

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50A181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Columbia Basin Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Nat Washington Way Ephrata, WA 98823	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to timely investigate and report, as required, an allegation of neglect for 1 of 3 residents (Resident 1) reviewed for abuse and neglect. This deficient practice disallowed the facility from identifying the extent of the allegation and placed residents at risk for unidentified and ongoing abuse/neglect. Findings included. Review of the Washington State Department of Social and Health Services (DSHS) Nursing Home Guidelines 'The Purple Book', dated October 2015, showed Appendix H, titled Responsibility Table, listed nursing home responsibilities included reporting all suspected incidents of abuse, neglect, financial exploitation, or misappropriated property immediately or as soon as resident is protected to the State Hotline. Review of the facility policy, titled Guidelines for Staff Reporting Resident Abuse or Neglect-Long Term Care, Assisted Living and Hospital, revised 02/19/2024, showed the facility would follow the guidelines in The Purple Book regarding investigating, determining, and reporting incidents of resident abuse and neglect. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility, on 06/24/2025, with diagnoses of dementia (a disease causing a progressive decline in cognitive skills beyond normal aging), aphasia (a disorder that affects how you communicate), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the comprehensive assessment and care plan, dated 09/07/2025, showed Resident 1 had severe cognitive impairment and required the assistance of one to two people for dressing, personal hygiene, eating, transfers, toileting, and incontinent care. Review of the nursing Progress Notes (PNs), dated 11/20/2025 at 11:03 AM, showed Resident 1 had a fever of 101.4 degrees Fahrenheit (a unit of measure of temperature) at 6:30 AM and was administered acetaminophen (a medication that lowers fever in the body). At 7:30 AM, Resident 1's Representatives (RRs) were notified of the fever and interventions taken. At 8:40 AM, Resident 1's temperature was 98.5 degrees Fahrenheit and the RRs requested for Resident 1 to be sent to the emergency room for evaluation and treatment. At 11:05 AM, RRs were notified that an order was received from the medical provider to transfer Resident 1 to the emergency room for evaluation. At 11:30 AM, Resident 1 was transported to the emergency room and care was transferred to the emergency room staff. During an interview, on 12/01/2025 at 11:00 AM, a RR stated they were concerned Resident 1 experienced a delay in treatment when five hours passed between the initial assessment of fever and Resident 1's transfer to the emergency room for evaluation. The RR stated the concern was reported to the facility's nurse management staff. Review of the facility investigation reporting log, on 12/01/2025 at 1:15 PM, showed no logged investigation involving Resident 1 or an investigation regarding an allegation of neglect. During an interview, on 12/01/2025 at 1:40 PM, Staff A, Chief Nursing Officer (CNO), stated they were made aware of the delay in treatment concern expressed by Resident 1's Representative on 11/21/2025. Staff A stated Resident 1 passed away on 11/25/2025 and due to the nature of the RR's concerns, Staff A initiated a Root Cause Analysis. Staff A stated the preliminary conclusion was that facility staff followed protocol. Staff A stated they did not report this incident to the State Hotline and they did not perceive the concerns expressed by Resident 1's Representatives as an allegation of neglect. During an interview, on 12/03/2025 at 3:10PM, Staff B, Director of Nursing (DON), stated they were aware of the concerns expressed by Resident 1's Representatives and Staff A completed an investigation. Staff B stated they did not report the investigation to the State Hotline because the concerns regarding Resident 1's death were not proven. Staff B stated they would report an incident to the State Hotline when the facility's investigation showed the facility was at fault. Reference: WAC 388-97-0640 (5)(a)</p>		