would be maintained by staff and stored at the nursing station.</p> <p>During an interview on 11/14/2024 at 10:04 AM, Resident 45 stated they were a current smoker, and they were able to smoke when they wanted. Resident 45 stated they smoked in the facility designated smoking area and disposed of their used cigarettes in the cigarette disposal container. Resident 45 stated they kept their cigarettes and lighter with them in their room.</p> <p>An observation on 11/17/2024 at 10:04 AM, showed Resident 45 outside the exit door on the west hall smoking a cigarette. Resident 45 was not smoking in the designated smoking area.</p> <p>An observation on 11/18/2024 at 2:51 PM, showed Resident 45 smoking outside the exit door on the west hall and not in the designated smoking area.</p> <p>During an observation on 11/19/2024 at 11:02 AM, showed Resident 45 and Resident 13 in the front of the facility under the covered entrance smoking. The current weather condition was cool, dry and windy.</p> <p><Resident 27></p> <p>Review of the resident's medical record showed they were admitted to the facility with diagnoses including End Stage Renal Disease (the kidneys no longer function properly) with dialysis (a treatment that removes waste and excess fluid from the blood) and a history of a cerebral vascular accident (damage to the brain from interruption in blood flow) with right arm hemiplegia (a condition that causes paralysis or weakness to one side of the body). Review of the most recent comprehensive assessment dated [DATE] showed the resident had mild cognitive impairment and limited use of their right arm.</p> <p>During an interview on 11/13/2024 at 10:59 AM, Resident 27 stated they had smoked since they were [AGE] years old and were not interested in quitting. The resident patted their upper right pocket and stated they had a pack of cigarettes and a lighter under their jacket so they could smoke out front when they wanted to. Resident 27 was asked if they were aware there was a designated smoking area in the back of the building, and they stated yes but only smoked out front and further stated they kept their cigarettes and lighter in their room. I don't turn them in because I like to keep them close.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a document in the resident's record titled Smoking Policy showed Resident 27 had signed it on 05/24/2024. The document outlined the conditions for remaining an independent smoker as follows:</p> <p>Smoking materials must be stored at the nurse's station. Residents cannot keep materials in their room or on their person.</p> <p>The resident smoking area is located off campus (out back), there are no other designated smoking areas on the campus.</p> <p>Residents who fail to comply with this policy will lose their independent smoking privileges and may be subject to discharge.</p> <p>During a concurrent observation and interview on 11/17/2024 at 1:40 PM, Resident 27 stated they had a new carton of cigarettes and showed the surveyor where they kept them along with their lighter in the top right drawer of their nightstand. I can keep them safe here; I do not need to give them to the nurse.</p> <p>During an interview on 11/17/2024 at 2:00 PM, Staff FF, Licensed Practical Nurse, stated they were aware that Resident 27 had cigarettes and a lighter in their room. Staff FF further stated they never turned in their cigarettes and lighter for safe storage at the nurse's station and preferred to keep them in their room.</p> <p>During an interview on 11/18/2024 at 11:12 AM, Staff A, Administrator, stated they were aware of the residents who kept their smoking equipment in their rooms and were not smoking in the designated area. Staff A stated their preference was for the residents to comply with the smoking policy however they just do not.</p> <p>Reference: WAC 388-97-1060(3)(g)</p> <p>46722</p> <p>39652</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652</p> <p>Based on interview and record review, the facility failed to ensure dialysis (the kidneys no longer function and require a process to remove waste and excess fluids from the blood stream) services met professional standards of care for 1 of 2 residents (Resident 27), reviewed for dialysis. The facility did not have an effective or coordinated process for communication between the facility and the offsite dialysis center for continuity of care. This failure placed residents receiving dialysis at risk for complications and unmet care needs.</p> <p>Findings included .</p> <p>Review of a policy titled Dialysis: Hemodialysis [(HD) a medical treatment that filters waste/excess fluid from the blood] Provided by a Certified End-Stage Renal Disease (ESRD) Facility, revised 08/07/2023, showed . the care of the patient receiving HD must reflect ongoing communication, coordination, and collaboration between the facility and dialysis staff .communication and responses will be documented in the medical record.</p> <p><Resident 27></p> <p>Review of the resident's medical record showed they were readmitted to the facility with diagnoses including ESRD (the kidneys no longer work) with dialysis and diabetes (the body has too much sugar in the blood). Review of the most recent comprehensive assessment dated [DATE] showed the resident had mild cognitive impairment.</p> <p>Record review of the November 2024 physician orders showed the resident received dialysis twice weekly at an offsite dialysis center.</p> <p>Review of Resident 27's Hemodialysis Communication Records from 06/03/2024 to 11/18/2024, showed the resident had 50 forms initiated for communication between the facility and the dialysis center, however, 22 of the forms were incomplete. The incomplete dialysis communication forms did not adequately monitor the resident's condition pre/post dialysis and placed them at risk for unforeseen complications.</p> <p>During an interview on 11/15/2024 at 11:20 AM, Staff F, Unit Manager, stated the pre/post dialysis communication forms were sent with the resident in a dialysis book. If the book was not returned or the form was not completed, the nurses were to call the dialysis center to obtain the information.</p> <p>During an interview on 11/18/2024 at 12:57 PM, Staff B, Senior Director of Nursing, stated their expectation was that the pre/post dialysis communication form be sent with the resident and returned to the facility completed. Staff B further stated, It has been a struggle getting this to happen.</p> <p>Reference: WAC 388-97-1900(1)(6)(a-c)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care, in accordance with professional standards of practice for 1 of 2 residents (Resident 62), reviewed for trauma informed care. The facility failed to accurately assess, monitor, and care plan Resident 62's experiences and preferences regarding their past trauma and potential triggers (a stimulus that could prompt a recall of a previous traumatic event, even if the stimulus itself was not traumatic or frightening) that may cause re-traumatization (a reliving of the traumatic experience). This failure placed the resident at risk for unidentified triggers and re-traumatization.</p> <p>Findings included .</p> <p><Resident 62></p> <p>Review of the medical record showed Resident 62 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a degenerative disease that causes movement problems) with dyskinesia (a side effect of Parkinson's disease medications that causes involuntary, erratic, writhing movements of the face, arms, legs, or trunk), kidney failure, and depression. The 09/26/2024 comprehensive assessment showed Resident 62 required substantial/maximum assistance of one staff member for activities of daily living. The assessment also showed the resident had a severely impaired cognition. Resident 62 was able to make their needs known.</p> <p>A concurrent observation and interview on 11/13/2024 at 10:08 AM, showed Resident 62 sitting in their wheelchair in their room. The lights were dimmed. Resident 62 stated they had trauma in their past related to the deaths of their son and daughter in law. They stated they became really sad when certain songs were played, when they saw others with their family members, or when people talked about their family.</p> <p>Record review of a Clinical Admission assessment dated [DATE], showed Resident 62 answered yes to three of five questions related to trauma informed care (history of a traumatic event and reactions to traumatic event).</p> <p>Record review of a Trauma Questionnaire dated 09/26/2024, showed Resident 62 had answered no to all ten questions related to trauma.</p> <p>Record review of Resident 62's comprehensive care plan dated 11/13/2024, showed no focus area, goals, interventions, or triggers related to Resident 62's trauma.</p> <p>During an interview on 11/19/2024 at 9:37 AM, Staff B, Senior Director of Nursing, stated the process for screening for trauma included social services completing an assessment. If a trauma history was identified, it would be put into the care plan. Staff B stated the process included both nursing and social services departments to communicate their findings with each other. They stated the trauma and triggers should have been care planned for Resident 62, discussed in their morning meetings, and the information should have been shared.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/2024 at 12:36 PM, Staff A, Administrator, stated the process for trauma informed care included screening for trauma on admission. They stated any identified trauma should be well documented, care planned, along with triggers identified. They stated they did not want to retraumatize the resident by not identifying the triggers. Staff A stated the process for trauma informed care was not followed.</p> <p>Reference: WAC 388-97-1060(3)(e)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>45117</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of competent nursing staff to provide care and services for 12 of 12 residents (Resident 62, 26, 49, 8, 9, 14, 2, 51, 55, 5, 19, and 50) reviewed for resident rights, social services, activities, and restorative nursing programs. These failures placed residents at risk of not having their needs met and potential negative outcomes to their physical and mental health.</p> <p>Findings included .</p> <p><Resident Rights></p> <p><F-550 Exercise Rights></p> <p>The facility failed to ensure a process was in place to allow residents to exercise their constitutional right as a United States Citizen to vote in the 2024 Presidential Election.</p> <p><Resident 26></p> <p>During an interview on 11/13/2024 at 10:33 AM, Resident 26 stated they did not get to vote this year. They stated they had completed their ballot and had asked their nursing assistants and nursing staff to mail their ballot, but no one had mailed it for them. They stated it was important for them to vote, and they were disappointed that their ballot did not get mailed.</p> <p><Resident 8></p> <p>During an interview on 11/18/2024 at 12:30 PM, Resident 8 stated they were unable to see their ballot, and no one would help them fill it out. Resident 8 stated they tried to get someone to help them. Resident 8 stated they were very upset, mad, disappointed, and cheated out of their rights.</p> <p><Resident 49></p> <p>During an interview on 11/18/2024 at 2:23 PM, Resident 49 stated they did not get to vote in the recent election. They stated they were interested in the election but could not figure how to vote. They stated no one at the facility had provided information on how to register and vote.</p> <p><Resident 62></p> <p>During an interview on 11/18/2024 at 2:39 PM, Resident 62 stated they did not get to vote in this year's Presidential election. Resident 62 stated no one had asked them if they wanted to vote and would have like to.</p> <p><F-561 Self Determination></p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility failed to provide choices for the resident's dining experience due to staff shortages.</p> <p><Resident 51></p> <p>During an interview on 11/13/2024 at 11:05 AM, Resident 52 stated they would like to eat in the dining room and make some new friends I get so lonely sometimes. The resident further stated they were unable to eat in the dining room because it was always closed.</p> <p>During an interview on 11/13/24 12:14 PM Staff MM, Nursing Assistant, NA stated the dining rooms had been closed related to not having enough staff to assist with eating in both the dining rooms and resident rooms.</p> <p><Resident 2></p> <p>During an interview on 11/13/2024 at 3:33 PM, Resident 2 stated they would love to eat in the dining room. The resident stated, I get so tired of being bound to my room to eat.</p> <p><Resident 14></p> <p>During an interview on 11/15/2024 at 12:55 PM, Resident 14 stated they were unsure why no one ate their meals in the dining room and very seldom saw anyone in there. Resident 14 stated they would like to eat in the dining room, but no one was ever there so they might as well just stay in their room.</p> <p><Resident 9></p> <p>During an interview on 11/15/2024 at 2:10 PM, Resident 9 stated they would like to eat in the dining room, they missed eating with their friends.</p> <p>During an interview on 11/15/2024 at 3:01 PM Staff B, Senior Director of Nursing, stated the dining rooms have remained closed due to low staffing. Staff B stated they did not have enough staff to pull Nursing Assistants off the floor to staff the dining rooms. Staff B further stated it was the residents right to choose to eat in the dining room and they knew it was an issue with their rights.</p> <p><Social Services></p> <p><F-644 Pre-Admission Screening and Resident Review (PASARR - a federally required form that is used to help ensure individuals were not inappropriately placed in nursing homes for long term care) ></p> <p>The facility failed to ensure a Level II comprehensive evaluation was obtained for a resident that had major depressive disorder (MDD - a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves) and Post Traumatic Stress Disorder (PTSD - a mental health condition caused by an extreme stressful or terrifying event).</p> <p><Resident 41></p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of Resident 41's PASARR, updated 08/08/2024, showed the resident had serious mental disorder indicators of MDD and PTSD. The form showed a Level II evaluation was required and was to be forwarded to the Behavioral Health Administration PASARR contractor immediately.</p> <p><Baseline Care Plan F-655></p> <p>The facility failed to develop a baseline care plan, within 48 hours of admission, that documented resident-specific goals and treatment plans.</p> <p><Resident 62></p> <p>Review of the Resident 62's showed a baseline care plan had not been completed.</p> <p><Resident 35></p> <p>Record review of Resident 35's care plan showed there were no documented focus areas, goals, or interventions related to social services until 11/05/2024, six days after admission to the facility.</p> <p><Resident 26 ></p> <p>During an interview on 11/17/2024 at 1:21 PM, Resident 26 stated they did not remember receiving anything regarding their care or goals when they were admitted to the facility.</p> <p>Review of Resident 26's medical record showed no documentation on the baseline care plan that addressed their dietary orders.</p> <p><Trauma Informed Care F-699></p> <p>The facility failed to accurately assess, monitor, and care plan Resident 62's experiences and preferences regarding their past trauma and potential triggers (a stimulus that could prompt a recall of a previous traumatic event, even if the stimulus itself was not traumatic or frightening) that may cause re-traumatization (a reliving of the traumatic experience).</p> <p>During an interview on 11/19/2024 at 9:37 AM, Staff B stated the process for screening for trauma included social services completing an assessment.</p> <p><Activities F-679></p> <p>The facility failed to provide, individualized, meaningful activities for residents.</p> <p><Resident 5></p> <p>During an interview on 11/13/2024 at 1:04 PM, Resident 5 stated they only watched television (TV), and got bored. Resident 5's representative (RR) stated the resident was always in bed with the TV on during their daily visit. The RR stated Resident 5 gets so bored just watching TV, they (staff) do nothing else for them.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/15/2024 at 9:23 AM, Staff H, Activities Director, (AD) stated they were unsure why the residents never out of bed and at activities.</p> <p><Resident 41></p> <p>During an observation and interview on 11/15/2024 at 1:35 PM, showed Resident 41 lying in their bed awake with the television on. Resident 41 stated they had not been out of bed yet and was waiting for staff to help them get up for the day. Resident 41 stated they enjoyed basketball, football and county music. Resident 41 stated they had not been to activities at the facility and only was able to sit in their wheelchair by the nurse 's station. Resident 41 stated they were not informed when activities were happening at the facility.</p> <p><Resident 51></p> <p>During an observation and concurrent interview on 11/17/2024 at 10:21 AM, Resident 51 was sitting in their room alone in the dark as their curtains were pulled and no lights were on. Resident 51 stated I just do not have anything to do here but sit in my room. The resident stated, I miss going outside and I get so lonely.</p> <p><Resident 26></p> <p>During an observation and interview on 11/17/2024 at 1:21 PM, Resident 26 was again lying in bed, flat on their back. They stated, all I do is watch TV all day. They stated no one came in to visit them or do activities with them.</p> <p><Resident 14></p> <p>During an interview 11/17/2024 at 3:13 PM, Resident 14 stated they got bored a lot and would like to go to activities with other people. Resident 14 stated they had asked staff to remind them of the activities and they have only been reminded once.</p> <p>During an interview on 11/19/2024 at 10:00 AM, Staff B stated their expectation was for the nursing assistants to get the residents up and bring them to activities but I don't see it happening.</p> <p><Restorative F-688></p> <p>The facility failed to ensure restorative therapy services were implemented to prevent avoidable reduction of range of motion (ROM) and mobility.</p> <p><Resident 50></p> <p>During an interview 11/13/2024 at 10:47 AM, Resident 50 stated when they were discharged from skilled therapy services, they were given a paper with instructions on how to do exercises in their own in their bed. Resident 50 stated staff did not help them with their exercises.</p> <p><Resident 5></p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/13/2024 at 1:18 PM, Resident 5 stated they had not had anyone working with them from therapy or providing any exercises for their range of motion (ROM) and they would like to exercise. Resident 5's representative stated the facility did not provide any programs or exercises for Resident 5 and they would really like for them to have some form of therapy, they just lay in bed all day.</p> <p>During a concurrent interview on 11/15/2024 at 9:36 AM, Staff PP, NA and Staff G, NA, stated the facility did not have a restorative program due to staffing. They stated there was no available to do the restorative programs.</p> <p><Resident 9></p> <p>During an interview on 11/15/2024 at 12:26 PM, Resident 9 stated they did not have any ROM or exercise programs. Resident 9 stated the nursing assistants placed their splint on their right hand but did not do any stretching of their right upper extremity.</p> <p><Resident 19></p> <p>During an interview on 11/18/2024 at 4:00 PM, Resident 41 stated it hurt when the nursing assistants helped them to get dressed. They stated their left arm was so stiff and it would not move. They stated their fingers often got stuck on their clothes and it hurt.</p> <p>During an interview on 11/15/2024 at 12:32 PM, Staff F, Unit Manager, stated staffing was a struggle. They stated the facility did not have enough staff in general. During a follow up interview on 11/19/2024 at 9:04 AM, Staff F stated there was not enough staff at the facility, across the board to take care of our residents. They stated the lack of staff effected resident's getting showers, skin checks, wound care, and nursing documentation. Staff F stated, we don't have the staff to stay in the dining room with the residents. They stated they had residents came to them and voiced concerns about being short staffed.</p> <p>During an interview on 11/19/2024 at 10:54 AM, Staff B stated the process for staffing included ensuring each day was staffed correctly. They stated the call outs were extreme. Staff B stated they did not have enough people to cover a monthly schedule that allowed for days off or vacations for the nursing assistants. Staff B stated the licensed nurses were in general, staffed with the use of agency. During a follow up interview at 11:06 AM, Staff G stated they were unable to have residents dine in the dining room. They stated they needed to ensure there was enough staff to cover the floor before the dining room opened.</p> <p>During an interview on 11/19/2024 at 1:02 PM, Staff A, Administrator, stated, honestly, we do not have enough nursing assistants, and the facility was currently working without social services staff. Staff A stated the facility had an issue with retaining staff.</p> <p>Reference WAC 388-97-1080 (1), -1090 (1)</p> <p>46722</p>		

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<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>45117</p> <p>Based on interview and record review, the facility failed to obtain registry verification to ensure staff met competency evaluation requirements before allowing them to serve as a nursing assistant for 2 of 6 staff (Staff N and OO), reviewed for staff qualifications. This failure placed the residents at risk for abuse/neglect and unmet care needs.</p> <p>Findings included .</p> <p>The Washington State Nursing Assistant Registry [(OBRA) Omnibus Budget Reconciliation Act] is a database that includes the names of all individuals that meet the federal requirements to provide cares to residents of long-term care in Washington State. The OBRA registry also informs long term care facilities of individuals that are ineligible to work in long term care due to findings of abuse, neglect, or misappropriation of property.</p> <p><Staff N></p> <p>Review of Staff N's, Nursing Assistant (NA), personnel file showed their date of hire was 09/23/2024. The file showed no documentation of OBRA registry for Staff N.</p> <p><Staff OO></p> <p>Review of Staff OO's, NA, personnel file showed their date of hire was 05/20/2024. The file showed no documentation of OBRA registry for Staff OO.</p> <p>During an interview on 11/17/2024 at 11:36 AM, Staff I, Scheduler/NA, stated they were responsible for ensuring the human resources personnel files were accurate. They stated nursing assistants should have OBRA verification upon hire but had missed Staff N and Staff OO.</p> <p>During an interview on 11/19/2024 at 1:04 PM, Staff A, Administrator, stated the process for new hire NAs was to verify that they were on the OBRA registry, prior to working with the residents. They stated the new hire process was not followed for Staff N and Staff OO.</p> <p>Reference: WAC 388-97-1820</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46722</p> <p>Based on observation, interview, and record review, the facility failed to ensure 3 of 3 medication storage rooms (North, East, and [NAME] Hall) ensured proper disposal of expired and/or discharged resident's medications, and 1 of 3 medication carts (East Hall) were locked when left unsupervised by nursing staff. These failures placed residents at risk for receiving expired and/or compromised medications, access to potentially harmful medications, and negative health outcomes.</p> <p>Findings included .</p> <p>Review of the policy titled, Medication Administration, dated 01/2024, showed the medication cart was to be kept closed and locked when out of sight of the nurse, and when medications were administered, the medication cart was to be clearly visible when unlocked.</p> <p>Review of the policy titled Medication Storage, dated 01/2024, showed outdated, contaminated, and discontinued medications were to be removed immediately and disposed of.</p> <p><Medication Cart></p> <p>An observation and interview on 11/15/2024 at 10:57 AM, showed the East Hall medication cart unlocked and unattended by staff. At 11:03 AM, Staff NN, Licensed Practical Nurse (LPN), walked up to the unlocked medication cart and logged into the computer. Staff NN then walked away from the medication cart and walked down the hall, without locking the cart. Staff NN returned to the unlocked medication cart at 11:08 AM, used the computer and then walked away and sat at the nurse's station behind the unlocked medication cart. During these observations, four visitors walked past the medication cart.</p> <p><Medication Storage Rooms></p> <p><North Hall></p> <p>An observation and interview on 11/17/2024 at 11:12 AM, showed the North Hall medication room countertop held partially used blister pack cards (a cardboard card with foil on the back to hold a single dose of a medication) of discontinued medications for expired residents, combined with active medications for current residents including pre-filled syringes of an injectable medication. In addition, the countertop had a thick layer of dust and debris along the edges to the wall and a sink with a crusty white film on the handles, faucet, and drain. Staff R, LPN, stated they did not know why the medications were on the countertop and they did not know the process for returning and/or disposing of medications after a resident was discharged or expired.</p> <p><East Hall></p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview on 11/17/2024 at 11:57 AM, showed the East Hall medication room countertop had two full bins of miscellaneous, partially used, expired, and/or discontinued medications for residents. The countertop also had newly delivered medications and supplies for residents next to the bins. Staff J, Registered Nurse (RN), stated they did not know the process for disposing of medications. Staff J stated their process was to put the non-scheduled medications (medications used to treat medical conditions such as high blood pressure and infections) on the counter or in a bin and night shift nursing was responsible for proper disposal.</p> <p><West Hall></p> <p>An observation and interview on 11/17/2024 at 12:27 PM, showed the [NAME] Hall medication room countertop held a Keurig (brand name) coffee maker, coffee grinder with ground coffee inside, an opened box of Folgers (brand of coffee) coffee pods wedged under the hand soap dispenser, and reusable coffee pods on the counter next to the sink amongst blood drawing supplies. The sink contained a used and soiled coffee mug with coffee stains on the drink edge and bottom of the mug. The sink was dripping water, had a thick white and brown scaly film around the handles, faucet base and spout, drain, and basin. The countertop had expired medications laying on the countertop. In addition, there was a white bin with two packs of cigarettes opened with missing cigarettes, that were unlabeled for which resident they belonged to. Staff NN, stated they were unaware there was coffee supplies and products in the medication room.</p> <p>During an interview on 11/17/2024 at 1:02 PM, Staff B, Senior Director of Nursing, stated the process for disposal of medications was to place the medication into a bin for the pharmacy company to retrieve when they came to the facility. Staff B stated when a medication did not return to the pharmacy and needed to be disposed of by the facility, nursing staff were to place the medication in Stericycle (a drug disposal company) bins. Staff B stated they checked the medication rooms weekly in conjunction with Staff F, Unit Manager, and Staff BB, Unit Manager. Staff B stated the medication rooms were to be checked for medications that needed to be returned or disposed of nightly by the night shift nurses.</p> <p>During an observation and interview on 11/17/2024 at 1:13 PM, Staff B observed the East Hall medication room and stated the two bins of medications needed to be processed and the night shift nurse had probably not developed a process for returning medications, as the facility had been short staffed. Staff B stated some of the medications in the bins were to be destroyed in the Stericycle bins and not returned to pharmacy and did not know why they had not been. Staff B stated they had educated the nurses on the process and that process should have been implemented. Staff B stated they had not checked the East Hall Medication room for a while, as that room was for Staff F to check. Staff B stated there was a lot of expired and/or discontinued medications in the medication room and they should have been disposed of.</p> <p>During an observation and interview on 11/17/2024 at 1:26 PM, Staff B observed the North Hall medication room and stated the room was for medical supplies and medications. Staff B stated the countertop should not have medications from expired/discharged residents mixed with current residents' medications and there should have been a bin for these medications to be placed into for disposal or return. Staff B stated the countertop was used for intravenous [(IV) medications and fluids administered into a vein] therapy and should be clear of medications and supplies. Staff B further stated the countertop and sink were not clean and IV therapy should not be prepared where the countertop and sink were not clean.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 11/17/2024 at 1:35 PM, Staff B observed the [NAME] Hall medication room and stated the Keurig coffee maker, coffee grinder, and coffee pods should not be in the medication room. Staff B stated the sink was not clean, was dripping water from the faucet, and the two opened cigarette packs needed to be labeled with a resident name. Staff B stated the nurses were not following the process for medication disposal.</p> <p>During an interview on 11/19/2024 at 11:40 AM, Staff A, Administrator, stated they had observed the North, East, and [NAME] Hall medication rooms and there should not be any new/current medications mixed with expired/discharged medications, should not be coffee equipment in the medication room, and the medication rooms were not clean.</p> <p>Reference WAC: 388-97-1300(1)(b)(ii)(2)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48368</p> <p>Based on observation, interview, and record review, the facility failed to ensure the contracted Dietary Manager (DM) was certified and qualified for that position. This failure placed residents at risk of receiving unsafe dietary services from staff that did not have the required competencies and skills to carry out food and dining services.</p> <p>Findings included .</p> <p>Review of a policy titled, Dining Service Department, dated 10/2022, showed the facility and the contracted dietary group would employ sufficient staff with appropriate competencies and skill sets. If the qualified dietician or other clinically qualified nutrition professional was not employed full time, a DM of food and nutrition services who met the necessary qualifications would be employed.</p> <p>During an interview on 11/17/2024 at 12:14 PM, Staff T, DM, stated they had not yet taken the test to become certified as a DM. Staff T stated they took the course a long time ago and just have not gotten around to taking the test.</p> <p>During an interview on 11/17/2024 at 12:53 PM, Staff A, Administrator, stated they were made aware Staff T was not a certified DM in late September 2024. Staff A stated the Registered Dietician was only part time (20 hours a week) and the DM had no oversight. Staff A further stated they needed to get someone in the building to oversee the kitchen until Staff T obtained their DM certification.</p> <p>Reference: WAC 388-97-1160(1)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>46722</p> <p>Based on observation, interview, and record review, the facility failed to provide meals that were palatable and served at an appetizing temperature for 3 of 3 residents (Resident 17, 13, and 19) reviewed for food. These failures resulted in residents expressing dissatisfaction with the food and placed residents at risk for inadequate nutritional intake and weight loss.</p> <p>Findings included .</p> <p>Review of a policy titled, Dining Service Department, dated 10/2022, showed food would be palatable and served at a safe and appetizing temperature. Hot foods would be held at a minimum of 135 degrees Fahrenheit [(F) a unit of temperature measurement] and cold foods would be held at a maximum of 41 degrees F.</p> <p><Resident 17></p> <p>Review of the medical record showed Resident 17 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), and cancer. The 10/18/2024 comprehensive assessment showed Resident 17 was dependent on one to two staff members for activities of daily living (ADLs), set up only for eating. The assessment also showed the resident had a moderately impaired cognition.</p> <p>During an interview on 11/13/2024 at 11:07 AM, Resident 17 stated that their meals were usually cold by the time they received their food.</p> <p>During an interview on 11/18/2024 at 2:16 PM, Resident 17 stated their pureed (food that has been blended, mashed, or strained) eggs were like ice and not what they had asked for.</p> <p><Resident 13></p> <p>Review of the medical record showed Resident 13 was admitted with diagnoses including diabetes, heart disease and absence of left lower leg. The 09/18/2024 comprehensive assessment showed Resident 13 was independent for ADLs, able to use a manual wheelchair for mobility, and had an intact cognition.</p> <p>During an interview on 11/13/2024 at 10:04 AM, Resident 13 stated the facility food was tasteless, never hot, and barely warm. Resident 13 stated they ate the facility cheeseburgers for lunch and dinner every day, as they felt these would be hard to mess up. Resident 13 stated they have a lot of food delivered from outside sources, often for snacks and drinks.</p> <p>During an interview on 11/18/2024 at 11:45 AM, Resident 13 stated the breakfast that morning was not good and not warm. Resident 13 stated the facility also ran out of hamburgers this week and for two days they did not get the cheeseburgers they requested and had to eat what was on the menu, as they were hungry.</p> <p><Resident 19></p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record showed the resident admitted with diagnoses to include a traumatic brain injury (an injury to the brain that occurs when an external force impacts the head) and stroke. The 08/14/2024 comprehensive showed Resident 19 required the assistance of two staff members with ADLs and had impairment to both their upper and lower extremities. The assessment showed Resident 19 had an intact cognition.</p> <p>An observation and concurrent interview on 11/15/2024 at 9:08 AM, showed Resident 19 sitting in their wheelchair with their breakfast tray on the bedside table in front of them. The tray consisted of eggs, toast, milk and coffee. Resident 19 stated they were still waiting for sugar, and their coffee and eggs were cold like ice water.</p> <p>An observation and concurrent interview on 11/15/2024 at 9:19 AM, showed Staff T, Dietary Manager, checked the temperatures of Resident 19's coffee, eggs and milk. The temperature on Resident 19's coffee was 98.0 degrees Fahrenheit (F); eggs 80.8 degrees F, and milk 61.3 degrees F. Staff T stated the temperatures were out of the safe temperature range (safe holding temperature for eggs is at least 155 degrees F and milk is 41 degrees F or lower) and Resident 19 needed a new breakfast tray.</p> <p><Temperatures></p> <p><Steam Table></p> <p>During an observation on 11/12/2024 at 6:45 PM, the steam table in the kitchen and cold foods were checked for safe temperatures (safe temperatures for hot foods on the steam table is 135 degrees F and cold foods is 41 degrees F or lower) by Staff T, after dinner serve out was completed, with the following results:</p> <ul style="list-style-type: none"> - Apple juice 57.5 degrees F -Milk 48.4 degrees F -Apple sauce 50.5 degrees F -Red baked potatoes 114.5 degrees F -Pureed chicken 104.3 degrees F -Mashed potatoes 116.8 degrees F <p><Test Tray></p> <p>On 11/13/2024 at 12:59 PM a test tray was checked for temperatures by Staff T with the following results:</p> <ul style="list-style-type: none"> -Pizza square 130.0 degrees F -Broccoli 117.8 degrees F -Orange Juice 52.2 degrees F <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Milk 58.2 degrees F</p> <p>During an interview on 11/17/2024 at 12:02 PM, Staff T stated the holding temperatures for hot foods was 135 degrees F and 41 degrees F for cold foods. Staff T stated the process for foods outside of the acceptable temperature range would be to reheat the food to a safe temperature. Staff T stated the test tray, and the steam table foods were not within a safe temperature range.</p> <p>Reference WAC 388-97-1100(1)(2)</p> <p>48368</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>45117</p> <p>Based on observation, interview, and record review, the facility failed to honor food preferences for 2 of 2 residents (Resident 17 and 22) reviewed for dietary preferences. This failure placed the residents at risk for dissatisfaction with their dining experience and weight loss.</p> <p>Findings included .</p> <p>Review of a policy titled, Dining Service Department, dated 10/2022, showed the Dietary Manager (DM) was to interview each resident for individual food preferences, document them on the Food Preference Interview assessment, upload the assessment into the resident's medical record, and update their plan of care.</p> <p><Resident 17></p> <p>Review of the medical record showed Resident 17 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), and cancer. The 10/18/2024 comprehensive assessment showed Resident 17 was dependent on one to two staff members for activities of daily living (ADLs), set up only for eating. The assessment also showed the resident had a moderately impaired cognition.</p> <p>During an interview on 11/18/2024 at 2:16 PM, Resident 17 stated they had asked the kitchen staff multiple times to serve the eggs with gravy over them for every meal. Resident 17 further stated they have had to send their meal trays back to the kitchen almost every time.</p> <p>Record review of a diet order, dated 10/08/2024, showed Resident 17 was to have a puree texture diet with no diet preferences documented on the order.</p> <p>Record review showed no Food Preference Interview, assessment had been completed for Resident 17.</p> <p>Record review of Resident 17's care plan, dated 9/30/2024, showed no dietary preferences listed.</p> <p><Resident 22></p> <p>Review of the medical record showed Resident 22 was admitted with diagnoses including a non-traumatic brain dysfunction (brain damage caused by internal factors such as lack of oxygen or pressure from a tumor). The 10/17/2024 comprehensive assessment showed Resident 22 was dependent on one to two staff members for ADLs; set up only for eating. The assessment also showed the resident had a severely impaired cognition.</p> <p>During an interview on 11/14/2024 at 9:35 AM, Resident 22's Representative (RR), stated Resident 22 was Japanese and the facility only served Resident 22 American foods. The RR stated they brought Resident 22 their favorite foods when they could and would like the facility to provide Resident 22 with the foods they preferred.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a diet order dated 11/23/2023, showed Resident 22 was to have a regular diet with no diet preferences documented on the order.</p> <p>Record review of an assessment titled Food Preference Interview, dated 07/13/2021, showed no dietary preferences. Further review showed no other Food Preference Interview assessments had been completed since 07/13/2021.</p> <p>During an interview on 11/17/2024 at 12:02 PM, Staff T, Dietary Manager, stated the process for dietary preferences was to complete a food preference interview on admit, change of condition, and review every six months. Staff T stated they tried to follow that process but it does not always happen.</p> <p>Reference: WAC 388-97-1120(3)(a)(c)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>45117</p> <p>Based on interview and record review, the facility administrative staff failed to effectively manage the facility in compliance with state and federal regulatory requirements. The facility failed to ensure there was active and engaged oversight and monitoring of systems related to recognizing abuse/neglect, accident hazards, activities, restorative therapy programs, and sufficient staffing. These failures placed the residents at risk for continued abuse/neglect, injury, decline in physical function, and dissatisfaction with their quality of life.</p> <p>Findings included .</p> <p>Review of a job description titled, Administrator, dated 01/01/2016, showed the Administrator was responsible for creating an environment where staff were highly engaged and focused on providing the highest level of clinical care and compassion to residents and families. They were responsible and accountable for all activities and departments of the facility to ensure proper healthcare services were provided to the residents, according to regulations put forth by government agencies. The Administrator directs and coordinates all activities of the facility to ensure the highest degree of quality of care was consistently provided to the residents.</p> <p>Review of a policy titled, Director of Nursing Responsibilities, revised 06/15/2022, showed the Director of Nursing had the administrative authority, responsibility, and accountability for the functions and activities of the facility ' s nursing staff, to ensure effective nursing services meet the needs of the residents.</p> <p><Recognizing Abuse/Neglect (Refer to F607)></p> <p>The facility administration failed to implement the abuse prohibition policy to ensure a system to implement five of eight key components required in the development and implementation of abuse and neglect policies and procedures; the prevention, identification of allegations of abuse and neglect to include allegations communicated in any form of a reported grievance, protection of residents, reporting the allegations of abuse and neglect as a mandated reporter, and the timely and thorough investigation to rule out abuse and neglect for the identified allegations. This failed system resulted in an Immediate Jeopardy situation.</p> <p>During an interview on 11/15/2024 at 8:08 AM, Staff A stated the system for reporting allegations related to abuse/neglect was very broken. Staff A stated they had not been aware of some of the grievances alleging abuse/neglect filed as they had not been presented to them. Staff A further stated even though they did not review all the grievances, they stated the responsibility belonged to the Administrator. Staff A stated staffing had been an issue, and the staff were burned out.</p> <p><Accident Hazards (Refer to F689)></p> <p>The facility administration failed to ensure residents remained free of avoidable accidents. The facility failed to provide supervision to prevent avoidable accident hazards. This is a repeat citation from 10/18/2023.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/18/2024 at 11:12 AM, Staff A stated residents were not smoking in the designated smoking area. The area where they smoke did not have a fire extinguisher or receptacle for cigarette butts. They stated, I do not want them smoking out there, it is not the designated smoking area.</p> <p><Activities (Refer to F679)></p> <p>The facility administration failed to provide an activities program that supported residents in their choice of activities to meet the physical, mental, and psychosocial well-being of each resident. This is a repeat citation from 10/18/2023.</p> <p>During a follow-up interview on 11/19/2024 at 10:00 AM, Staff B stated their expectation was for the nursing assistants to bring the residents to activities but I don't see it happening.</p> <p>During an interview on 11/19/2024 at 12:30 PM, Staff A, Administrator, stated the process for activities was a broken system.</p> <p><Restorative Nursing (Refer to F688)></p> <p>The facility administration failed to ensure services were provided to ensure an interdisciplinary system of Restorative Nursing for residents in order to implement preventative measures and prevent decline in range of motion. This is a repeat citation from 10/18/2023.</p> <p><Sufficient Staffing (Refer to F725)></p> <p>The facility failed to have sufficient staff to provide and supervise care to residents that received assistance with their activities of daily living, including dining services, restorative therapy, supervision of accident hazards, quality of care, and activities. This is a repeat citation from 10/18/2023.</p> <p>During an interview on 11/12/2024 at 8:26 PM, Staff A, Administrator, stated staffing was horrid, challenging. They stated they were using agency staff, and it was very expensive.</p> <p>During an interview on 11/15/2024 at 3:01 PM, Staff B, Senior Director of Nursing, stated they did not have enough staff to re-open and staff the dining room.</p> <p>Reference: WAC 388-97-1620(1)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>48368</p> <p>Based on interview and record review, the facility failed to develop and maintain a current hospice (a type of care that focuses on comfort and quality of life for people who were terminally ill or near the end of their life) plan of care (POC) in collaboration with contracted hospice services, that identified the provider responsible for performing each or any specific services/functions for 1 of 3 sampled residents (Resident 17) reviewed for hospice services. This failure placed residents at risk for not receiving necessary care and services.</p> <p>Findings included .</p> <p>Review of a policy titled Hospice, dated 03/01/2018, showed each resident's POC would include both the most recent hospice POC and the facility's POC to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing.</p> <p><Resident 17></p> <p>Review of the medical record showed the resident admitted to the facility with diagnoses including esophageal (the muscular tube that moves food from the throat to the stomach) cancer. The 10/18/2024 comprehensive assessment showed Resident 17's cognition was moderately impaired and required assistance of one to two staff members for activities of daily living. Further review showed Resident 17 was receiving hospice services.</p> <p>Review of Resident 17's facility plan of care dated 10/21/2024, showed the resident was placed on hospice services on 10/18/2024 related to esophageal cancer. Resident 17's plan of care was not unique to the needs of the resident's hospice care and lacked documentation of the hospice orders/input.</p> <p>During an interview on 11/18/2024 at 8:31 AM, Staff A, Administrator, stated the process for hospice services was for the hospice POC to be integrated into the facility's POC. Staff A further stated the process was not followed for Resident 17.</p> <p>Reference WAC 388-97-1060(1)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722</p> <p>Based on observation, interview and record review, the facility failed to implement infection control interventions intended to mitigate the risk for transmission of infectious diseases for 3 of 3 residents (Resident 320, 35, and 19) reviewed for infection control. This failure placed the residents at risk for cross contamination and transmission of infectious disease.</p> <p>Findings included .</p> <p>Review of the Centers for Disease Control (CDC) guidance, Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings, updated 09/2024, showed contact precautions were intended to prevent transmission of infectious organisms, either by direct or indirect contact with the person or environment. The contact precautions included staff to wear gown and gloves for all interactions with the affected person and environment and wash their hands with soap and water.</p> <p>Review of the facility policy titled Clostridioides Difficile Infection [(CDI) a bacterial infection that can cause diarrhea, fever, nausea, and abdominal pain], revised 09/13/2024, showed staff were to maintain hand washing and explain proper hand washing to the resident and visitors; staff were not to use alcohol-based hand rub for hand hygiene.</p> <p><Contact Precautions></p> <p><Resident 320></p> <p>Review of the medical record showed Resident 320 was admitted to the facility on [DATE] with diagnoses including colon cancer and clostridium difficile [(C-Diff), CDI, a highly contagious bacterial infection of the colon that causes diarrhea and could become life-threatening]. Additionally, Resident 320 required the assistance of one staff member for activities of daily living (ADLs) and was able to make their needs known.</p> <p>An observation and interview on 11/13/2024 at 2:57 PM, showed Resident 320's room had a sign posted outside that identified the room as Standard plus Contact Precautions and required staff to wash their hands with soap and water before and after contact with resident, their environment, and removal of personal protective equipment [(PPE) a type of clothing or equipment that protects the wearer from the spread of infection or illness]. Staff LL, Nursing Assistant, (NA), exited the resident's room with their PPE removed, carried it with their bare hands down the hall and entered a soiled utility room, and disposed of their used PPE. Staff LL exited the soiled utility room and did not wash their hands with soap and water. Staff LL stated they were unsure of the reason to wear PPE in room Resident 320's room, did not dispose of their used PPE in the resident room as there was not a trash can for use, and used the hand sanitizer to clean their hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024 at 2:37 PM, a Collateral Contact with Hospice Services (CC), stated they provided personal cares to Resident 320. The CC stated they did see the sign outside the door that showed to Stop, please see the nurse, prior to entering the resident's room. The CC stated they asked the nurse on the resident's unit what the precautions were for and were told they did not know. The CC stated they wore a gown, gloves and a surgical mask for Resident 320's personal cares and after they removed their PPE, placed into their bag and used hand sanitizer. The CC stated there was not a trash can to dispose of their used PPE and did not wash their hands with soap and water as the sign stated.</p> <p>During an interview on 11/19/2024 at 8:21 AM, Staff M, RN (RN)/Infection Preventionist (IP), stated all staff were to wear gown and gloves with residents on contact precautions. Staff M stated Resident 320's room required staff to wear PPE upon entry and were to remove the PPE prior to exiting the room. Staff were to dispose of the PPE in the resident ' s room and wash their hands with soap and water. Staff M stated all staff had been educated on the process.</p> <p><Resident 35></p> <p>Review of the medical record showed Resident 35 was admitted to the facility on [DATE] with diagnoses of C-Diff, 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 ADLs: touch assistance/supervision for eating. The assessment also showed Resident 35 had a moderately impaired cognition.</p> <p>During an interview on 11/13/2024 at 9:54 AM, Staff P, Licensed Practical Nurse (LPN), stated Resident 35 was on contact precautions for the wound on their back.</p> <p>During an interview on 11/13/2024 at 12:26 PM, Staff M, stated Resident 35 was on contact precautions for C-Diff and staff should be following the posted precaution signage.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Columbia Crest Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 East Nelson Road Moses Lake, WA 98837	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 11/15/2024 at 10:01 AM, showed Resident 35's room had a sign posted outside the room that identified it as a Contact Precautions room. There was a cart outside the room that contained PPE that included gowns, gloves, and surgical masks. Staff C, NA, and Staff Q, NA, put on their PPE and entered the room to perform incontinent care for Resident 35. Staff P and Staff R, LPN, also put on the appropriate PPE and entered the room. Staff Q assisted Resident 35 to lay on their left side as Staff C began to clean their genital area with moistened wipes. Staff C stated they needed an additional package of wipes. Staff R removed their PPE and left the room without performing hand hygiene with soap and water. They returned to the room, put on new PPE, and gave a package of wipes to Staff C. Staff R had one remaining package of wipes in their ungloved hands. Staff C finished wiping the residents genital area and placed a clean brief under them, without changing gloves or washing their hands. Staff P applied a barrier cream to Resident 35's genital area. Staff P removed their gloves and put on clean gloves, without washing their hands with soap and water. Staff C and Staff Q positioned Resident 35 on their right-side using pillows, handed to them by Staff P. Staff P assisted in positioning Resident 35's lower extremities. Staff R placed the extra package of wipes on the resident's sink, removed their PPE, picked up the package of wipes and left the room without washing their hands with soap and water. Staff Q removed their PPE, took the resident's water jug from Staff C (still wearing soiled gloves), and left the room without performing handwashing. Staff Q returned to the room with the same water jug that was filled with ice, handed it to Staff C, removed their gloves, and left the room, still without performing handwashing with soap and water. Staff C and Staff P removed their PPE and washed their hands with soap and water prior to leaving the resident's room.</p> <p><Hand Hygiene></p> <p><Resident 19></p> <p>Review of the medical record showed Resident 19 was admitted to the facility with diagnoses including spinal cord injury, dementia (a progressive disease that destroys memory and other important mental functions) and a bladder infection. Resident 19 required the use of a urinary catheter (a flexible tube inserted into the bladder to drain urine) and had a moderately impaired cognition.</p> <p>During an observation on 11/16/2024 at 12:08 PM, Staff Q, NA, was at Resident 19's bedside. Staff Q donned (put on) gloves, placed a clean brief, wet washcloths, and a package of incontinent wipes at the bottom of the bed and began providing incontinent care. Staff Q removed the soiled brief, placed it in a garbage bag on the floor, removed incontinent wipes out of the container with the same soiled gloves on, and cleaned bowel movement (BM) from Resident 19's buttock area. Resident 19 continued to have a BM. Staff Q, while waiting, placed their hands with the same soiled gloves that were smeared with BM on Resident 19 ' s air mattress with no barrier between the dirty gloves and mattress. Staff Q removed more incontinent wipes from the container and cleansed Resident 19's buttocks of BM. Staff Q placed their hands, wearing the same soiled gloves, on the air mattress while leaning over the bed. Staff Q removed more incontinent wipes from the container and continued with incontinent care. Staff Q placed a clean brief on Resident 19 with the same soiled gloves, pulled Resident 19's sweatpants up, pulled their shirt down, and adjusted the blankets and pillows, all while wearing the same soiled gloves. Staff Q lifted the garbage bag off the floor, closed the incontinent wipes container, threw the garbage away, and set the container of contaminated incontinent wipes on the counter next to the sink without changing gloves or performing hand hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Columbia Crest Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 East Nelson Road Moses Lake, WA 98837	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview on 11/18/2024 at 12:50 PM, showed Staff R performed hand hygiene with alcohol-based hand rub sign into the computer on the medication cart, donned gloves and prepared two vials of medication for Resident 19's intramuscular injection (a medical procedure that involves injecting a substance into a muscle). Staff R, removed their gloves, did not perform hand hygiene and walked down the hall to Resident 19 ' s room. Upon entrance to Resident 19's room, Staff R obtained gloves from the box on the resident's room wall and put them on. Staff R pushed up Resident 19's right arm sleeve and attempted to withdraw the medication from the vial. Staff R stated they were unable to withdraw the medication and removed their gloves, did not perform hand hygiene, left the resident's room, and went to the medication room to obtain a new syringe. Staff R returned to Resident 19 ' s room, donned new gloves, held onto the resident's right arm and injected the medication. After the medication was given, Staff R removed their gloves and washed their hands in Resident 19's sink and exited the room. Staff R stated they were unaware they did not perform proper hand hygiene throughout the process, and stated they should have each time they donned and doffed their gloves.</p> <p>Reference: WAC 388-97-1320(1)(5)(b)</p> <p>39652</p>		