

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/11/2026
NAME OF PROVIDER OR SUPPLIER  Washington Odd Fellows Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure professional standards of practice were followed when nursing staff failed to accurately document insulin (an injectable medication used to regulate blood sugar levels) administration for 1 of 3 residents (Resident 1) reviewed for medication administration. This failure placed the residents at risk for unstable blood sugars, duplicate administration of the medication, and adverse outcomes. Findings included. Review of the Lippincott Manual of Nursing Practice, 11th edition, copyright 2019, Chapter 2, showed professional nursing had standards of practice that set minimum levels of acceptable performance for which practitioners were accountable. Departure of standards of care included failure to make prompt, accurate entries in a medical record. Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including breast and colon cancer, malnutrition, and diabetes (a group of diseases that result in too much sugar in the blood). The 01/02/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living (activities related to personal care) and required substantial assistance of one staff member for showering. The assessment also showed Resident 1 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Record review of Resident 1's physician orders dated 09/29/2025, showed an order for Insulin.inject 1 unit (a measurement of medication) subcutaneously (under the skin) after meals.for every 10 grams (a unit of measurement) of carbs [carbohydrates (a nutrient the body uses for quick energy)] eaten. Total daily dose of 40 units. Record review of Resident 1's Medication Administration Records (MAR) from September 2025 through 02/11/2026, showed no documentation of the amount of carbs Resident 1 had consumed or the amount of insulin administered. During an interview on 02/11/2026 at 1:20 PM, Staff B, Licensed Practical Nurse, stated before administering Resident 1's insulin, they would look at the resident's meal tray and determine how many carbs the resident ate. They stated they would administer 1 unit of insulin for every 10 grams of carbs consumed. Staff B stated they did not document the number of carbs eaten or the amount of insulin they administered. Staff B stated there needed to be a place on the MAR to document the number of units given. During an interview on 02/11/2026 at 1:52 PM, Staff C, Nurse Manager, stated dietary services provided the total carb count for the meal and documented that number on the tray card. Dietary staff then saved the meal tray for nursing to observe the amount of carbs eaten and the nursing staff would calculate the amount of insulin to administer. Staff C stated there was no process in place for documenting the carb count or the corresponding amount of insulin that was given. During an interview on 02/11/2026 at 11:58 AM, Staff D, Medical Director, stated documentation for the insulin administration should include documenting the total carb count and the amount of insulin given each time, and a rationale as to how much insulin was administered. During an interview on 02/11/2026 at 2:18 PM, Staff A, Director of Nursing Services, stated the process for Resident 1's insulin administration included dietary staff</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  505421	Facility ID:  505421  If continuation sheet Page 1 of 2

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>documenting the total carb count on the meal tray and nursing staff determining how many carbs Resident 1 consumed. Nursing staff should calculate the number of insulin units to administer and should document that administration in the progress notes. Staff A stated there was no process to consistently document the carb count and insulin administered. Reference: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i)</p>		