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	04/24/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure refrigerated medications were stored at proper temperatures in 1 of 1 medication refrigerator. The failure placed residents at risk of medications that could cause unintended outcomes due to improper storage. Findings Include. Review of the TUBERSOL(R) Tuberculin Purified Protein Derivative ([PPD], a serum used in a skin test to help diagnose tuberculosis infection) manufacturer's package insert showed the medication should be stored as follows: Refrigeration:ˆStore at 2 degrees to 8 degrees Celsius (C) (35degrees to 46 degrees Fahrenheit [F]). No Freezing:ˆDo not freeze; discard if the product has been exposed to freezing temperatures. Light Protection:ˆAlways protect from light (e.g., store in a brown paper bag). Opened Vial Stability:ˆOnce opened, the vial should be discarded after 30 days. Do not use after expiration date. During an observation and concurrent interview on 04/21/2026 at 12:43 PM, in the medication room a medication refrigerator showed two boxes of Tubersol on the inside the door of the refrigerator. Above the refrigerator was a medication refrigerator temperature monitor log with missing medication monitoring checks. Staff F, Licensed Practical Nurse (LPN), stated the temperatures were to be checked twice a day to keep the efficacy of the medications.ˆ Review of the medication refrigerator temperature monitor log dated April 2026 showed staff were to monitor medication temperatures daily in the AM and in the PM. Further review showed eleven shifts without temperature monitoring. ˆ During an interview and concurrent observation on 04/21/2026 at 3:07 PM, Staff B, Director of Nursing Services, acknowledged the missing shifts and stated the medication refrigerator temperature monitoring log should be checked twice a day. Staff B explained the temperature checks should be completed once with the dayshift nurse and once with the nightshift nurse. ˆ ˆ Reference: WAC 388-97-1300 (2)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for 3 of 3 residents (Resident 2. 10, and 12) reviewed for Beneficiary Notices. This failure placed residents and/or their representatives at risk of not having adequate information to make financial decisions related to the residents' stay within the facility. Findings included . Resident 2 Review of the medical record showed Resident 2 had been discharged to hospital on [DATE] and returned to the facility on [DATE]. There was no documentation in the record to show that Resident 2 had been provided with a SNF ABN. Resident 10 Review of the medical record showed Resident 10 had been discharged to a lesser care setting on 02/17/2026. There was no documentation in the record to show that Resident 10 had been provided with a SNF ABN. Resident 12 Review of the medical record showed Resident 12 had been discharged to a lesser care setting on 03/03/2026. There was no documentation in the record to show that Resident 12 had been provided with a SNF ABN. In an interview on 04/21/2026 at 3:23 PM, Staff B, Director of Nursing Services, stated the facility had not completed the beneficiary notice process. Staff B stated Residents 2, 10, and 12 had not been provided with the SNF ABN. Reference (WAC) 388-97-0300 (4) (a-c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment was maintained for 3 of 11 resident rooms (rooms [ROOM NUMBER]) reviewed for environment. This failure placed residents at risk for potential injury, diminished quality of life, and a lack of security within their environment. Findings included.room [ROOM NUMBER]An observation on 04/20/2026 at 10:20 AM showed: Bed Area (Window Side): Multiple wall gouges (deep grooves) to the left of the head of the bed measured at 12 inches (in-a unit of measure), 6 in, and 4 in. The wall behind the bed showed multiple deep scratches with exposed drywall and chipped paint. Sink Cabinet: Missing laminate with wood showing on the bottom left drawer (5 in by 1 in) and the bottom right drawer (2 in by 1 in). Wall (Adjacent to Bathroom Door): Multiple scratches with exposed drywall and missing paint in an area of 5 in by 1 in and an area of 1 in by1 in. Bathroom Door Trim: Multiple scratches with paint loss and exposed metal. Entrance Wall: A black scratch measuring 5 feet (ft-a unit of measure) was observed on the wall to the left of the entrance door. During an interview on 04/22/2026 at 1:35 PM, Resident 2 (resided in room [ROOM NUMBER]) stated they would like the items in their room to be repaired so that the environment feels more like home. room [ROOM NUMBER]An observation on 04/20/2026 at 3:00 PM showed: Closet Area: An 8 in by 5 in section of exposed drywall next to the door. Window Area: A 2 ft gouge under the window exposing drywall. Bed Area (Door Side): Three 1 ft gouges behind the bed exposing drywall. Bathroom Entry: Missing multiple dime sized areas of drywall to the left of the door; trim showed paint chips and exposed metal. Doors: The bathroom door had a 1 in by 2 in- gouge; the room entry door had a 4 in gouge under the knob. room [ROOM NUMBER]An observation on 04/21/2026 at 1:30 PM showed: Bathroom Entry: Missing multiple dime sized areas of drywall to the left of the door; trim showed paint chips and exposed metal. Entrance Wall: The wall to the right of the entry showed a 3-ft area with bubbling paint and exposed drywall. During an interview on 04/22/2026 at 3:26 PM, Staff B, Director of Nursing Services, stated the facility utilized an electronic ticket system called the Works Hub that was directly sent to maintenance. Staff B stated they were not aware of the environmental issues identified in rooms [ROOM NUMBER]. Staff B stated, I would expect staff to put in those tickets for those room issues; they all know how to do it. During an interview on 04/22/2026 at 3:50 PM, Staff C, Maintenance Manager, stated the Works Hub portal allowed every employee to submit maintenance tickets. Staff C performed a system search and confirmed that no work orders had been submitted for rooms [ROOM NUMBER]. Staff C stated their team conducted general facility rounds, but they did not typically enter occupied resident rooms and relied on staff to report issues. Staff C stated that staff failed to communicate environmental needs. Staff C stated they were unaware that repairs were needed in the referenced rooms. Reference WAC: 388-97-0880 (1)(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 were free of unnecessaryˆpsychotropicˆ(drugs that change brain chemistry to alter a person's mood, thoughts, behavior, or perceptions) medications by failing to provide a clinically valid and accurate diagnosis to justify medication use for 3 ofˆ 5 residents (Residents 1, 3, and 6) Reviewed for unnecessary medications. This failure placed residents at an increased risk for falls, medication-related adverse side effects, and unmet care needs.ˆ Findings included.ˆˆ Review of the policy titled, Monitoring of Psychotropic Medications, dated 04/04/2025, showed, psychotropic medications will only be given to treat a specific diagnosis and documented conditions. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life, unlike temporary, situational stress). The comprehensive assessment date 04/02/2026 showed the resident required assistance of one staff member with transfers and their cognition was intact. Review of a physician's order dated 12/22/2025 showed an order for an anti-depressant medication to beˆadministered daily for a diagnosis ofˆtransition from acute care to long term care.ˆˆ Resident 3 Review of the medical record showed Resident 3 admitted to the facility on admitted on [DATE] with diagnoses including anxiety disorder and depression (a serious, common medical illness causing persistent sadness, loss of interest in activities, and functional impairment). The comprehensive assessment dated [DATE] showed Resident 3 required assistance of one staff member with Activities of Daily Living (ADLs) and their cognition was intact. Review of a physician's order dated 12/24/2025 showed an order for an anti-depressant medication to beˆadministered daily for a diagnosis ofˆLives in long-term care facility.ˆˆ In an interview on 04/21/2026 at 8:45 AM, Staff K, Licensed Practical Nurse, stated there were medications without an appropriate indication of use/diagnosis. Resident 6 Review of the medical record showed the resident was admitted to the facility with diagnoses including Lewy body dementia (a progressive brain disease) with agitation and psychosis (a mental (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health symptom where a person loses contact with reality, making it difficult to distinguish what is real form what is not). The 03/18/2026 comprehensive assessment showed Resident 6's cognition was moderately impaired and required the assistance of one to two staff members for Activities of Daily Living (ADLs). Further review showed Resident 6 received antianxiety (a class of drugs used to treat symptoms of anxiety, such as feelings of fear, dread and uneasiness) and antipsychotic (a class of drugs used to treat symptoms of psychosis, such has hallucinations [seeing or hearing things that are not there], delusions [strong beliefs that are not true] and severely disorganized thinking) medications. Review of a physician's order dated 12/22/2025 showed an order for an anti-anxiety medication to be administered twice daily for a diagnosis of pain aggravated by activities of daily living. Review of a physician's order dated 12/22/205 showed an order for an anti-psychotic medication to be administered twice daily for a diagnosis of hospice care patient. During an interview on 04/21/2026 at 3:11 PM, Staff B, Director of Nursing Services, stated that Resident 6 was not currently receiving hospice services and has not been on hospice for approximately one year. Staff B stated the diagnoses listed for the antianxiety and antipsychotic medications were incorrect and did not clinically support the use of those specific drugs. Staff B stated the facility lacked a formal process to ensure that resident diagnoses were accurate or appropriately linked to medications. Staff B further stated the facility's pharmacist did not have a consistent process for reviewing diagnoses during monthly psychotropic medication reviews. Reference: WAC 388-97-1060 (3)(k)(i)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure restorative nursing services programs were implemented for 1 of 4 residents (Resident 12), reviewed for restorative nursing and limited range of motion [(ROM) the extent the joint can move within the expected (normal) range of values]. This failure placed the residents at risk for loss of ROM, deconditioning, pain, and worsening contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included . Resident 12Review of the medical record showed the resident admitted with diagnoses including stroke. (when blood supply to part of your brain is suddenly cut off) and contractures. The 03/18/2026 comprehensive assessment showed Resident 12's cognition was moderately impaired and required the assistance of one to two staff members with activities of daily living and had impairment to both their upper and lower extremities. The assessment further showed Resident 12 had no restorative nursing programs in place. An observation and concurrent interview on 04/20/2026 at 2:52 PM showed Resident 12 lying in bed with a notable contracture of the right ring finger. Resident 12 stated no one works with my fingers, and indicated that movement causes pain. An observation and concurrent interview on 04/22/2026 at 11:28 AM showed Resident 12 in their wheelchair with the right arm at their side. During the observation of the resident's right hand, it was noted to be held in a fixed, contracted position resembling a clenched fist. The thumb was pulled inward toward the center of the hand and tucked tightly inside the palm. Resident 12 was able to extend the index, middle, and pinky fingers; however, the thumb and ring finger remained in a rigid, flexed position that could not be straightened. Record review of Resident 12's care plan, dated 01/01/2026, showed no restorative nursing programs or interventions were in place to address Resident 12's right hand contractures. Review of the restorative nursing programs binder on 04/23/2026 showed no active restorative program or individualized interventions for Resident 12's upper extremities. Review of the Occupational Therapy (OT) assessment dated [DATE] showed Resident 12 was evaluated for contracture management of right hand, wrist and elbow. The OT documented Resident 12 would benefit from skilled OT intervention to prevent further decline and worsening of existing contractures. During an interview on 04/22/2026 at 12:36 PM Staff H, Director of Rehab, stated although an initial OT assessment was completed on 04/01/2022, there was no documented evidence that any therapy was subsequently provided or that the resident was evaluated for a restorative nursing program. Staff H stated they would expect a resident with identified contractures to be enrolled in a restorative or maintenance program. Staff H stated there was no documentation to support ongoing monitoring or preventive care for Resident 12's contractures since the 2022 evaluation. During an interview on 04/23/2026 at 9:33 AM Staff G, Nursing Assistant, stated they only performed a walking program with Resident 12 and did not provide any other restorative programs. Staff G stated they had never performed a restorative program for the resident's right hand or arm, nor have they seen any restorative programs in place for those areas. Staff G stated, (Their) arm hurts her, so you have to be really gentle with her, and when dressing the resident, they hold their hand in a contracted position. Staff G stated they informed the nurse of these issues, but they were unaware of any follow-up or interventions from therapy. During an interview on 04/24/2026 at 10:07 AM Staff B, Director of Nursing Services, stated they would expect any resident with contractures to be evaluated and treated by therapy and be placed on a restorative maintenance program. Staff B stated they were aware the restorative program needed attention and they needed to formalize the program to incorporate the care of the resident's needs. Reference: WAC 338-97-1060 (3)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview, and record review, the facility failed to ensure a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice by not identifying triggers (a stimulus that causes a reaction, often an emotional or physical response) regarding a resident history of Post-Traumatic Stress Disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening or traumatic event) for 1 of 5 residents (Resident 2) reviewed for trauma-informed care . This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included.Review of the resident's medical record showed they were admitted to the facility with diagnoses including PTSD. The 02/04/2026 comprehensive assessment showed Resident 2 required the assistance of one staff member for activities of daily living and had intact cognition. During an interview on 04/21/2026 at 8:38 AM, Resident 2 stated they were a survivor of sexual assault. The resident stated that certain men made them feel very uneasy and uncomfortable, creating a significant trigger of anxiety. Resident 2 stated that receiving care from male caregivers, such as during bathing or dressing, was extremely uncomfortable for them. Resident 2 stated they had a past traumatic experience involving a family member, which caused them to panic at the sound of sirens, an event that occurred as recently as last week. Resident 2 further stated staff had never asked them about their trauma history or identified their specific triggers. Record review of Resident 2's care plan, dated 06/26/2025, showed no trauma-informed care plan was in place that included Resident 2's triggers, behaviors, or person-centered interventions. Record review of Resident 2's Social Work initial assessment, dated 08/27/2024, showed no documentation addressing the resident's diagnosis of PTSD. Further review showed the assessment contained no mention of specific trauma-informed care needs or potential triggers. During an interview on 04/21/2026 at 2:30 PM, Staff B, Director of Nursing Services, stated that they were responsible for formulating the care plans for trauma-informed care. Staff B stated they did not address the PTSD or the specific triggers for Resident 2 within the current care plan. Staff B stated they would expect a resident's triggers to be clearly documented to facilitate trigger avoidance and to ensure staff have the necessary information to provide competent care. Staff B further stated neither the triggers nor the trauma history were present in Resident 2's medical record and the process was not followed for this resident. During an interview on 04/21/2026 at 2:36 PM, Staff E, Social Services Director, stated they completed the Social Work Initial Assessment which was to include the trauma assessment for each resident upon admission to the nursing home. Staff E stated the Social Worker Assessment completed on 08/27/2024 contained no mention of PTSD or specific triggers. Staff E stated all PTSD screening results, including history and triggers, should have been added to the care plan to ensure staff knew how to properly care for the residents. Staff E stated the correct information was currently missing from Resident 2's care plan. Staff E further stated the facility's process was not correctly followed regarding the resident's assessment and care plan. WAC Reference: 388-97-1060 (3)(e)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the nursing staff posting was posted daily and/or reflected the actual nursing staff hours worked during 3 of 5 days (04/20/2026, 04/21/2026, and 04/22/2026) of the survey period. This failed practice prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff.^ ^ Findings included . During an observation on 04/20/2026 at 10:30 AM, and 04/21/2026 at 1:36 PM there were no nursing staff postings within the facility available to view for the residents/ resident representatives, or for visitors to view the actual staff available to provide resident care. During an observation on 04/22/2026 at 9:26 AM, the facility had no nursing staff posting viewable for residents or the public to show the actual staffing availability for resident care. During an interview on 04/22/2026 at 2:42 PM, Staff F, Licensed Practical Nurse, (LPN), stated their white board was not used for the nursing staff postings. Staff F stated they were told by Director of Nursing Services (DNS) that they no longer had to post actual nurse staffing, because the information was available online. During an interview on 04/23/2026 at 3:54 PM, Staff B, Director of Nursing Services, stated it was their understanding that the postings were online and did not have to have it posted after switching to the computer system. Staff B stated, It was an oversight on my part. Reference: WAC 388-97-1620(2)(b)(i)^