

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/06/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse by Resident 1 for 1 of 5 residents (Resident 2) reviewed for abuse. This failure placed the residents at risk for continued abuse, injury, and emotional distress. Findings included. Review of a policy titled, Abuse, Neglect and Exploitation, dated 08/27/2025, showed the facility would provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. Abuse means the willful infliction of injury or intimidation with resulting physical harm, pain or mental anguish, which can include resident to resident altercations. Sexual abuse is non-consensual (a physical act or contact that occurs without clear, voluntary, and affirmative agreement) sexual contact of any type with a resident. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including a cerebral infarction (a loss of blood flow to part of the brain that can cause brain damage), major depressive disorder (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), and anxiety disorder (a mental health condition characterized by excessive and/or persistent fear or worry). The 05/04/2026 comprehensive assessment showed Resident 1 required assistance of one to two staff members for activities of daily living (ADLs, activities related to personal care). 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). Resident 2 Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including bipolar schizoaffective disorder (a chronic mental health condition combining symptoms like psychosis, delusions, or hallucinations with extreme mood swings) and dementia (a decline in mental ability severe enough to interfere with daily life). The 04/13/2026 comprehensive assessment showed Resident 2 required assistance of one to two staff members for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Record review of an investigation dated 06/22/2026 at 3:40 PM, showed Staff C, Registered Nurse, observed Resident 1 sitting in the dining room in their wheelchair facing Resident 2, who was seated in a chair at their table. Resident 1 had their right hand on Resident 2's upper back, then took their left hand and ran it over Resident 2's left breast. Staff C separated the residents and informed Resident 1 that they witnessed them touching Resident 2's breast and that was inappropriate behavior. Staff C asked Resident 1 if they understood and they responded yes. Staff C went back to Resident 2 and asked them what happened. Resident 2 stated Resident 1 had touched them, and they did not want Resident 1 to do that. Record review of Resident 1's care plan last reviewed on 06/23/2026, showed a focus area, dated 06/15/2022, identifying Resident 1 had touched nursing assistants inappropriately during cares and may engage in sexual behaviors with themselves. Staff should ask Resident 1 to go to their room and close the curtain during those times. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff should immediately document the inappropriateness of Resident 1's sexual behaviors to nursing and the social worker. During a concurrent observation and interview on 07/06/2026 at 10:49 AM, Resident 2 sitting in the dining room. They stated Resident 1 had came into the dining room and started to touch me. They stated Resident 1 started rubbing my (breast) and demonstrated by grasping their left breast. Resident 2 stated they were kind of scared. They stated the nurse came over and told Resident 1 to leave me alone. Resident 2 stated they did not want Resident 1 to touch them. During an interview on 07/06/2026 at 10:57 AM, Staff D, Nurse Manager, stated they completed the facility investigation for the resident-to-resident altercation between Resident 1 and Resident 2. They stated they had completed investigations in the past related to Resident 1, as they had a history of inappropriate sexual behaviors. Staff D stated Resident 2 did tell them the touching was non-consensual. Staff D stated the touching violated Resident 2's boundaries. During an interview on 07/06/2026 at 11:07 AM, Staff C stated they were at their medication cart outside of the dining room when the altercation occurred. They stated they saw Resident 1 place their hand over Resident 2's left breast. Staff C stated they separated the two residents and assessed Resident 2 for harm. They stated Resident 2 told them they did not want Resident 1 to do that to them. Staff C stated what they observed was intentional and identified the incident as sexual abuse. During an interview on 07/06/2026 at 1:13 PM, Staff A, Administrator, stated they were aware that Resident 1 grabbed Resident 2's chest. They stated Resident 2 was ok with it at first then changed to say they were uncomfortable. Staff A stated they did not see the incident as abuse as Resident 2 was fine with it, then not. During an interview on 07/06/2026 at 1:40 PM, Staff B, Director of Nursing Services, stated the facility did everything right and they disagreed with the findings related to abuse. Reference: WAC 388-97-0640(1)		