STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505320	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Crest Center	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were given the opportunity to formulate advanced directives (AD) nor periodically notified of their right to formulate an AD for 3 of 4 residents (Resident 56, 8 and 61) reviewed for AD. This failure denied residents the right to make an informed decision regarding formulation of an AD and placed residents at risk for losing the right to have their preferences and choices honored regarding emergent/end-of-life care. Findings included .Review of the facility's policy titled, Health Care Decision Making, dated 06/05/2025, showed that AD were written instructions, such as a living will (a legal document that specifies an individual preferences regarding medical treatment) or durable power of attorney for health care (a document delegating an person that is authorized to make health care decision for you, if your unable to communicate the decisions yourself). The policy showed that facility residents would be provided with written information regarding AD and offered the right to formulate or not formulate AD. The policy stated residents would be approached by the facility's social services staff member on admission and quarterly to discuss the residents' wishes to develop an AD. The policy stated that if the resident had completed AD or were previously brought into the facility by the resident or their representative a copy would be placed in the resident's medical record. Resident 56Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a lung condition, anxiety and depression. The 10/28/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Additionally, the resident's medical record did not include AD documents. Review of the social service quarterly assessment dated [DATE], showed Staff F, Social Service Director (SSD), documented that Resident 56 had an AD already completed and a copy was placed in their medical record. The record showed that no additional conversations regarding advance care planning was provided to Resident 56. During an interview on 01/08/2026 at 2:01 PM, Resident 56 stated that facility staff had reviewed and educated them on the physician orders for life-sustaining treatment (POLST, a document designed to improve resident care by creating a form that records treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency and is not an AD), but they had never been given the opportunity to formulate an AD or education on what an AD was. The resident stated they had recently added selective treatment on their POLST form due to wanting specific care completed in the event of an emergency and was not aware that an AD could specify that for them. Resident 56 stated they would have wanted to formulate an AD. Resident 8Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a stroke (when blood supply to the brain is blocked or reduced), dysphagia (difficulty swallowing) following the stroke, and dysarthria (a speech disorder, sometimes following a stroke, that occurs when muscles used for speech are weak or difficult to control, leading to slow or slurred speech). The 09/05/2025 comprehensive assessment showed the resident had a severely impaired cognition but was able to make their needs known. Additionally, the resident's medical record did not include AD documents. Review of the social service quarterly assessment dated [DATE], showed (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff F, documented that Resident 8 had an AD already completed and a copy was placed in their medical record. The record showed that no additional conversations regarding advance care planning was provided to Resident 8 or their representative. During an interview on 01/08/2025 at 2:36 PM, Resident 8 stated they had informed facility staff before on an AD that was previously completed and was informed that it was in their medical records. Resident 8 stated they would want to have one formulated so their representative could make health care decisions for them in an emergency. Resident 61Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, anxiety and depression. The 10/17/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of the social service initial assessment dated [DATE], showed Staff F, documented that Resident 61 had an AD already completed and a copy was placed in their medical record. The record showed that no additional conversations regarding advance care planning had been provided to Resident 61. During an interview on 01/08/2026 at 1:07 PM, Staff F stated that all facility residents were offered information on AD when they were admitted into the facility. Staff F stated residents were given the opportunity to formulate an AD, but they never want to, and referred the Surveyor to a POLST form. Staff F stated the POLST form was reviewed on admission/quarterly during the social service assessment and that when the resident wanted to make changes, the POLST form would be reviewed with the resident and updated. Staff F was not aware the POLST form was not an AD and had not been providing residents with the opportunity to formulate an AD. During an interview on 01/08/2026 at 1:44 PM, Staff U, Regional Social Services, stated they oversaw/worked with social services in the facility. Staff U reviewed Resident 56 and 8's medical records and did not see AD documents in either of the resident's medical records. Staff U stated the SSD was mixing up the POLST versus the AD. Staff U stated the SSD had not been following the facility's process with discussing or providing facility residents with the opportunity to formulate an AD. During an interview on 01/09/2026 at 12:50 PM, Staff A, Administrator, stated AD should be discussed with all facility residents or their representative and facility staff should be providing all facility residents with the opportunity to formulate an AD. Staff A stated the correct process was not being followed. Reference: WAC 388-97-0280 (1)(3)(a)(c)(d)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to review, and validate the Preadmission Screening and Resident Reviews (PASARR, an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were correct on admission or corrected and updated for 3 of 5 residents (Residents 50, 7 and 35) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.Finding included.Resident 50Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a feeling of unease, worry, or fear about something that might happen in the future). The 12/22/2025 comprehensive assessment showed Resident 50's cognition was intact and received anti-anxiety and anti-depression medications. Review of Resident 50's 12/11/2025 Level 1 PASARR assessment showed the resident had SMIs documented for their diagnoses of depression and anxiety but then documented no to the SMI question. The assessment also showed the resident did not require a Level II referral, which was required when a resident had SMIs. Resident 7Review of the medical record showed the resident was admitted on [DATE] with diagnosis including a stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage) dementia (a progressive disease that destroys memory and other important mental functions), bipolar (a mental illness that causes extreme shifts in an individual's mood, energy, and activity levels) disorder, anxiety and narcolepsy (a disorder that affects the brains ability to regulate sleep-wake cycles leading to daytime sleepiness and sudden sleep attacks). The 12/30/2025 comprehensive assessment showed the resident had a moderately impaired cognition and was on psychotropic medications (medications capable of affecting the mind, emotions, and behavior). Review of Resident 7's Level I PASARR screening, dated 01/03/2025, showed the resident had serious mental illness indicators for bipolar and anxiety. A Level II referral was documented as required, but no records of a Level II referral being sent/completed were noted in Resident 7's medical records. Resident 35Review of the medical record showed Resident 35 was admitted to the facility on [DATE] with diagnoses including insomnia, depression, anxiety and chronic pain. Resident 35's most recent comprehensive assessment dated [DATE] showed they were cognitively intact and were ordered medications for anxiety, depression and insomnia. Review of Resident 35's PASARR Level I dated 11/07/2025 showed it was completed at a different facility with the diagnoses of depression and anxiety listed, as well as checked as exempt from requiring a Level II assessment because a less than 30-day stay was expected in the other facility. Resident 35 moved to the facility on [DATE] and a new PASARR Level I had not been completed as of 01/08/2026. During an interview on 01/08/2026 at 3:28 PM, Staff E, Admissions Coordinator, stated they received Level I PASARR assessments prior to a resident being admitted . Staff E stated they reviewed the assessments for accuracy and whether the resident required a Level II referral and ensured they were referred prior to admission. Staff E stated the PASARRs then would be the responsibility of the Social (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services Director (SSD) for any follow-ups, updates, or changes. Staff E stated they were not normally responsible for reviewing the PASARRs and had recently taken them over while the new SSD had been trained. Staff E stated they did not realize Resident 50's SMIs were incorrectly completed, therefore they did not realize they required a Level II referral. Additionally, Staff E stated they were not aware of Resident 7's Level I PASARR completed on 01/03/2025 and was not able to present documentation of the Level II referral being completed. During an interview on 01/09/2026 at 2:40 PM, Staff A, Administrator, along with Staff R, Resource Nurse Manager, stated they were not aware the process for PASARRs needed worked on but realized there were gaps that need to be worked on. Reference: WAC 388-97-1915 (1)(2)(a-c)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were provided with food preference/substitute meal choices for 3 of 5 residents (Residents 61, 16 and 47) reviewed for dining. This failed practice put residents at risk for decreased intake and nutritional complications.Findings included .Resident 61Review of the medical record showed the resident admitted to the facility on [DATE] and was alert and oriented. Resident 61's meal order was a regular low salt diet. The 11/10/2025 food preferences interview sheet showed the resident preferred whole milk with meals. Resident 61 meal dislikes included fruit juices, oatmeal, hot cereals and cold cereal.to include any type of melon.During an observation and concurrent interview during the lunch meal on 01/07/2026 at 12:30 PM, Resident 61 stated the food has not met their needs and was not satisfying. They were a meat and potato person and did like cottage cheese which they had ordered with each meal. The resident was served a small cheeseburger with potato chips and cottage cheese. During the conversation the resident stated they would even like a baked potato once and in while to enjoy. Resident 61 stated they usually ordered a sandwich or a cheeseburger, cottage cheese and chips off the secondary menu.During an observation and concurrent interview during the lunch meal on 01/08/2026 at 11:40 AM, Resident 61 was not satisfied with their noon meal. The meal ticket showed cheeseburger with chips. Resident 61 stated they were told the kitchen ran out of cottage cheese and no alternative was offered. The meal ticket showed the resident did not want orange juice, no melon of any kind. The resident was served cantaloupe (a dislike item), hamburger and chips. Resident 61 was not happy with their meal.Resident 16Review of the medical record showed the resident admitted to the facility on [DATE] and was alert and oriented. Resident 16's diet was a regular diet. The 11/20/2025 food preference interview showed the preferred water, fruit juices and disliked milk, hot cereal, coleslaw and buttermilk but liked sausage and bacon.During an observation and concurrent interview on 01/08/2026 at 11:50 AM, the resident was seated in their wheelchair in front of their bedside table with their lunch tray which consisted of a cheeseburger, French fries, cantaloupe and drinks. Resident 16 stated they disliked cheese on their hamburger and it was a consistent mistake. Resident 16 stated they requested different foods but were told they could not have anything unless it was on the menu.Resident 47During an interview on 01/08/2026 at 12:15 PM, Resident 47 stated they continue to receive oatmeal in the morning even though they had marked their menu not to have oatmeal. During the interview Resident 47 showed a copy of the menu items they submitted to the kitchen for the week of January 4, 2026, through January 10, 2026, which showed their request for hot cream of wheat for their breakfast cereal. The resident stated they had talked to the charge nurse and other staff about the situation.During an interview on 01/08/2026 at 12:20 PM, Staff N, Registered Nurse, stated there was a lack of communication with kitchen staff and did report resident's concerns, but it did not always get addressed for the residents.During an interview with Staff K, Dietary Manager, they stated Resident 61 did not get cottage cheese because they ran out of it and no alternative was offered. Staff K stated Resident 16 had complained about food choice and had not been satisfied with meals. Additionally, Staff K had received Resident 47's request and placed it on their meal ticket, but the dietary staff had not recognized the change and did not follow through.During an interview on 01/08/2026 at 12:15 PM, Staff W, Kitchen Manager stated that Staff K was to utilize a shopping list, review menus, recipes and inventory to ensure there would be enough food to support any changes made to the menu. There should have been a substitute offered. Staff W stated that all staff should read the residents' meal tickets carefully and anything listed should be provided (special request, dislikes and condiments). The cook needed to read the ticket first and then the dietary aide to make sure the meal served was correct. Dietary staff did not follow the procedures.Reference WAC 388-97-1140(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff maintained components of an infection prevention control program to prevent the development and transmission of infections for, 1) hand hygiene and glove change for 4 of 10 staff (Staff T, V, L, and Q) observed during resident cares and, 2) use of Personal Protective Equipment (PPE) in an enhanced barrier precaution (EBP, indicated with high contact resident care activities with an infection, a long term wound, central line device or colonization [the presence of a bacteria that has not yet started its infection process] of an multi drug resistant organism) rooms for 2 of 5 staff (Staff L and Q) reviewed for infection control. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included .Review of the facility's policy titled, Hand Hygiene, revised 05/01/2025, showed that hand hygiene was to be implemented by all facility staff to reduce the harmful spread of infections. The policy showed that staff were to perform hand hygiene before/after contact or performing cares on a resident and after touching a resident or their surroundings. Additionally, the policy showed the use of gloves did not replace hand hygiene and if a task required gloves, then hand hygiene would be performed by staff before putting on the gloves and immediately after removing the gloves. Review of Center for Disease Control and Prevention recommendations titled, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs, bacteria that has become resistant to certain antibiotic medications), dated 04/02/2024 showed EBP was the implementation of putting on PPE, a gown and gloves, for high-contact resident care activities, which included dressing, bathing/showering, transferring, providing hygiene, and when changing linens/briefs or assisting with toileting. Additionally, EBPs were to be used with residents that had indwelling devices like urinary catheters (device that can be placed with the bladder to drain urine) or any skin opening that required a dressing. Resident 7Review of the medical record showed the resident was admitted on [DATE] with diagnosis including a stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage) dementia (a progressive disease that destroys memory and other important mental functions) and kidney complications. The 12/30/2025 comprehensive assessment showed the resident had moderately impaired cognition but was able to make their needs known, a urinary catheter device was in place and they required wound care. Observations on 01/07/2026 from 9:46 AM to 10:32 AM showed Staff V, Nursing Assistant (NA), and Staff T, NA, in Resident 7's room, with a nurse, performing a brief change, bed bath and wound care on the resident after putting on a gown and gloves for EBPs. Care observations showed: Staff V's gloves were soiled (unclean or dirty) from cleaning up the resident's first bowel movement and without performing a glove change or hand hygiene, assisted the nurse in grabbing a cloth barrier for the resident's clean wound care supplies to be placed on. Staff V then proceeded to grab a trash bag from their pocket with the same soiled gloves and then touched multiple surfaces in the resident's environment before conducting a glove change without performing hand hygiene. Staff T was bathing the resident then proceeded to assist in cleaning the resident's second bowel movement and took off one pair of gloves with another pair underneath the first pair, without performing hand hygiene. Staff T then continued with bathing the resident while touching multiple drawers of the resident furniture and manipulating the resident's clean linen with the same soiled gloves. Staff T had just completed washing the resident's legs/feet then moved to perineal care (cleaning of the private areas on a resident) and with the same soiled gloves and cloth, used for perineal care, proceeded to perform (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary catheter care without conducting a glove change and hand hygiene. During an interview on 01/07/2026 at 10:55 PM, Staff T stated the correct process was not followed during Resident 7's brief change/catheter care. Staff T stated they should have performed glove change/hand hygiene when they moved from the resident's perineal care to the resident's urinary catheter care and should not have utilized the same soiled cloth. Resident 50Review of the resident's medical records showed they were admitted with diagnoses of urinary blockage and used an indwelling catheter (a tube inserted into the bladder that drains urine). The record showed Resident 50 required EBPs due to the use of the indwelling catheter. During an observation and concurrent interview on 01/07/2026 at 11:34 AM, showed Staff L, Licensed Practical Nurse, and Staff Q, Nursing Assistant, provided wound care for Resident 50. Staff L and Staff Q both washed their hands and put on gloves. Staff L removed the soiled dressing to the right heel and cleansed the heel with wound cleanser. Staff L then changed their gloves but did not perform hand hygiene before putting a new pair of gloves on. Neither Staff L nor Staff Q wore PPE consistent with the EBP. Staff L stated they should have put on gowns as well as gloves and needed to pay better attention to the signage outside of the door before entering. Upon leaving the room, there was a sign outside of the door that showed the resident required a gown and gloves to be worn during high contact resident care. During an interview on 01/09/2026 at 10:09 AM, Staff C, Director of Nursing Services, and Staff R, Resource Nurse Manager (stand in for Infection Preventionist), stated that facility staff should be performing hand hygiene with any glove change. Staff C stated that staff T should have completed a glove change and hand hygiene after providing perineal care for Resident 7 and before moving to the resident's urinary catheter care and the same cloth should not have been used. Staff C and Staff R stated staff were not implementing correct infection control measures and that all staff should be wearing a gown and gloves when entering a EBP rooms to provide wound care. Reference: WAC 388-97-1320 (1)(2)(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were educated on the potential risk versus benefits when offering the pneumococcal and influenza immunization (specific vaccines that protects against pneumococcal bacteria and viruses that can lead to lung, nose and throat infections) nor documentation that indicated vaccinations were accepted or refused for 4 of 5 residents (Resident 61, 2, 72 and 35) residents reviewed for immunizations and infection control. This failure placed residents at risk of exposure to contagious diseases without the knowledge of the risk/benefits in order to make an informed decision.Findings included .Review of the facility's policy titled, Pneumococcal Vaccination, revised 09/13/2024, and Influenza Immunization, revised 12/16/2024 showed the facility would provide its residents with the opportunity to accept or refuse the influenza and pneumococcal vaccines, obtain the immunization history of the residents and then offer the appropriate vaccination. The policy stated that a resident or representative would complete a consent form and staff would provide education/counseling on the benefits/potential side effects of the vaccine. Additionally, an immunization informed consent would be completed and documented in the resident's medical record. Resident 61Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, anxiety and depression. The 10/17/2025 comprehensive assessment showed the resident was cognitively intact, able to make their needs known and was not offered nor had they received the influenza or pneumococcal vaccine.Review of Resident 61's immunization informed consent record showed the resident had not been offered the opportunity to accept or refuse the influenza or pneumococcal vaccinations nor had they been educated on the risk versus benefits and potential side effects regarding both vaccines.During an interview on 01/09/2026 at 9:09 AM, Resident 61 stated they had not received any information or education regarding the risk versus benefits/potential side effect regarding the influenza or pneumococcal vaccines. Additionally, the resident had not been approached nor offered the opportunity to accept or refuse the influenza or pneumococcal vaccinations and would want information about them to make a decision.Resident 2Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including wound infection and depression. The medical records did not indicate a history of the resident being administered with any of the pneumococcal vaccines. The 12/17/2025 comprehensive assessment showed the resident was cognitively intact, able to make their needs known and the pneumococcal vaccine had been offered and refused by the resident.Review of Resident 2's immunization informed consent record showed the resident received the influenza vaccine September 2025, from an outside source, which was reported to facility staff by the resident on 10/07/2025. The records did not include documentation of the pneumococcal vaccine being offered after the resident's admission on [DATE] nor that education on the risk versus benefits and potential side effects was conducted with the resident.During an interview on 01/09/2026 at 9:58 AM, Resident 2 stated they had previously received the pneumococcal vaccine before admitting to the facility and decided to get the influenza vaccine outside of the facility but let the facility staff know after it was completed.Resident 72Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnoses including heart/lung complications and a bladder infection. The 12/31/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known, was offered the influenza/pneumococcal vaccines and refused them.Review of Resident 72's immunization informed consent record showed the resident refused the influenza and pneumococcal vaccines on 12/17/2025, but no documentation of the resident being provided education on the risk versus benefits nor the potential side effects when they refused both the vaccines.Resident 35Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including heart complications, anxiety and depression. The (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/13/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known and was administered the influenza vaccine on 11/12/2025.Review of Resident 35's immunization informed consent record showed the resident received the influenza vaccine but did not show documentation of the resident being provided education on the risk versus benefits and potential side effects regarding the influenza vaccine.During an interview on 01/08/2026 at 3:46 PM, Staff C, Director of Nursing Services, and Staff R, Resource Nurse Manager (stand in for Infection Preventionist), stated the facility's process was to offer all facility residents the influenza/pneumococcal immunizations and complete consent forms which included a resident's choice on accepting or refusing the vaccines and the education that was provided regarding the risk versus benefits with potential side effects of the influenza/pneumococcal vaccines. Staff C and Staff R stated they were currently hiring for an Infection Preventionist staff, they were aware that not all residents had been offered/educated, work in progress, and were currently working on getting all the residents vaccine records updated. When reviewing sampled resident record for immunizations, both staff stated the correct process was not being followed for offering/education or documentation of resident vaccinations and were unable to present additional records. Reference: WAC 388-97-1340(2)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representative were offered/educated on the 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) immunization (a specific vaccine for the COVID-19 virus) benefits/risks and potential side effects associated with the COVID-19 vaccine for 5 of 5 sampled residents (Resident 61, 2, 72, 35 and 56) reviewed for immunization status. This failure placed the resident and/or their representative at risk of making an uninformed decision and resident contracting the COVID-19 virus.Findings included .Resident 61Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, anxiety and depression. The 10/17/2025 comprehensive assessment showed the resident was cognitively intact, able to make their needs known and was not up to date on the COVID-19 vaccine.Review of Resident 61's immunization informed consent record showed the resident had not been offered the opportunity to accept or refuse the COVID-19 vaccinations nor had they been educated on the risk versus benefits and potential side effects regarding the vaccine.During an interview on 01/09/2026 at 9:09 AM, Resident 61 stated they had not received any information or education regarding the risk versus benefits/potential side effect regarding the COVID-19 vaccine. Additionally, the resident had not been approached nor offered the opportunity to accept or refuse the COVID-19 vaccinations and would want information about them to make a decision.Resident 2Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including wound infection and depression. The 12/17/2025 comprehensive assessment showed the resident was cognitively intact, able to make their needs known and was not up to date on the COVID-19 vaccine.Review of Resident 2's immunization informed consent record showed the resident had not been offered the opportunity to accept or refuse the COVID-19 vaccinations nor had they been educated on the risk versus benefits and potential side effects regarding the vaccine.During an interview on 01/09/2026 at 9:58 AM, Resident 2 stated they had previously received the pneumococcal vaccine before admitting to the facility, decided to get the influenza vaccine outside of the facility but let the facility staff know after it was completed.Resident 72Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnoses including heart/lung complications and a bladder infection. The 12/31/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known, was not up to date on the COVID-19 vaccine.Review of Resident 72's immunization informed consent record showed the resident refused the COVID-19 vaccine on 12/17/2025, but no documentation of the resident being provided education on the risk versus benefits nor the potential side effects when they refused the vaccine.Resident 35Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including heart complications, anxiety and depression. The 11/13/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known and was not up to date on the COVID-19 vaccine.Review of Resident 35's immunization informed consent record showed the resident had not been offered the opportunity to accept or refuse the COVID-19 vaccinations nor had they been educated on the risk versus benefits and potential side effects regarding the vaccine.Resident 56Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a lung condition, anxiety and depression. The 10/28/2025 comprehensive assessment showed the resident was cognitively intact, able to make their needs known and not up to date on the COVID-19 vaccine. Review of Resident 56's immunization informed (continued on next page)

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Columbia Crest Center	1100 East Nelson Road Moses Lake, WA 98837

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent record showed the resident had not been offered the opportunity to accept or refuse the COVID-19 vaccinations nor had they been educated on the risk versus benefits and potential side effects regarding the vaccine.During an interview on 01/08/2026 at 3:46 PM, Staff C, Director of Nursing Services, and Staff R, Resource Nurse Manager (stand in for Infection Preventionist), stated the facility's process was to offer all facility resident the COVID-19 vaccine and to complete consent forms which included education that was provided regarding the risk versus benefits with potential side effects of the vaccine. Staff C and Staff R stated they were currently hiring for an Infection Preventionist staff, they were aware that not all residents had been offered/educated, work in progress, and were currently working on getting all the residents vaccination records updated. When reviewing sampled resident for the COVID-19 vaccine, both staff stated the correct process was not being followed regarding offering/education or documentation resident COVID-19 vaccinations and they were unable to present additional information. Reference: WAC 388-97-1620(2)(b)(i)(ii)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents on psychotropic medications (a collective term used for medication classes that affect brain activities associated with mental processes, emotions and behavior, like antipsychotics or anxiolytics) were being monitored for individualized behaviors prior to administration to reflect the adequate need of the medication for 1 of 2 residents (Resident 4) reviewed for psychotropic medication side effects. This failure placed residents at an increased risk for experiencing medication-related adverse side effects, and unmet care needs. Finding included . Review of the facility's policy titled, Behaviors: Management of Symptoms, revised 09/15/2025, showed that residents behavioral symptoms would be individually evaluated to identify the underlying causes that may contribute to the resident's behavior. The policy showed the facility would implement and monitor individualized, person-centered behaviors of residents on psychotropic medications.Review of the resident's medical record showed they were admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including progressive multiple sclerosis (a disease where the body attacks its own nervous system and can cause numbness, weakness, vision problems, balance issues and cognitive difficulties), heart complications, anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), end stage renal disease (the final stage where an individual's kidneys fail, requiring dialysis [the filtering of waste and/or extra fluid from blood] or a kidney transplant) and on palliative care (medical care focused on providing relief from symptoms, pain and stress for individuals with serious illnesses, aiming to improve the quality of life). The 10/14/2025 comprehensive assessments showed the resident was cognitively intact, able to make their needs known, and was receiving hospice care (a specialized, team-based approach on care focused on comfort, dignity, and quality of life for people with serious, terminal illnesses). Review of Resident 4's Physician orders, showed: On 12/19/2025 Haloperidol (an antipsychotics medication used to manage symptoms like hallucinations [a false perception of objects or events involving your senses that seem real, but are not] and disordered thinking) that could be administered every six hours as needed (PRN) for anxiety. On 12/22/2025 Lorazepam (an anxiolytics medication that slows down the brains activity, leading to relaxation and reduces nervousness) that could be administered every six hours PRN for anxiety, agitation (an unpleasant state of extreme restlessness, tension, and/or irritability) or shortness of breath. During a concurrent observation and interview on 01/05/2026 at 12:26 PM showed Resident 4 in their bed asleep, not able to wake with verbal communication. Staff T, Nursing Assistant (NA), came into the room and started cleaning out the resident's mouth with a wet sponge on a stick. Resident not waking and very slightly moved head to side as Staff T inserted the sponge into the resident's mouth. Staff T stated that Resident 4 had been asleep/non communicative .maybe a couple of weeks . Resident 4 observed to have a small/slight jerking of the head but did not wake and heard mumbling, very softly incoherent words then back to sleep. Observation on 01/06/2025 at 8:24 AM showed Resident 4 in bed, eyes closed, unable to wake or respond to verbal communication by the surveyor.Review of Resident 4's medication administration records (MAR) for January 2026 showed the resident was administered a dose of Haloperidol on 01/01/2026 at 5:10 AM and on 01/06/2026 at 9:53 PM. Additionally, the record showed the resident was administered doses of Lorazepam by Staff O, Licensed Practical Nurse (LPN), on 01/02/2026 at 4:54 PM and on 01/07/2026 at 2:44 PM. Review of Resident 4s Treatment administration records (TAR) behavior monitoring for January 2026 showed no documentation of Resident 4 having any behaviors requiring the used of the antipsychotic or anxiolytics medications were noted.During a concurrent observation and interview on 01/08/2026 at 9:44 PM, showed Resident 4 asleep in bed, not responding to verbal communication, unable to wake and open their eyes. Staff Y, LPN, stated Resident 4 had not been waking up or (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responding withing the past couple of weeks, and they had been monitoring for behaviors like agitation/anxiety with the resident crying out or waking from a bad dream scared. Staff Y stated the resident would communicate their symptoms of nausea (feeling like you are going to throw-up), agitation or anxiety verbally with the nursing staff, and Resident 4's behaviors would be documented on the TAR with the behavior monitoring. Staff Y stated they had not observed any behaviors with Resident 4 in January 2026 yet. During an interview on 01/08/2026 at 12:35 PM, a Collateral Contact associated with hospice provider, stated that Resident 4 had been obtunded (a reduction in an individual's responsiveness and no longer alert to the environment) the past two days they had visited and was no longer able respond to verbal or touch stimulation. The Collateral Contact stated that nursing staff should be monitoring Resident 4's behaviors before administering psychotropic medications like haloperidol or lorazepam and document the behaviors.During an interview on 01/08/2026 at 2:52 PM, Staff O, LPN, stated that all resident psychotropic medication behaviors were continuously monitored and documented in the TAR. Staff O stated with Resident 4 they monitored yelling out or the resident waking up scared from a dream about their significant other. Staff O stated they administered Resident 4 lorazepam on 01/02/2026 at 4:54 PM and on 01/07/2026 at 2:44 PM and documented anxious. Staff O stated they did not chart the actual behaviors and heard from another staff member that the resident was anxious. Staff O stated they did not document the behaviors on the TAR like they should have and were unable to give more information on the resident's behaviors. During an interview on 01/09/2026 at 11:14 AM, Staff J, Resident care Manager, stated that since Resident 4 was on psychotropic medication, nursing staff should be monitoring specific behaviors towards the resident anxiety/agitation, like yelling out, screaming, hallucinations and shortness of breath. Staff J reviewed Resident 4 records and stated that behaviors were not monitored with the psychotropic medications that had been administered in January 2026. Staff J stated the correct process was not being followed and nursing staff .should not be giving the Haldol or the lorazepam if you are not able to show why.During an interview on 01/09/2026 at 12:18 PM, Staff A, Administrator, stated they would expect nursing staff to document targeted behaviors to show the justification for administering psychotropic medications. Reference: WAC 388-97-1060(3)(k)(i)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the resident and their representative with a summary of a baseline care plan that included the initial goals of the residents, a summary of the residents medications and dietary instructions and services and treatments to be administered by the facility staff for 2 of 4 newly admitted residents (Residents 35 and 37) reviewed for baseline care plans. This failure placed the residents and their representatives at risk for a lack of knowledge regarding the initial care plan for delivery of care and services and unmet care needs.Findings included .Resident 35Review of the resident's medical record showed Resident 35 was admitted to the facility on [DATE] with diagnoses including a fracture of the left foot, a history of falls, chronic pain and diabetes. Review of Resident 35's comprehensive assessment dated [DATE] showed they were cognitively intact and required maximum assistance with bed mobility and transfers.During an interview with Resident 35 on 01/05/2026 at 11:10 AM, they stated they had not received a copy of their baseline care plan, nor had anyone discussed their care plan goals with them for things such as physical and occupational therapies, what medications they were taking, pain management, or discharge plans since they were admitted to the facility.Further review of Resident 35's medical record did not show that a summary of the completion of the baseline care plan was given and discussed with the resident or their representative. Resident 37Review of the resident's medical record showed Resident 37 was readmitted to the facility on [DATE] with diagnoses including a stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage), aphasia (a language disorder from brain damage that impairs speaking, understanding, reading and writing), and cardiac disease. Review of Resident 37's comprehensive assessment dated [DATE] showed they had severely impaired cognition and could rarely understand others. Review of Resident 37's medical record did not show that a summary of the completion of the baseline care plan was given and discussed with the resident's representative. During an interview with Staff D, Registered Nurse, Minimum Data Set (MDS) (a standardized comprehensive assessment tool used to collect essential clinical and functional data to develop care plans in nursing homes) Coordinator on 01/09/2026 at 11:35 AM, they stated they started a care plan on the day of admission and they and the nursing staff added information to it as they gained more knowledge of the resident during their stay. Staff D stated they had not specifically completed 48-hour baseline care plans or given a copy of the baseline care plans upon completion to the resident or their representative because they did not know there was a requirement to do so. In addition, Staff D stated they thought social services were responsible for setting up the initial care conference meeting but was uncertain if they or any member of the interdisciplinary team discussed the components of the baseline care plan or gave a copy to the residents or their representatives. During an interview with Staff C on 01/09/2026 at 11:55 AM, they stated facility staff used to complete baseline care plans per the requirement but with the multiple changes in the administrative staff and interdisciplinary team members over the past few years, components of the regulation could have easily been forgotten to be completed with new admissions. Reference: WAC 388-07-1060(a)(3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (Residents 25) reviewed for activities of daily living (ADLs), received adequate dressing, grooming, nail, and oral care according to the resident's care plan. This failure placed the residents at risk for unmet hygiene needs.Findings included.Review of the resident's medical records showed they admitted to the facility with diagnoses to include Multiple Sclerosis (MS, a chronic disease where the immune system mistakenly attacks the protective covering of the brain and spinal cord nerve fibers that leads to communication issues between the brain and the rest of the body). The 11/12/2025 comprehensive assessment showed Resident 25's cognition was moderately impaired and required substantial to maximum assistance for their oral and personal hygiene needs and was dependent on staff for dressing. During an interview and a concurrent observation on 01/05/2026 at 12:17 PM, Resident 25 was lying in bed, dressed in a hospital gown, with a black, horseshoe-shaped neck pillow being used as a pillow under their head. Resident 25 had long fingernails with black and brown debris underneath the nail beds. Resident 25's Collateral Contact (CC) stated they visited Resident 25 often and the resident had not had their teeth brushed, fingernails trimmed and they had not been dressed in clothes, nor did they get up and in their wheelchair in a long while. The CC stated when they informed the Nursing Assistants (NAs) Resident 25 needed their nails cut, they handed the CC the tools for them to trim themselves. The CC stated they were the one to trim Resident 25's hair once a month. Staff S, NA, entered to assist the Resident with their lunch and stated they had worked at the facility for around two weeks, and they had not gotten the resident up out of bed nor did they offer. Staff S stated they were told the resident did not get out of bed. Review of the 01/02/2026 Care Plan (CP) showed on 01/02/2026 an intervention to provide oral care three times a day after meals. The CP showed when the resident refused cares, the staff were to encourage and reassure the resident. The CP showed another intervention on 04/26/2022 to provide oral care twice per day and as needed. The CP showed no interventions for nail care, daily clothes dressing, or how often their hair should have been trimmed. During a telephone interview on 01/06/2026 at 1:28 PM, the Resident Representative (RR) stated they had voiced their concerns to the facility management multiple times, regarding the inconsistency of nail care and the oral and mouth care. The RR stated care would improve for a few days but then would continue with the same behaviors. The RR stated there was no encouragement and if just asked and not encouraged, Resident 25 would lay in their bed all day. The RR stated Resident 25's mental capacity had changed due to their MS, so they needed encouragement. During an interview and concurrent observation on 01/07/2026 at 10:04 AM, showed Resident 25 lying in bed, unshaven, their teeth had yellow and white debris on the front of them, missing teeth, and dressed in a hospital gown. Resident 25 shook their head no when asked if their teeth had been brushed after breakfast. Resident 25's toothbrush and toothpaste were sitting on the sink in a basin, the toothbrush was dry, and the toothpaste was full. An observation on 01/07/2026 at 12:26 PM, showed Resident 25 lying in bed, same as they were that same day at 10:04 AM and the toothbrush was dry and in the same place. During interviews on 01/07/2026 at 2:56 PM and 4:07 PM, Resident 25 was lying in their bed, and when asked if they had their teeth brushed or had been cleaned up, the resident shook their head no. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The toothbrush was dry and in the same place as seen at 10:04 AM and 12:26 PM. Resident 25's fingernails were long and had brown and black sediment underneath the nail and around the nail bed. During an interview on 01/08/2026 at 8:50 AM, Staff T, NA, stated Resident 25 did not get up as much since they returned from the hospital due to their pain. Staff T stated they would ask the resident if they wanted to get up and they would decline. Staff T stated they did not provide encouragement when the resident would decline. Staff T stated they provided oral care during first rounds and after meals, which would have been two to three times during their day shift (6:00 AM to 2:30 PM). Staff T stated they did not provide oral care that morning because they were short one NA for their shift. Review of the January 2026 physician orders showed on 01/02/2026 an order for Resident 25 to receive oral care three times a day after meals. During an interview on 01/08/2026 at 5:14 PM, Staff C, Director of Nursing Services, stated they had provided most of the nail care more recently and must have missed Resident 25. Staff C stated they would expect oral care to be provided after meals and at bedtime. Staff C stated they were aware they had issues with encouraging residents to participate in their care needs. Reference: WAC 388-97-1060(2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to consistently offer or provide repositioning for a dependent resident for 1 of 2 residents (Resident 25) reviewed for quality of care. This failure placed all residents at risk for discomfort, skin breakdown, and negative health outcomes. Findings included.Review of the resident's medical records showed they were admitted to the facility with diagnoses to include Multiple Sclerosis (MS, a chronic disease where the immune system mistakenly attacks the protective covering of the brain and spinal cord nerve fibers that leads to communication issues between the brain and the rest of the body) and hemiplegia (severe or complete loss of use of one side of the body) to the right side. The 11/12/2025 comprehensive assessment showed Resident 25's cognition was moderately impaired and was dependent on staff for their positioning needs. During an observation and concurrent interview on 01/06/2026 at 9:51 AM, Resident 25 was lying in bed on their back and stated their bottom was hurting. Resident 25 stated they needed to move their bottom. Resident 25 turned on their call light for assistance with positioning. During an observation and concurrent interview on 01/06/2026 at 10:13 AM Staff C, Director of Nursing Services, entered Resident 25's room to answer their call light. Staff C exited the room less than a minute later with the call light back on. Resident 25 stated they were not repositioned and was observed still lying on their back, slumped (sit, lean, or fall heavily and limply) down in their bed. An observation on 01/07/2026 at 10:04 AM, showed Resident 25 lying in their bed, on their back, with a black horseshoe shaped pillow behind their neck. Resident 25 stated they had not been repositioned off their back that morning. An observation on 01/07/2026 at 12:26 PM showed Resident 25 lying on their back, same position as they were in at 10:04 AM observation with the same pillow behind their neck and head. Resident 25 was slumped down in the bed which caused the neck pillow to move up under the head and not the neck. During an observation and concurrent interview on 01/07/2026 at 2:56 PM and again at 4:07PM, Resident 25 lay on their back, the same position as they were in on the same day at 10:04 AM and 12:26 PM. Resident 25 shook their head from left to right when asked if they had been repositioned or moved side to side. During an observation and concurrent interview on 01/08/2026 at 8:50 AM, Resident 25 was lying in bed on their back. Staff T, Nursing Assistant (NA) exited the room with the breakfast tray. Staff T stated they repositioned the resident during their first rounds at the beginning of their shift and then again after meals and as needed. Day shift was from 6:00 AM to 2:30 PM. Staff T stated they were missing one NA for their shift so were unable to get that done during first rounds. During an observation and concurrent interview on 01/08/2026 at 10:41 AM, Resident 25 still lying on their back in the same position as they were on the same day at 8:50 AM. Review of the 01//02/2026 Care Plan (CP) showed a focused CP area for Resident 25 being at risk for having discomfort. The CP showed an intervention on 10/27/2014 to float the heels while in bed, and interventions dated 04/30/2021 to turn resident every two to three hours as needed and assist the resident to a position of comfort using pillows for positioning devices. The CP showed an intervention initiated 09/12/2024 for a positioning wedge to be used for offloading while in bed (there was no positioning wedge used or heels floated during observations on 01/05/2026, 01/06/2026, 01/07/226, or 01/08/2026). During an interview on 01/09/2026 at 12:39 PM, Staff V, NA, stated they were to trim nails and shave residents during showers twice a week. During an interview on 01/09/2026 at 2:40 PM, Staff A, Administrator, along with Staff R, Resource Nurse Manager, stated they identified there were issues with repositioning and mobility with their skin and pain issues and were working towards a process to improve in those areas. Reference: WAC 388-97-1060 (1)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review the facility failed to provide specialized services for footcare for 1 of 2 residents (Resident 25) reviewed for activities of daily living (ADLs). This failed practice placed residents at risk of skin breakdown, infections, and discomfort.Findings included.Review of the resident's medical records showed they admitted with diagnoses to include Multiple Sclerosis (MS, a chronic disease where the immune system mistakenly attacks the protective covering of the brain and spinal cord nerve fibers that leads to communication issues between the brain and the rest of the body). The 11/12/2025 comprehensive assessment showed Resident 25's cognition was moderately impaired and required staff assistance for personal hygiene. During an interview on 01/05/2026 at 12:17 PM, showed Resident 25 lying in bed on their back with a visitor at their bedside. The Collateral Contact (CC) stated they visited Resident 25 often and the Nursing Assistant (NA) staff did not provide Resident 25 with good nail care. The CC stated if they wanted the nails to be trimmed, the NAs would bring them the tools to do it themselves. During a telephone interview on 01/06/2026 at 11:28 AM, Resident 25's Resident Representative (RR) stated they had asked the Nursing and Administration staff multiple times about the resident's nail care with no follow through. Review of the 01/02/2026 Care Plan showed no focus for nail care or Podiatrist (a medical professional who specializes in treating issues with the foot, ankle, and lower leg) services. During an observation of care on 01/08/2026 at 11:57 AM, Resident 25 was being provided care by two NAs. Resident 25's toenails to both feet were long, thick, and yellow in color with the nails curved downwards towards the skin, almost touching the top of the toes.Review of a 03/25/2024 Podiatrist note showed the resident had diagnoses of Onychomycosis (a fungal infection of the nails that causes the nails to thicken, discolor, and split) and Dystrophic (thickened, discolored or misshapen) nails. The note showed the Podiatrist recommended Resident 25 to be seen again in two to three months. The record showed no other Podiatry visits after 03/25/2024 (21 months and 13 days). Review of a 12/25/2025 hospital visit note showed severe toenail dystrophy, foot hygiene appears to be very poor. The note showed the RR was at the bedside and stated they had tried to coordinate footcare from the facility for quite some time but had been unable to. The note showed the toenails would begin to cause skin breakdown if not addressed in the near future. The note further showed there was an order for an outside Podiatry referral. Review of Resident 25's physician orders for December 2025 and January 2026 showed no referral had been ordered for Podiatry. During an interview on 01/08/2026 at 5:14 PM, Staff C, Director of Nursing Services, stated they used to have a Podiatrist that would come to the facility every three months, but they had retired. Staff C stated obtaining a new Podiatrist was a work in progress. Staff C stated they provided most of the nail care to the residents and must have missed Resident 25. Staff C stated they were not aware of the Podiatry referral ordered for Resident 25 on their return from the hospital and would check in to it. Staff C could not provide any further information on Resident 25's nail care. Reference: WAC 388-97-1060 (3)(j)(viii)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Crest Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident was consistently supervised during smoking for 1 of 2 sampled residents (Resident 52) reviewed for smoking. This failure placed the resident at risk for avoidable accidents, injuries, and the potential risk of fire.Findings included.Review of a 02/24/2025 policy titled Smoking showed the staff responsible for supervising smoking would be in the direct area of the smoker, within eye contact and able to respond to emergency situations. The policy showed the resident's smoking materials would be maintained by the nursing staff and kept in the Nurse's station. Review of the resident's medical records showed they admitted with diagnoses to include a stroke (a complication when blood supply to the brain is blocked or reduced which can lead to brain damage) and seizure disorder. The 10/23/2025 comprehensive assessment showed Resident 52's cognition was moderately impaired and used a wheelchair independently for their mobility. An observation on 01/07/2026 at 10:07 AM, Resident 52 was observed outside, under the patio that was designated as the smoking area. Resident 52 was smoking a cigarette and there were no other residents or staff in the area. Resident 52 discarded their cigarette in the smoking receptacle provided and self-propelled themselves into the facility, backwards. Resident 52 went straight to their room and was not observed giving their smoking materials to the nurse. Review of Resident 52's smoking assessment, dated 10/21/2025, showed the resident was assessed to have a history of unsafe smoking habits and would share or sell their cigarettes or smoking materials to other residents. The assessment showed Resident 52 required supervision while they smoked. An observation on 01/07/2026 at 10:52 AM, showed Resident 52 in a stocking cap, outside smoking in the designated smoking area, unsupervised. During an interview on 01/08/2026 at 10:05 AM, Resident 52 stated they were supposed to have someone with them when they went outside to smoke but the facility did not always have someone to take them and would go outside on their own to smoke. Resident 52 stated the nurses were supposed to hold their cigarettes and lighter in between smoke breaks and declined to answer whether that was happening or not. During an interview on 01/08/2026 at 2:03 PM, Staff C, Director of Nursing Services, stated they did not have any residents that could go out and smoke unsupervised. Staff C stated they allowed smoking at the facility, but everyone could only smoke supervised and at the specified times. Staff C stated the staff shared responsibility of designated smoke times and there was not a specific designated staff member. Staff C stated if a resident wanted to go out to smoke, they could ask, and they would do their best to accommodate them. Staff C stated they were not aware Resident 52 was smoking unsupervised and did not think that was possible because the nursing staff held their smoking materials in between smoke breaks. An observation and concurrent interview on 01/08/2026 at 4:24 PM, Resident 52 was observed outside smoking in the designated smoking area, unsupervised. Resident 52 propelled themselves, backwards, to their room and did not give their smoking materials to the nurse prior to going to their room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/2026 at 4:30 PM, Staff P, Registered Nurse, stated they had given Resident 52 their smoking materials prior to the resident going outside to smoke. Staff P stated they assumed one of the Nursing Assistants (NA) went outside to supervise the resident while smoking. Staff P attempted to provide a list that was kept by the time clock that showed who was responsible for the smoking breaks that day but could not locate one. Staff P stated it would have to have been one of the NAs on the [NAME] end of the hall, closest to the smoking area. Staff P stated they were not aware Resident 52 had returned to their room after their smoke break, and confirmed they had not returned their smoking materials to Staff P. During an interview on 01/08/2026 at 4:31 PM, Staff O, Licensed Practical Nurse, on the [NAME] side of the building, stated they did not have any residents that smoked on their side of the building so smoking supervision would not have been assigned to one of their NAs. Staff O stated it would be the responsibility of the North or East who have residents that smoke. During an interview on 01/09/2026 at 2:01 PM, Staff A, Administrator, stated they had completed a behavioral plan with Resident 52 previously for them not following the smoking policy and would need to figure out another plan. Staff A stated Resident 52 puts the facility and the other residents at risk when they continue to smoke unsupervised. Reference: WAC 388-97-1060(3)(g)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to implement and ensure their system of records for controlled substances (CS, categories of drugs, regulated and classified based on their potential for abuse and potential to cause physical or mental dependence) disposition (the process of returning and/or destroying unused medications) and accurate reconciliation (a system of recordkeeping that ensures an accurate inventory of CS received, administered or destroyed) was completed in sufficient detail to enable the accurate accounting with these types of medications for 1 of 2 medication carts/CS logbooks (West hallway medication cart) reviewed for storage/disposition of controlled medications. This failure placed residents at risk for potential financial loss, uncontrolled pain, and possible drug diversion (the abuse of prescription drugs used for purposes other than intended by the prescriber). Findings included .Review of the facility's policy titled, Controlled Medication Storage, dated January of 2025, showed that at each shift change two Licensed nurses would verify/document the accurate reconciliation of the CS was correct from the previous shift. The policy stated that if the counts were incorrect, they would be reported to the Director of Nursing Services (DNS) immediately. The policy showed CS that remained after an order had been discontinued would have restricted access until destroyed. During a concurrent observation and interview on 01/08/2026 at 5:38 PM Staff O, Licensed Practical Nurse, was overseeing the [NAME] hallway medication cart. Staff O stated they had already performed the shift change CS reconciliation and documented completed with two nursing signatures in the CS logbook. Staff O stated the CS logbook was for recording [NAME] hallway resident specific CS medications administration during nursing shifts so that an accurate count was maintained. Staff O showed a resident's CS medication card (multiple doses of CS medications individually packaged) along with the corresponding logbook reconciliation, but the count from the logbook and the medication card did not match. Staff O stated they had given the medication previously to the resident and was trying to catch up with the documentation in the CS logbook. The CS logbook showed that Staff O had administered the CS medication on 01/07/2025 and 01/08/2025 but the number of CS medication logged after the administrations differed from the CS medications left on the resident's medication card. Staff O stated the CS logbook was incorrect and they were unsure of what date they had administered the CS medication but that it was not given on one of the days. Observations on 01/08/2026 at 5:45 PM, showed Staff D, Registered Nurse and Staff C, DNS, conducting a CS reconciliation on the [NAME] hallway medication cart and CS logbook. During the reconciliation observations: Two CS medication cards were noted with a hole torn in the back of the package where the CS medications tablets were accessible and had the potential to fall out of its original packaging without anything to keep the tablet in place. Two CS liquid medication bottles of Hydromorphone (a CS medication for pain) were noted for the same resident but were logged in two separate logbooks. One of the CS medication bottles was brand new and the other showed on the logbook that 14 milliliters (ml, a unit of measure) were left in the CS medication bottle, but the bottle was noted to have 6 ml left (an 8 ml difference) and a broken cap. Two CS medication cards from a resident that had discharged from the facility on 01/01/2026 were still noted in the reconciliation. Two CS liquid medication bottles of Morphine (a CS medication for pain), recorded on the same page in the CS logbook, one bottle had 7 ml and the other had 3 ml. The logbook did not differentiate the amounts between bottle one and bottle two but showed 12 ml total (a difference of 2 ml)During an interview on 01/08/2026 at 5:55 PM, Staff C, DNS, stated the facility's process was to have licensed nursing staff flag CS medications that needed disposition during the CS reconciliation so they could be destroyed or returned and an accurate reconciliation could be completed/documented. Staff C stated the flagged items would have included the two CS medications cards from the resident that had already been discharged , the two CS medication cards that had the packaging torn open on the back, the liquid CS (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydromorphone bottle with the broken cap and one of the two liquid CS morphine bottles that should have been documented on their own page. Staff C stated the CS reconciliation counts were not correct and needed further investigation. Staff C stated that accurate accounting and documentation of the CS medications was not maintained, and the facility process was not followed. During an interview on 01/06/2025 at 4:09 PM, Staff A, Administrator, stated that the CS medication count verification, logbook documentation and disposition should have been completed accurately. Staff A stated the correct process was not followed. Reference: WAC 388-97-1300(1)(b)(ii)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to provide a sanitary environment by not providing scheduled maintenance services for cleaning for ceiling vents for 1 of 1 kitchen. This failed practice placed the residents at risk for cross contamination, food borne illness, and negative health outcomes.Findings included .During an observation on 01/05/2026 at 10:06 AM, the two 24 by 24 inches air vent in the kitchen located on the overhead in the middle ceiling over the food preparation areas had fuzzy brown substances that were unclean around the 24 by 24 inches square air vent grill. The air vent grill, located on the ceiling over the cook area, had multiple areas of a dark brown and grayish fuzzy substances. The 24 by 24 inches air vent grill, over the staff handwashing sink in the kitchen had accumulated brown fuzzy dust. The ceiling by the wall across the kitchen room had two 24 by 24 inches dirty air vents which had fuzzy gray dust hanging and brown dust located on the air vents.During an interview on 01/05/2026 at 10:20 AM, Staff K, Dietary Manager visualized the vents in the kitchen and stated they were dirty and were not cleaned for a while. Staff K stated they had not had a maintenance person for cleaning the vents in the kitchen for some time and was unsure about when the air vents were to be cleaned.During an interview on 01/07/2026 at 12:46 PM, Staff H, Maintenance Supervisor, stated they were new to the position and the cleaning of the kitchen vents and ceiling had not been on a scheduled cleaning and needed to be on a cleaning schedule.Reference: WAC 388-97-3220(1)