

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

8845

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 07/11/2013
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NAME OF PROVIDER OR SUPPLIER COLUMBIA BASIN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Columbia Basin Hospital on 07/08/13, 07/09/13, 07/10/13, and 07/11/13. A sample of 16 residents was selected from a census of 25. The sample included 16 current residents.

The survey was conducted by:

██████████, R.N.
██████████, R.N.
██████████, R.N.
██████████, R.N.

The survey team is from:

Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit D
3611 River Road, Suite 200
Yakima, Washington 98908

Telephone: (509) 225-2800
Fax: (509) 574-5597

[Signature]
Residential Care Services Date

The facility was found to be in compliance with the requirements of 42 CFR part 483, subpart B for longterm care facilities. There were no federal deficiencies.

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Received
Yakima RGS
JUL 19 2013

7/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Nursing Administrator	(X6) DATE 07/18/13
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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.