STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505421	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Odd Fellows Home	534 Boyer Avenue Walla Walla, WA 99362

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 46722 Based on interview and record review, the facility failed to ensure residents had the ability to exercise self-determination related to aspects of life in the facility that were significant to the resident, including the frequency of bathing for 2 of 4 residents (Resident 5 and 6) reviewed for choices. The failure to allow residents to choose how often to bathe placed the residents at risk for hygiene concerns, decreased self-worth and powerlessness. Findings included . Review of the facility's undated policy titled, Resident Rights, showed the resident had the right to a dignified existence and self-determination .the right to make choices about aspects of their life that were significant to the resident including schedules for care. <Resident 5> Review of Resident 5's medical record showed they were admitted to the facility on [DATE] with diagnoses including stroke, depression, and anxiety. The 02/19/2024 comprehensive assessment showed Resident 5 was dependent on one to two staff for bathing and had an intact cognition. During an interview on 04/19/2024 at 9:50 AM, Resident 5 stated they received a shower once a week on Thursdays. Resident 5 stated they would like to have showers more than once per week and have asked staff multiple times to accommodate. Resident 5 further stated they have not received any additional showers per week. <Resident 6> Review of Resident 6's medical record showed they were readmitted to the facility on [DATE] with diagnoses including heart failure and kidney disease. The 01/15/2024 comprehensive assessment showed Resident 6 required substantial assistance of 1 to 2 staff for bathing and had an intact cognition. (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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2024 at 1:50 PM, Resident 6 stated they only received one shower per week on Wednesdays. Resident 6 stated they have asked staff for two showers per week and was receiving them until a few months ago. Resident 6 further stated they did not feel good about not receiving two showers per week. During an interview on 04/19/2024 at 10:04 AM, Staff F, Nursing Assistant Bath Aide, stated they were the only shower aide on duty and residents were only allowed one shower per week. Staff F further stated they did have residents who wanted more than one shower per week, however it was challenging to accommodate that request. During an interview on 04/17/2024 at 11:12 AM, Staff E, Staffing Coordinator, stated the facility had one bath aide for the residents and they should be able to provide showers once or twice a week based on resident preferences. Review of the shower records for Resident 5 and 6 showed they only received one shower per week and no refusals were documented. Reference WAC 388-97-0900(1)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review the facility failed to ensure an allegation of neglect was reported to the State Agency as required for 1 of 3 residents (Resident 2) reviewed for neglect. Failure to report allegations of neglect placed residents at risk for further neglect. Findings included . Review of the Nursing Home Guidelines titled, The Purple Book, dated October 2015, showed the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the Administrator of the facility and to other officials in accordance with State law .including to the State survey and certification agency. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses which included stroke with right sided weakness, aphasia (language disorder that affected ability to communicate) and osteoporosis (bone disease resulting in a decrease in bone strength which could increase the risk of fractures). Review of Resident 2's comprehensive assessment, dated 03/11/2024, showed the resident had no cognitive impairments. Review of Resident 2's plan of care, undated, showed they required extensive assistance with two staff for transfers. Review of Progress Notes (PNs), dated 02/23/2024 at 11:36 AM, showed the Licensed Nurse assessed a bruise to Resident 2's right arm, which had been reported by a Nursing Assistant (NA). The resident stated it happened during a transfer from their wheelchair to the bed. Resident 2 complained of pain to the right arm between the elbow and shoulder. The resident was being sent out for x-rays to the right arm. Review of PNs, dated 02/28/2024 at 3:45 AM, showed Resident 2 had a fracture of their right arm and a dislocated right shoulder per x-rays. Review of the facility's Reporting Log showed the incident on 02/23/2024 involving Resident 2 was logged but not reported to the State Agency as required for allegations of neglect. Refer to F610 for additional information. Reference (WAC) 388-97-0640(6)(c) This is a repeat deficiency from the Statement of Deficiencies dated 03/05/2024. 46722

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on observation, interviews and review of records, the facility failed to thoroughly investigate an allegation of potential neglect and unwitnessed falls which resulted in substantial injuries to 3 of 3 residents (Residents 1, 2 and 3) reviewed for incidents and accidents. Failure to conduct thorough investigations to identify a root cause placed residents at risk for unidentified neglect, lack of corrective action and/or recurrent falls with injury. Findings included . Review of the facility policy, titled Use of Gait Belt, undated, showed gait belts were to be utilized for all residents that could not independently ambulate or transfer for the purpose of safety. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses which included stroke with right sided weakness, aphasia (language disorder that affected ability to communicate) and osteoporosis (bone disease resulting in a decrease in bone strength which could increase the risk of fractures). Review of Resident 2's comprehensive assessment, dated 03/11/2024, showed the resident had no cognitive impairments. Review of Resident 2's plan of care, undated, showed they required extensive assistance with two staff for transfers. Review of Progress Notes (PNs), dated 02/23/2024 at 11:36 AM, showed the Licensed Nurse assessed a bruise to Resident 2's right arm, which had been reported by a Nursing Assistant (NA). The NA stated it was tender to the touch when assisting Resident 2 with dressing that morning. The resident stated it happened during a transfer from their wheelchair to the bed. Resident 2 was unable to give a clear description due to their aphasia and only was able to answer questions with one to two words at a time. Resident 2 complained of pain to the right arm between the elbow and shoulder. The resident was being sent out for x-rays to the right arm. Review of PNs, dated 02/26/2024 at 5:18 AM, showed Resident 2 continued to complain of soreness to the right arm where the bruise was located. The resident cried any time the bruised area was touched or the right arm was moved. Review of PNs, dated 02/28/2024 at 3:45 AM, showed Resident 2 had a fracture of their right arm and a dislocated right shoulder per x-ray results. The resident's right arm was in a sling with instructions to wear it at all times. Review of the facility investigation report, dated 02/23/2024 at 11:25 AM, showed there was a bruise to Resident 2's right, upper arm with complaints of pain to that area. Interviews were only conducted with two staff, G and H, NAs. Staff G stated they had been asked by Staff F to assist with Resident 2's transfer from their wheelchair to the bed. Staff G touched Resident 2's right arm and they complained of pain so they no longer utilized that arm but assisted with the transfer from the back of Resident 2. Staff H stated the transfer of Resident 2 was successful with no complaints of pain by the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/2024 at 9:10 AM, Resident 2 was observed seated in their wheelchair with their right arm in a sling. The resident stated the incident in which they fractured their arm occurred in the morning after breakfast during a transfer from their wheelchair to the bed. The resident was unable to recall the date and exact time of the incident or the names of the involved staff. Resident 2 stated there was a staff member on each side of the wheelchair and a gait belt was not utilized during the transfer. The resident was already standing when they got pushed by the staff member on the right side of the wheelchair. Resident 2 stated they had immediate pain to the right arm. Interviews with Staff G on 04/17/2024 at 3:04 PM and Staff H on 04/19/2024 at 11:56 AM, showed a gait belt had not been utilized during their transfer with Resident 2 on 02/23/2024. On 04/18/2024 at 1:25 PM, Resident 2's representative stated they visited the resident everyday. The representative stated they were told by Staff I, Director of Nursing, the resident fractured their arm upon being put to bed as staff was pushing the resident. Resident 2 had osteoporosis and their bones were brittle. Further review of the facility investigation report, dated 02/23/2024, showed the investigation did not conclude how Resident 2 sustained a fracture to their right arm and a right shoulder dislocation. There were no observations made during the investigation of transfers being made by staff. The investigation did not address the lack of utilizing a gait belt during the transfer of Resident 2. Review of education, dated 03/08/2024 (14 days following the incident relative to the use of gait belts during transfers) was only given to Staff H, despite Staff G also being involved in the transfer. Education regarding gait belts was provided during a staff meeting on 03/14/2024 (20 days following Resident 2's fracture). No interviews were conducted with Resident 2, despite the resident having no cognitive impairments. In addition, there were no interviews conducted with the resident's representative, who visited Resident 2 on a daily basis; or the staff member who initially reported the bruise on 02/23/2024 and stated it was tender to the touch upon dressing Resident 2 that morning. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses which included dementia, anxiety and glaucoma (eye disease that could cause vision loss and blindness). Review of Resident 3's comprehensive assessment, dated 02/16/2024, showed they had moderate impairment of their cognition. Review of Resident 3's plan of care, undated, showed they required extensive assistance with activities of daily living and supervision with eating. In addition, the plan of care, undated, addressed that Resident 2 was at high risk for falls due to gait/blanace problems, incontinence, glaucoma, and a history of falls. Care plan interventions included wearing non-skid soles when walking and checking the resident every three hours at night for toileting. Review of the facility investigation report, dated 03/01/2024 at 5:30 AM, showed staff heard a loud noise coming from Resident 3's room. The resident was found on the floor in the bathroom. The resident stated they had lost their balance and fell . Review of Progress Notes, dated 03/02/2024 at 4:01 PM, documented by Staff J, Licensed Practical Nurse, showed there was a large bump to Resident 3's right side of the head with a bruise that trailed down the right side of their face. Resident 2 was transferred to the emergency room (ER) where they were cleared of any head trauma. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ER report, dated 03/01/2024, showed Resident 2 had an unwitnessed fall. Resident 2 stated they felt like they were moving too fast and they were going to fall. In the ER they complained of a headache, right-sided shoulder, hip and knee pain. On 04/19/2024 at 12:50 PM, Staff J stated Resident 3 went into the bathroom and used the toilet. Despite the plan of care showing Resident 3 was extensive assist with one staff for toileting Staff J stated Resident 3 was independent using a four wheeled walker. The resident had a shuffling gait and did not call for assistance. Further review of the facility investigation relative to Resident 3's fall on 03/01/2024, showed the investigation was not thorough due to no interviews had been conducted; when had the resident last been toileted or observed; type of footwear worn; medication review; observation of the environment; and use of the four wheeled walker. There was no documented conclusionary statement regarding the fall. Despite a thorough investigation not being conducted corrective action showed to continue current interventions of a call light pendant and hourly safety checks. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses which included heart problems. Review of Resident 4's comprehensive assessment, dated 01/23/2024, showed they had moderately impaired cognition. Review of Resident 4's plan of care, undated, showed they required staff assistance with activities of daily living. Review of Progress Notes (PNs), dated 02/04/2024 at 1:46 PM, showed Resident 4 was found on the floor on their left side with their head towards the dresser in their room. Resident 4 stated they did not know how they fell , I just got up to get my shoes and I fell . Resident 4 complained of pain to their left leg and hand. Resident 4 was transferred to the ER. Review of PNs, dated 02/04/2024 at 5:55 PM, showed Resident 4 was in surgery for a fractured left hip and mildly displaced middle finger of the left hand. Review of PNs, dated 02/06/2024 at 11:38 AM, showed they were seen by their provider on 01/22/2024 for possible seizure activity reported by a family member. The provider started Resident 4 on Namenda (a medication used to treat moderate to severe Alzheimer's type dementia) for memory loss and dementia, which they attributed the possible seizure like activity to. Review of the facility investigation report, dated 02/04/2024 at 10:00 AM, showed Resident 4 displayed poor safety awareness and was not always aware of physical limitations. The resident had a history of falling and attempting to self-toilet/transfer. The investigation was not conducted in a thorough manner as there were no interviews conducted (which included Resident 4); assessment of environment; medication review (which was significant due to the administration of Namenda since 01/23/2024) which had side effects of sleepiness and dizziness; last time observed by staff; and possible need for toileting. Reference (WAC) 388-97-0640(6)(a)(b) 46722

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 46722 Based on interview and record review, the facility failed to follow and/or clarify physician orders for 1 of 4 residents (Resident 1) reviewed for services provided met professional standards of practice. This failure placed the resident at risk for negative health outcomes and unmet care needs. Findings included . <Resident 1> Review of Resident 1's medical record showed they were admitted to the facility on [DATE] with diagnoses including cellulitis (a bacterial skin infection that caused pain, redness and swelling) and heart failure. The medical record also showed Resident 1 had an intact cognition. Review of Resident 1's hospital discharge orders dated 04/10/2024, showed the resident had a medication order change to increase furosemide (medication to help the body lose fluid) from 40 milligrams (mg-unit of measure) to 80 mg every morning and an additional 40 mg at 1:00 PM for seven days. During an interview on 04/16/2024 at 5:35 PM, Resident 1 stated they went to the hospital on 04/10/2024 for shortness of breath and retention of fluid. Upon their return to the facility, staff was to increase their Furosemide dosage to 80 mg every morning and an additional 40 mg at 1:00 PM for seven days. Resident 1 stated Staff C, Licensed Practical Nurse, and Staff D, Registered Nurse, refused to administer the additional 40 mg of Furosemide stating the new orders would become effective the following day. During an interview on 04/17/2024 at 3:34 PM, Staff C, stated Resident 1 did go to the hospital and returned with new increased medication orders for Furosemide. Staff C stated they entered the orders into the residents record to begin the new dosage on the following day and not the day they returned from the hospital. Staff C further stated they believed Resident 1 was administered their afternoon dose of 40 mg of Furosemide. During an interview on 04/20/2024 at 9:36 AM, Staff D stated they did not administer the additional 40 mg of Furosemide to Resident 1 upon their return from the hospital. Staff D stated they were aware of the new Furosemide order and were told by Staff C to not administer the medication until the following day. Review of Resident 1's April 2024 Medication Administration Record showed the resident was not administered the increased dose of Furosemide on 04/10/2024. Reference WAC 388-97-1620(1)(2)(b)(ii)