STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A181	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Basin Hospital	200 Nat Washington Way Ephrata, WA 98823

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview and record review the facility failed to obtain informed consent regarding the potential risks and benefits associated with the use of a psychotropic medication (medications that affects behavior and alter mental thought processes) for 3 of 5 residents (Residents 2, 7, and 11) reviewed for psychotropic medications. This failure placed residents and/or the legal representative at risk of not being fully informed about the medication prior to administration or discontinuation. Findings included . <Resident 2> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and Post Traumatic Stress Disorder (PTSD-symptoms lasting for an extended time over a traumatic event). The 02/06/2025 comprehensive assessment showed Resident 2 was alert and oriented, made their needs known, had signs/symptoms of depression (sad affect) and anxiety (feelings of negative outcomes of events), was on an antidepressant (a type of psychotropic medication) and two antianxiety (a type of psychotropic medication) medications during the assessment period. Review of Resident 2 ' s physicians' order showed that an antidepressant and two antianxiety medications were ordered on 08/27/2024 and consents were signed at that time. During an interview on 03/11/2025 at 1:43 PM, Resident 2 stated they were concerned about their antianxiety medications being discontinued without them being informed and there was no discussion with their provider prior to the medications being discontinued. Resident 2 stated their pain had increased a bit and their anxiety was okay, but they were not happy with their current provider and asked them to be removed. Resident 2 stated they had chosen another provider to handle their medications and care. During an observation on 03/11/2025 at 2:00 PM, Resident 2 had a flat affect (lack of facial expressions) when talking to other staff. Resident 2 was able to express their feelings and communicate to staff and family who visited daily. (continued on next page)

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	Review of a 02/11/2025 pharmacist recommendation showed to discontinue all psychotropic medications, which included the combination of three or more Central Nervous System (CNS) active medications which could cause an increase in falls and fractures. The consultation report recommended the prescriber assess the risk/benefits if they continued the medications and the provider declined the recommendation. On 02/17/2025 the attending provider discontinued Resident 2's routine Buspar (a specific antianxiety medication) medication, and their routine clonazepam (a specific antianxiety medication) medication. The provider did not communicate with Resident 2 about the change or if Resident 2 consented to the proposed change in their antianxiety medications. Review of Resident 2 ' s psychotropic/behavior meeting, dated 02/06/2025, showed the residents psychotropic medications and/or behavior changes were not addressed. The psychotropic/behavior committee meeting consisted of the pharmacist, Social Services Director (SSD), Director of Nursing Services (DNS), and the physician. During an interview on 03/11/2025 at 2:30 PM, Staff K, SSD, stated the provider did not speak with them, the nursing staff, or Resident 2 about their medication changes. The order was received by the charge nurse on 02/17/2025. On 03/12/2025 at 10:00 AM, Staff B, Resident Manager, stated their process was to ensure Resident 2 was notified of changes in their medications but had not been notified of the medication changes on 02/17/2025. Also, as of 03/11/2025 Resident 2 had not had a discussion regarding the risks and benefits of continuing with these medications. <Resident 7> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of heart failure, depression, and anxiety. Review of the 12/23/2024 comprehensive assessment showed the resident was alert and able to make their needs known and required minimal assistance with activities of daily living (ADLs). The assessment showed Resident 7 used a wheelchair for mobility. Review of the 03/21/2024 Medication Administration Record (MAR) showed Resident 7 was started on Lexapro (a specific antidepressant) and Trazadone (a specific antidepressant) on 03/23/2024. During an interview on 03/10/2025 at 10:00 AM, Resident 7 stated they had not been educated or given information by the facility staff concerning their antidepressant or antianxiety medications and had not signed any consents for the medications. During an interview on 03/10/2025 at 10:40 AM, Staff K stated they did not review informed consents on Resident 7 for ordered antianxiety and antidepressant medications. Staff K stated it was the facility's process to review psychotropic medications with the resident/or Resident's Representative (RR) before administration of the medications to a resident. <Resident 11> (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to included dementia (cognitive impairment) with behavioral disturbances, falls, and heart disease. Review of the 01/20/2025 comprehensive assessment showed the resident had impaired memory/cognition and required assistance in their ADLs. Resident 11 used a front wheeled walker for mobility. Review of the physicians ' orders for 01/15/2024 and 12/03/2024 showed that Duloxetine (a specific antidepressant medication) was started on 01/15/2024 for pain, and Risperidone (a specific type of psychotropic) was started on 12/03/2024 for increased verbal behaviors. During an interview on 03/11/2025 at 12:45 PM, Staff K stated they did not obtain consents or review risk and benefits of the psychotropic medications with Resident 11's RR. Staff K stated it was the policy of the facility to review these medications before administering them. During an interview on 03/13/2025 at 2:15 PM, Staff B stated the facility was to ensure the resident and/or the RR were informed of psychoactive medications benefits and side effects before administration of the medications. Staff B stated the facility failed to follow through on informed consent recommendation for new medications and when changes were made to resident psychotropic medications. Reference: WAC 388-97-0260(1)(a)(b)(2)(d)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview, and record review the facility failed to comprehensively assess and identify side rails attached to resident beds as a physical restraint for 2 of 2 residents (Residents 8 and 7) reviewed for physical restraints. This failure placed the residents at risk for injury and poor quality of life. Findings included . Record review of a facility policy titled, Long-Term Care Residents Physical Restraints, revised 12/31/2024 showed, . Physical restraints are identified as .side rails that keep the resident from voluntarily getting out of bed. Procedure: A. A Safety Device Assessment will be completed by the licensed staff for the need of the restraint related to a medical symptom. B. The resident's consent will be obtained .and documented on the assessment form. C. A physician's order will be obtained prior to the use of the restraint. D. Family will be consulted by nursing or social services in the event the resident is unable to give consent. E. Multidisciplinary care planning [NAME] be done quarterly to reassess usage and identify least restrictive alternatives. <Resident 8> Review of the resident's medical record showed they were admitted with diagnoses that included dementia, atrial fibrillation (an irregular heartbeat), and dysphagia (difficulty swallowing foods or liquids). Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and required substantial assistance with their activities of daily living (basic skills required to care for oneself). An observation and interview on 03/10/2025 at 2:23 PM, showed Resident 8 lying in their bed with half side rails attached to both sides of their bed and in the up position. The resident had their arms crossed over their chest and was lying in the center of the bed. When asked if they used the side rails to move around in bed, Resident 8 stated, I don't know they just keep me in. Record review of Resident 8's care plan dated 12/11/2024 showed no information on the side rail use including directions for use. Review of the February 2025 and March 2025 physician orders showed no orders or medical symptom to justify the use of side rails. Additionally, there was no Safety Device Assessment or consent to use the side rails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/11/2025 at 1:45 PM showed Resident 8 in bed with the side rails in the down position. During an interview on 03/11/2025 at 1:46 PM, Staff H, Registered Nurse, stated Resident 8 had side rails to assist them to move around in bed and they should be placed in the down position after cares and while in bed. Staff H stated there were no specific written care plan guidance on how to use Resident 8's side rails to include when the rails should be in the up or down position. During an observation on 03/12/2025 at 7:50 AM, showed Resident 8 lying in bed with both half rails in the up position. During an observation on 03/12/3025 at 11:15 AM, Resident 8 was in their room resting in bed with their side rails in the down position. During an interview on 03/12/2025 at 2:03 PM, Staff I, Nursing Assistant (NA), stated they were routinely assigned to work with Resident 8 and were very familiar with their care needs. Staff I stated they put up Resident 8's side rails because it made them feel safe and secure in bed as well as they prevented them from falling out of bed. Additionally, Staff I stated they also placed the side rails in the down position after cares as well. Staff I stated there were no specific directions on how to use Resident 8's side rails they just knew what to do. <Resident 7> Review of the resident's medical record showed the resident was admitted to the facility with diagnoses of depression, anxiety, heart failure, and respiratory issues. The comprehensive assessment dated [DATE] showed the resident was alert, oriented, and able to make their needs known. Additionally, Resident 7 required oversight assistance to transfer. On 03/10/2025 at 3:32 PM, observations of side rails for Resident 7 showed the residents bed on the left side was against the wall and half rails on both sides of the bed, in the up position. The half side rails when in the up position extended from the top of the bed to the middle of the bed. On 03/11/2025 at 8:40 AM, Resident 7's right half side rail was observed in the down position and the left side rail was in the up position. On 03/12/2025 at 1:30 PM, both half rails were in the up position while Resident 7 was napping in bed. On 03/13/2025 at 3:00 PM, an observation showed Resident 7's half rails were both in the up position. During an interview on 03/13/2025 at 3:39 PM, Resident 7 stated they had not been informed of the use of the side rails by staff, and they used the half rails in bed so they would not roll out of bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2025 at 2:30 PM, Staff B, Resident Manager, stated there were no assessments, physician's orders, consents, or care plans for the use of any resident side rails. Staff B further stated they understood the need for an assessment for the side rails as some of the residents could be potentially restrained or injured using side rails. Reference: WAC 388-97-0620(1) 31168

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 39652 Based on interview and record review the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that met at least quarterly and included the Infection Preventionist who was a required member of the QAA committee. This failure minimized the effectiveness of the interdisciplinary QAA team ' s ability to identify processes and outcomes related to infection control practices and disease management. Findings included . Record review of the QAA quarterly committee team minutes dated 05/01/2024 to 03/06/2025 showed no input from the Infection Preventionist related to infection prevention and control data. Additional review of the minutes showed the third quarter QAA committee meeting was missed, and the data was included in the fourth quarter meeting (three months late). During an interview on 03/13/2025 at 10:17 AM, Staff Q, Infection Preventionist (IP), stated they had never participated or prepared a report for the QAA committee on infection control data and stated, I was not aware that I was required to be at the QAA committee or present any data. During an interview on 03/14/2025 at 9:24 AM, Staff G, Nursing Services Manager, stated the IP had not been included in the QAA committee meetings over the past year and infection control data had not been presented. Staff G stated they agreed that the IP needed to be at all the quarterly QAA meetings so infection control data could be reviewed and analyzed as a part of the meeting. Additionally, Staff G stated the third quarter QAA committee meeting had been missed therefore they had combined the two quarters and presented the data for both quarters together. Reference: WAC 97-388-1760(1)(2)

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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. 39652 Based on interview and record review the facility failed to implement an effective and individualized Infection Prevention and Control Program (IPC) for long-term care (LTC) residents that met the Center for Medicaid and Medicare Services federal regulatory requirements included monthly surveillance, monitoring/tracking of infectious diseases. This failure disallowed the designated Infection Preventionist (IP) the ability to identify trends and implement interventions. The failure placed residents at risk for infectious diseases and deterioration in their health status. Findings included . Record review of the October 2024 through March 2025 infection control process and reports which included all infections the hospital showed the LTC unit infectious diseases had not been tracked or reviewed for trends and infection rates. During an interview on 03/13/2025 at 10:11 AM, Staff Q, IP, stated they were the IP for the long-term care unit and the hospital. Staff Q stated they did not identify infection trends or rates specific to the LTC unit and had no surveillance reports or identifying data to include the infection rates. Staff Q further stated they looked at infections for the whole hospital including the Assisted Living unit, however had been unaware of the additional requirements for LTC and did not have a process in place. During an interview on 03/14/2025 at 9:50 M, Staff G, Nursing Operations Manager, stated Staff Q was new in the IP role and had not received the training they needed after the other IP left the position. Staff G stated the LTC Infection Control Program should have specific reports and data for the unit. Reference: WAC 388-97-1320(1)(a)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39652 Based on interview and record review the facility failed to ensure the designated Infection Preventionist (IP) responsible for the facility's Infection Control Program met the education qualifications for certification prior to accepting the role as the IP in a long-term care facility. This failure placed residents at risk for not having an adequate oversight of infection control issues specific to long-term care. Findings included . During an interview on 03/13/2025 at 10:17 AM, Staff Q, IP, stated they had been hired as the IP for the hospital and the long-term care unit. Staff Q stated they had not completed the required infection control training for certification as an IP. No one told me I needed to be certified so I have not taken any of the trainings for long-term care. During an interview on 03/13/2025 at 2:36 PM, Staff B, Resident Manager, stated they were not aware that there were specific training requirements for the IP to be certified and stated they understood why it was important for the IP to have the training. Reference: WAC-388-97-1320(1)(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31168 Based on observation and interview the facility failed to provide a sanitary environment by not providing scheduled maintenance services for cleaning 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 03/10/2025 at 11:24 AM, the 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 air filter vent grills. The air vent ' s grill, located on the ceiling over the cook's area, had multiple areas of a dark brown fuzzy substances. The air vents grill, over the first entry door to the kitchen and towards the dry goods storage area had accumulated brown fuzzy dust. The ceiling air vent ' s grill, located inside of the second entryway had brown fuzzy substances. Additionally, the overhead light fixture and plastic covering located over the cook's area and food serve out area was dirty with yellow brown substances. During an interview on 03/10/2025 at 2:20 PM, Staff M, Environmental Services-Lead, visualized the vents in the kitchen and stated they were dirty and were not cleaned for a while. Staff M stated they had an assigned custodian for the kitchen and one of their responsibilities was to clean the kitchen vents but was not sure when the vents were scheduled to be cleaned. During an interview on 03/13/2025 at 12:46 PM, Staff L, Environmental Services Director, stated it had been two months of not cleaning the accumulation of dust and grime on the vents. Staff L stated they would replace the lighting fixtures over the stove which were discolored and unable to be cleaned. Staff L stated the cleaning of the kitchen vents and ceiling had not been on a scheduled cleaning and needed to be on a schedule. Reference: WAC 388-97-3220(1)