

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2026
NAME OF PROVIDER OR SUPPLIER Buena Vista Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 151 Buena Vista Drive Colville, WA 99114	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain 1 of 1 ice machines (Ice Machine 1) in a sanitary manner. This failure placed the residents at risk of consuming contaminated ice and foodborne illness. Findings included. In the initial observation of the kitchen on 06/08/2026 at 10:45 AM, Ice Machine 1 was observed with thick dust debris covering the vents located on both sides of the machine. Staff D, Dietary Manager, stated the ice machine was cleaned on 06/05/2026. In a second observation of the kitchen on 06/11/2026 at 1:00 PM, Ice Machine 1 continued to be covered with thick dust debris that covered the vents located on both sides of the ice machine. In an interview on 06/11/2026 at 1:50 PM, Staff D stated it was important to keep the ice machine free of dust debris as the dust could enter the ice machine and cause contamination. In an interview and observation on 06/11/2026 at 2:50 PM, Staff E, Maintenance Director, stated the ice machine was cleaned monthly. Staff E observed the ice machine and stated it was important to keep the ice machine clean and to ensure it worked properly. Reference: WAC 388-97-1100(3), 2980		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain consent for psychotropic medications (medications that affect the mind, mood, and emotions) prior to administration of the first dose, for 1 of 5 sampled residents (Resident 2), reviewed for unnecessary medications. This failure placed the resident at risk of not being fully informed of the risks and benefits of medications and making a fully informed choice about their medical care. Findings included . On 02/09/2026, a provider order was given to administer risperidone (a medication used to treat PTSD) daily. The March 2026 medication administration record showed Resident 2 received their first dose of risperidone on 03/26/2026. The 04/01/2026 admission assessment documented Resident 2 had diagnoses that included depression and post-traumatic stress disorder (PTSD, a mental health condition caused by an extremely stressful or terrifying event). Resident 2 was cognitively intact and received medication for PTSD. The 04/06/2026 psychotropic medication use care plan documented Resident 2 received psychotropic medications. The care plan instructed nursing staff to administer the medications as prescribed and to obtain informed consent for usage. A review of Resident 2's medical record showed the informed consent for the risperidone was obtained via verbal consent from Resident 2 on 06/04/2026. In an interview on 06/12/2026 at 10:56 AM, Staff D, Registered Nurse, stated they were unsure when psychotropic medication consents needed to be obtained. Staff D stated it would be important to obtain the residents' consent, so they were aware of the risks of the medication. In an interview on 06/12/2026 at 1:56 PM, Staff B, Director of Nursing, stated informed psychotropic consents needed to be obtained the day the medication was started. Staff B stated it was important to obtain the consent prior to administration because the residents could have a reaction to the medication and needed to be aware of the risks. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to develop care-planned goals and interventions related to peripheral edema (swelling of the lower legs, ankles and feet due to fluid buildup caused by poor circulation, heart, liver, or kidney conditions or certain medications) for 2 of 2 sampled residents (Residents 5 and 44) reviewed. This failure placed the residents at risk for possible worsening health conditions and decreased quality of life. Findings included. The 03/05/2026 Cleveland Clinic Pitting Edema retrieved at https://my.clevelandclinic.org/health/symptoms/pitting-edema defined pitting edema as a type of swelling where pressure on an affected area left a dent in the skin and was usually the sign of a serious health condition. The extent of the edema was graded on a scale of one to four and included pressing on a swollen body part for five or more seconds and measuring the depth of the indent. Grade 1 edema was defined as an indent depth of 2 millimeters (mm). Grade 2 depth measured 3-4 mm, Grade 3 depth measured 5-6 mm, and grade 4 depth measured 8+ mm. The deeper the dent, the more severe the swelling was. Possible consequences of pitting edema included venous ulcers, pressure injuries or slow wound healing. <Resident 5> The 05/20/2026 baseline care plan had no goals or interventions developed related to Resident 5's lower extremity edema. There were no orders obtained to monitor the edema that was present when Resident 5 was admitted . The 05/26/2026 comprehensive admission assessment documented Resident 5 had diagnoses that included hypo-osmolality (loss of electrolytes in the blood such as sodium, and potassium or water retention forces water into cells and causes them to swell), hyponatremia (low levels of sodium in the blood) and high blood pressure. Resident 5 needed partial assistance of staff for most Activities of daily living (ADLs) and was cognitively impaired. The 05/26/2026 Medical Doctor admission History and Physical documented Resident 5 was admitted to the hospital for severe right hip pain. While there, the resident had mild ongoing hyponatremia related to a diuretic medication (a medication that flushed the kidneys of excess sodium and water from the body that relieved swelling and lowered blood pressure.) The medication was discontinued during the hospitalization to allow sodium levels to recover. The 05/26/2026 admission Nursing Assessment documented Resident 5 had 2+ non-pitting edema of both lower extremities. On 06/09/2026 at 9:33 AM, Resident 5 was observed resting on top of their bed. Resident 5 had a pillow under their knees that elevated their lower legs; their heels were resting on the mattress. The resident was barefooted, and their lower legs, ankles, and tops of their feet were puffy. Resident 5 stated they were unsure when their feet became puffy and it was uncomfortable. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/2026 at 9:04 AM, Resident 5 was resting on their bed visiting a family member. Resident 5's lower legs were elevated with a pillow and their heels rested on the mattress. Resident 5 had on a pair of non-skid slipper socks. The elastic at the top of the socks pressed into their lower leg above the ankle and left very clear indentations. A similar observation of the socks pressing into Resident 5's lower legs was seen on 06/11/2026 at 8:17 AM. On 06/11/2026 at 2:00 PM, Resident 5's lower legs and feet were observed with Staff H, Nursing Assistant. Staff H stated they had showered Resident 5 and the resident returned to rest in their bed. Resident 5's lower legs were elevated on a pillow. The non-skid slipper socks had been removed, and lines where the socks had pressed into the resident's skin could be seen above both ankles. The tops of the feet were puffy. Resident 5 had a family member present. They stated Resident 5's legs had gotten noticeably puffier since their admission. The family member stated the resident's fluid pill had been stopped at the hospital because of their sodium level. The family member stated the same thing had happened in the past and Resident 5's legs became so swollen it affected their ability to walk and they had told one of the nurses about this the week prior. During an interview on 06/12/2026 at 9:23 AM, Staff H stated Resident 5's feet and lower legs had been puffy all of the times they cared for the resident. They stated Resident 5 was at risk for skin breakdown and it was important to keep their heels elevated off the mattress. They stated if they noticed any resident's legs or feet becoming more swollen they reported it to the nurse. During an interview on 06/12/2026 at 10:57 AM with Staff B, Director of Nursing and Staff C, Resident Care Manager, Staff B stated Resident 5 had 2+ edema documented on their admission nursing assessment. Staff C stated they saw a progress note dated 06/04/2026 that documented the resident had a trace amount of edema. Staff B stated follow up blood work had been done to recheck Resident 5's sodium levels before the resident's medication was restarted. Staff B and Staff C agreed that an order to monitor Resident 5's edema should have been obtained and added to Resident 5's plan of care. On 06/13/2026 at 8:08 AM, Resident 5's lower legs were observed with Staff I, Licensed Practical Nurse. Staff I removed non-skid socks from the resident's feet. Fingertip pressure was applied to the tops of the resident's feet, and indentations formed. There were lines across the resident's legs above their ankles where the elastics from the socks had pressed into the skin. Staff I stated the edema was 2+ pitting edema. <Resident 44> The medical record documented Resident 44 had diagnoses that included chronic kidney disease (CKD, when the kidneys are damaged and cannot filter blood properly) and high blood pressure. The 06/02/2026 admission skin assessment documented Resident 44 had generalized edema. The assessment did not specify the grade of edema. The 06/02/2026 base line care plan did not have a care area, goals or interventions developed related to Resident 44's CKD, high blood pressure or edema. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 06/09/2026 physician progress note documented Resident 44 had 1+ edema to their bilateral lower extremities. The note instructed nursing staff to monitor blood pressure, renal function and symptoms of fluid overload. Review of Resident 44's Medication Administration Record and Treatment Administration Record (MAR/TAR) showed no edema monitoring. Review of Resident 44's progress notes from 06/02/2026 through 06/12/2026 showed there was a note on 06/06/2026 that stated the resident had minimal edema. There were no other notes in Resident 44's medical record that addressed their edema. In an observation on 06/08/2026 at 12:54 PM, Resident 44 was sitting in their recliner in their room and their legs were visible. Resident 44's legs were edematous (swollen with an excessive accumulation of fluid), shiny and taut (stretched or pulled tight) in appearance. In an observation on 06/10/2026 at 8:48 AM and 06/11/2026 at 8:13 AM, Resident 44 was sitting in their recliner in their room. Resident 44's legs were edematous, shiny and taut. In an observation with Staff D, Registered Nurse, on 06/12/2026 at 11:53 AM, Resident 44 was sitting in their recliner in their room. Staff D assessed Resident 44's legs. Resident 44's family member was present and stated their edema had worsened. Staff D stated an edema monitor needed to be in place. Resident 44's family member stated they had a prescription from the primary care physician for Lasix (a diuretic that rids the body of fluid) for three days at a time when needed and that was helpful. At 11:57 AM, Staff D stated Resident 44 had 2-3+ pitting edema to their mid-calf. In an interview on 06/12/2026 at 11:58 AM, Staff D stated edema monitoring was placed depending on the resident's admitting diagnoses. Staff D stated if a resident was admitted with edema, an edema monitor was put in place. Staff D stated it was important to monitor edema, so heart failure and vascular compromise did not occur. In an interview on 06/12/2026 at 12:05 PM, Staff B, Director of Nursing, stated edema monitoring depended on the resident's diagnoses and orders. Staff B stated if a resident was admitted with edema, an edema monitor was typically put in place. Staff B stated Resident 44's main admitting diagnosis was a pelvic fracture and that could result in edema. Staff B stated the nurses should have monitored Resident 44 for edema. Staff B stated it was important to monitor edema because it had the potential to cause cardiac and kidney problems. Reference: WAC 388-97-1020(1)(2)(a)(b)		

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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 implement the bowel protocol for 1 of 5 sampled residents (Resident 2) reviewed for constipation. This failure put the residents at risk of discomfort and health consequences. Findings included. The facility policy titled, Bowel Protocol revised March 2023, documented staff were to check a resident's bowel record every shift and implement the following interventions if appropriate: 1) Four ounces of prune juice to be given in the morning and evening if applicable on the third day with no bowel movement (BM), 2) Give two Senna (laxative) or one Bisacodyl (laxative) tablet on the fourth day of no BM, 3) If Senna or Bisacodyl were ineffective, Milk of Magnesia (MOM, laxative) was to be given on the next shift (day four), 4) If MOM was ineffective, a stimulant laxative suppository was to be given on the next shift, 5) If the suppository was ineffective, an enema was to be given on the next shift, 6) If the enema was ineffective, the nurse needed to complete a bowel assessment and notify the physician. The 04/01/2026 admission assessment documented Resident 2 had diagnoses which included diabetes and depression. Resident 2 was cognitively intact and was dependent on staff for toileting. The 04/06/2026 care plan for Resident 2 did not address constipation, goals or interventions. Review of Resident 2's provider orders showed the following: -House bowel protocol: initiate at second day if no BM unless contraindicated, provider to specify contraindications-Bisacodyl suppository as needed for constipation, given on following shift if MOM was ineffective, -Bisacodyl tablet twice daily as needed for constipation, -Fleets enema as needed for constipation, given on following shift if suppository was ineffective, -MOM as needed for constipation, given on the third day of no bowel movement, -Prune juice twice daily as needed for constipation. Review of Resident 2's bowel record from 05/01/2026 through 06/10/2026 showed no BM from 05/05/2026 to 05/08/2026 (four days), 05/10/2026 to 05/12/2026 (three days), and 06/08/2026 to 06/10/2026 (three days). The May and June 2026 Medication Administration Record (MAR) showed Resident 2 received Prune juice on 05/13/2026. The facility failed to follow the BM protocol. In an interview on 06/12/2026 at 9:15 AM, Staff G, Nursing Assistant, stated BMs were monitored and documented every shift. Staff G stated Resident 2 experienced constipation. In an interview on 06/12/2026 at 10:56 AM, Staff D, Registered Nurse, stated bowel movements were monitored every shift and a small bowel movement did not count. Staff D stated MOM was given on the third day of no BM and if that was ineffective a suppository was administered 24 hours later. Staff D stated it was important to administer bowel medications to prevent bowel obstruction and pain. In an interview on 06/12/2026 at 1:56 PM, Staff B, Director of Nursing, stated nursing printed a bowel report twice daily. Staff B stated prune juice was given on the third day with no BM and if ineffective the physician's bowel orders were followed. Staff B stated it was their expectation nursing administered bowel medications as ordered to prevent obstruction. Reference: WAC 388-97-1060(1)-(3)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to implement resident specific interventions to prevent pressure ulcer/injuries for 1 of 4 sampled residents (Resident 2) reviewed for pressure ulcers. This failure placed residents at risk for development of pressure ulcers, medical complications, and unmet care needs. Findings included .Review of the facility's policy titled Skin Integrity updated March 2026, documented if a resident admitted with or developed a skin ulcer/pressure ulcer/wound, care would be provided to treat, heal, and prevent, if possible further development of skin ulcers/pressure ulcers/wounds. Review of the 03/26/2026 Braden assessment, (an assessment that explains the risk of getting skin breakdown) documented a score of 17, which indicated Resident 2 was at risk for skin breakdown. The 03/26/2026 skin integrity care plan showed Resident 2 was at risk for skin breakdown related to incontinence, left foot drop (the inability to lift the front part of the foot) and polyneuropathy (condition where multiple peripheral nerves outside the brain and spinal cord were damaged at the same time and caused numbness, tingling, weakness and pain in the hands and feet). The 03/26/2026 care plan had no documentation of prevention of skin issues or pressure ulcers. The 04/01/2026 annual assessment documented Resident 2 had diagnoses that included diabetes, polyneuropathy and depression. The assessment documented Resident 2 was identified as being at risk of developing pressure ulcers. Review of a progress note dated 04/09/2026 at 3:30 PM, documented Resident 2 complained of left heel pain. A light purple non blanchable area to the back of Resident 2's left heel was found. The 04/09/2026 facility incident investigation showed Resident 2 was found to have a suspected deep tissue injury (SDTI, a severe localized pressure ulcer or injury) to their left heel. A care plan intervention was added at that time to place a pressure relieving boot on Resident 2's left heel while in bed and a non-skid sock was to be worn for transfers. The 06/08/2026 updated care plan showed to float Resident 2's heels and on 06/09/2026 the care plan showed a STDI to Resident 2's left heel. During an observation and interview on 06/08/2026 at 3:02 PM, Resident 2 was lying in bed and had a pillow under their legs. The weight of Resident 2's legs pushed the pillow down and their heels were resting on the bed. Resident 2 stated they had a blister on their heel and acquired it at the facility. Resident 2 stated it was possibly related to their bed because they were large for the size of their bed. In an interview on 06/12/2026 at 10:56 AM, Staff D, Registered Nurse, stated it was determined if a bed was large enough by assessing the resident's height, weight and ensuring their feet were not squished up against the bed. Staff D stated they had never seen Resident 2's heels resting on the foot board of the bed and felt they had enough room. Staff D stated they knew what care to provide the residents with by looking at their notes in their room and by their plan of care. Staff D stated residents who were at risk for breakdown had interventions placed on their care plans. In an interview on 06/12/2026 at 12:12 PM, Staff B, Director of Nursing, stated for residents who were at risk for skin breakdown, their heels were floated, a Braden scale was completed, and interventions were determined after the resident's assessment. Staff B stated all residents had a pressure relieving mattress and acknowledged Resident 2 did not have specific interventions in place to prevent skin breakdown to their heel. Reference: WAC 388-97-1060 (3)(b)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure a urinary catheter system (a tube inserted into the bladder that drained urine into a collection bag) was maintained in a clean manner for 1 of 1 sampled residents (Resident 22) reviewed. This failure placed the resident at risk for infection and injury if the collection bag and tubing were damaged. Findings included. The 05/04/2026 quarterly assessment documented Resident 22 had diagnoses that included obstructive uropathy (blockage in the urinary tract that prevents urine flow) and urinary retention. The resident had an indwelling catheter and required a wheelchair for mobility. The 03/13/2020 bowel and bladder care plan documented Resident 22 had a suprapubic catheter (a surgical opening above the pubic bone with a tube inserted through it into the bladder) because of urinary retention. Staff were instructed to clean the catheter every shift, ensure the urinary collection bag was hung below the bladder (to prevent backflow of old urine) and that there were no kinks in the tubing. Staff were to maintain the resident's dignity with a dignity bag that covered and were to make sure the tubing to the catheter was secured to prevent the catheter from being pulled out. On 06/08/2026 at 2:28 PM, Resident 22 was observed scooting in their wheelchair. A urinary collection bag was in a canvas dignity bag and was hung on the frame under the seat of the resident's wheelchair. The tubing from the collection bag was dragging on the floor next to the front small wheels of the resident's chair, went under their pant leg and up to the catheter insertion site. The dignity bag was dark blue and had greyish colored dirt smears and a wad of lint on the outer bottom part of the bag. Similar observations of the dignity bag showed greyish colored dirt smears and the catheter dragging on the floor were made on 06/10/2026 at 8:41 AM, 06/11/2026 at 8:20 AM, and 06/12/2026 at 9:23 AM. During an interview on 06/12/2026 at 9:23 AM, Staff H, Nursing Assistant, stated that when Resident 22 was assisted into their wheelchair, they hung the collection bag under the seat of the wheelchair in the dignity bag. Staff H stated the resident wore a strap around their leg to prevent the tubing from getting pulled and they had to make sure the tubing was not wrapped around anything. Staff H stated the dignity bag was made of heavy fabric. They stated there was no schedule to change the dignity bag with a clean one, but there probably should have been because it hung so low. Staff H stated the bag could be sent to the laundry to be washed and the resident's got lint and stuff on it. On 06/12/2026 at 1:21 PM, Staff H was observed emptying Resident 22's urinary collection bag. Staff H put on a gown and gloves and removed the collection bag from the dignity bag. The dignity bag remained below the seat of the wheelchair and was on the floor. The tubing dragged on the floor as the collection bag was drained. Staff H placed the collection bag in a basin and removed the dignity bag from the frame of the wheelchair. The bag had a large wad of lint stuck to the bottom, and the fabric was covered on the bottom with dirt and debris from the floor and it was no longer pliable. Staff H replaced the dignity bag with a new, clean one. During an interview on 06/12/2026 at 3:10 PM with Staff B, Director of Nursing, and Staff C, Resident Care Manager, Staff B stated it was not recommended to have the dignity bag and catheter tubing dragging on the floor. Staff C stated the floor was not sanitary, and there was a risk of running over the tubing with the wheelchair, risk of breaking the bag open, and increased risk of infection. Staff B stated if the dignity bag and tubing were noticed on the floor, they expected staff to clean the tubing and replace the dignity bag with a clean one and keep them off of the floor. Reference: WAC 388-97-1060(3)(c)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and interview, the facility failed to develop a comprehensive plan to prevent the growth of water-borne viruses and bacteria such as Legionella (bacteria that caused a potentially fatal form of pneumonia when water mist or vapor that contained the bacteria was inhaled) for the Water Management Plans reviewed. This failure placed residents at risk of illness and decreased quality of life. Findings included . The 09/30/2025 Centers for Disease Control and Prevention (CDC) Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings toolkit documented healthcare facilities where people with chronic medical problems or weakened immune systems were housed were at increased risk for Legionella. A water management program included the following key steps:-establishing a water management program team,-describing the building water systems using text and flow diagrams,-identifying areas where Legionella could grow and spread,-deciding where control measures should be applied and how to monitor,-establishing ways to intervene when control limits are not met,-making sure the program is running as designed and is effective, and-documenting and communicating the activities.On 06/12/2026 at 12:50 PM, the facility Water Management Plan was reviewed. The plan included a document that identified the facility was at risk for Legionella because of their population served and included a diagram of the facility water systems. A corporate policy was provided that described what Legionnaires disease was and the symptoms when infected with Legionella bacteria. The policy discussed what the facility would do if there was an outbreak and the areas in facility water systems in general created a risk for growth of Legionella. There was no documentation in the plan that showed facility risks for growth of Legionella had been identified, where the risks were in the facility, what the facility did to mitigate their risk, and how the plan was monitored. The plan had no documentation regarding who made up the Water Management Team, what activities the team would undertake and how the team's activities were documented and communicated.The facility Legionella Water Temperature Log 2026 documented resident rooms and areas in the facility where water temperatures were monitored. The log documented Legionella grew best in the range of 77-113 degrees Fahrenheit and if water temperatures were within that range an adjustment was needed. There were no temperatures recorded that warranted an adjustment for each month of 2026.During an Interview on 06/12/2026 at 2:39 PM, Staff A, Administrator, acknowledged areas of the Water Management Plan that needed further development. Reference: WAC 388-97-1320(1)(a)		