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	08/08/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility failure to ensure food was prepared and served for (1 of 1 kitchen) in accordance with professional standards of safety. Facility kitchen staff did not wear facial hair restraints and beard restraints while serving residents food. This failure left residents at risk of food contamination and food-borne illness. Findings included . Observations on 08/06/2025 at 11:55 AM, food service of the noon meal began in the kitchen. Staff O, Dietary Supervisor, (DS), Staff P, Cook, Staff Q, Dietary Assistant, (DA), and Staff R, DA, were in the kitchen tray line while food was served. All staff identified had beards and long exposed facial hair over an inch long, and none wore facial hair/ beard restraints: During the same observations on 08/06/2025 at 11:55 AM, Staff O had a full beard and a moustache and walked around the steam table with uncovered food and the preparation area where desserts, sandwiches, and other foods were located. Staff P had served food from the steam table to residents' plates with an uncovered full beard. Additionally, Staff P was working over other food preparation surfaces without a beard hair restraint. Staff Q had handled food utensils and placed them on resident trays with facial hair exposed. Staff R handled resident trays and had exposed facial hair. During an interview on 08/06/2025 at 12:10 PM, Staff U, Dietary Manager, stated they had a supply of facial hair/beard restraints, but staff had not worn them. Reference WAC: 388-97-1100(3)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews (PASARR, an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities are not inappropriately placed in nursing homes for long term care) were correct on admission and had a required level two referral if residents had a positive level one PASARR for 4 of 7 residents (Residents 41, 1, 5, and 30) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their mental health needs. Findings included. Resident 41 Review of Residents 41's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include anxiety (a feeling of worry, nervousness, or unease), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired, able to understand, and make their needs understood. Review of Resident 41's PASARR, dated 10/02/2024 showed SMI indicators, in section 1A, were check marked for Resident 41's diagnosis of depression, anxiety and Post Traumatic Stress Disorder (a condition that develops after experiencing or witnessing a traumatic event). The PASARR showed no level two referral or evaluation was completed. Review of an undated facility PASARR audit showed Resident 41 admitted on [DATE] as a hospital exempted [level two not required unless the resident's stay goes beyond 30 days] stay. The audit showed Resident 41 needed a level two evaluation and referral, but the audit showed no referral had been submitted (nine months after the 30-day stay was up, and the admitting PASARR did not show it was an exempted stay). Resident 1 Review of the resident's medical records showed they admitted with diagnoses of depression and dementia (a group of symptoms that affect memory, thinking, and behavior) with anxiety. Review of the 06/14/2025 comprehensive assessment showed Resident 1's cognition was moderately impaired and received treatment for depression and an antipsychotic (a type of medication used to stabilize mood and reduce anxiety in SMI) medication. Review of Resident 1's 10/24/2024 PASARR showed no SMI were identified on admission therefore a level two evaluation was not obtained. Resident 5 Review of the resident's medical records showed they admitted with diagnoses of schizoaffective disorder (a mental health condition where individuals experience periods of emotions ranging from joy to rage and hallucinations (false perceptions/or sensory experiences that are not real) or delusions (false beliefs that persist despite evidence that they are not real), dementia with anxiety, and insomnia (the inability to sleep). The 07/21/2025 comprehensive assessment showed Resident 5's cognition was moderately impaired and received antipsychotic medications. Review of Resident 5's 08/21/2024 PASARR showed Resident 5 had SMI indicators for (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schizoaffective disorder, but no level two evaluation was indicated on the form. Review of an undated facility PASARR audit showed Resident 5 admitted on [DATE] and was determined to needing a level two evaluation but the referral was not sent until 01/20/2025 (nearly five months after identification of SMI and admission on [DATE]). Resident 30 Review of the resident's medical records showed they admitted with diagnoses to include depression and dementia with agitation (a state of severe restlessness or inner tension). The 05/12/2025 comprehensive assessment showed Resident 30's cognition was severely impaired and received antipsychotic (a medication that changes the balance of chemicals in the brain and used to treat psychosis, a condition where a person has difficulty knowing what is real and what is not) and antidepression (a medication that alters the brain chemistry to alleviate symptoms associated with depression) medications. Review of the 02/03/2025 PASAAR showed Resident 30 had SMI and a level two evaluation was required. Review of an undated facility PASARR audit showed Resident 30 admitted on [DATE] and a PASARR level two evaluation was needed. The audit showed the referral for the level two evaluation was not sent until 04/03/2025 (two months after admission). During an interview on 08/06/2025 at 11:42 AM, Staff N, Social Services Director, stated they reviewed PASARRs prior to admission and for any changes. Staff N stated they kept an audit to remind them when someone needs a level two referral and when the level two should be completed. Staff N stated they were behind but had caught them up, and that could have been the reason for the late submissions for the level two referrals. During an interview on 08/08/2025 at 12:35 PM, Staff B, Director of Nursing Services, stated Staff N and the admissions nurse reviewed the PASARRs prior to the resident's admission and if they required a level two evaluation, they would have the referral sent by the hospital. Staff B stated they assumed that process was being followed. Reference WAC: 388-97-1915 (1)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision, revised care plan interventions for efficacy, and ensured care planned interventions were consistently followed to prevent avoidable repeated falls for 3 of 3 residents (Residents 51, 15, and 28) reviewed for falls. This failure placed the residents at risk for unsupervised self-transfers leading to falls, serious injury, and a decline in health status. Findings included . Review of the facility's undated policy titled Fall Prevention Program, showed residents would be assessed for fall risk upon admission and received care and services in accordance with their risk level (low, moderate, or high risk) to reduce the likelihood of falls. Interventions included increased frequency of rounds, accessible call lights, and scheduled toileting assistance. Resident 51 Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including a bladder infection treated at the hospital, falls, supranuclear palsy (a neurological disease that affects movement, balance, eye function and cognitive abilities), osteoporosis (brittle bones), and hearing loss. The 05/05/2025 comprehensive assessment showed the resident had memory issues but was alert and able to make their needs known. Resident 51 required substantial assistance to transfer from their wheelchair. The resident was discharged from the facility on 05/21/2025. Review of the 04/29/2025 nurses progress notes showed at 5:06 PM Resident 51 had fallen after being left alone seated at the side of their bed while a Nursing Assistant (NA), went down the hall to retrieve items to change the resident. The progress notes also showed the resident was on the floor with a swollen right eye. Review of the 04/29/2025 at 5:06 PM fall incident report showed Resident 51, shortly after admission, had an unwitnessed fall from their bed after a NA left them unattended to get some supplies. Resident 51 sustained a swollen eye with a bruise around the eye. Review of the 04/29/2025 Fall Risk assessment showed Resident 51 was at high risk for falls related to their cognition, required hands on assistance, not able to stand independently, and exhibits loss of balance. Review of Resident 51's 04/29/2025 baseline care plan did not include fall risk preventions until 05/01/2025 where positioning bars were added to the bed and a fall mat at bedside. During an interview on 08/07/2025 at 10:06 AM, Staff M, Resident Care Manager, stated that another Licensed Nurse (LN) completed the incident report and was no longer at the facility.^^Staff M stated Resident 51, who was reviewed as a high fall risk, was left on the side of the bed without supervision and sustained a fall with an abrasion and bruise over their right eye.^Staff M stated they had to get permission from the family for the resident to use positioning bars on their bed and it took some time. Staff M stated Resident 51 should not have been left seated on the side of their bed without safety measures in place and the resident fell. ^ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 15 Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including dementia (impaired cognition), repeated falls, history of bladder infections, and spinal stenosis (narrowing of the spinal canal which caused pressure on spinal cord nerves). The resident's 07/24/2025 comprehensive assessment showed the resident was cognitively impaired and only spoke in their native language but understood some English and could respond with basic yes or no answers. The assessment showed the resident required substantial assistance with all activities of daily living. During an observation on 08/04/2025 at 12:20 PM, Resident 15 was seated in their wheelchair in the dining room being assisted by NA staff.^^The resident acknowledged a question asked, smiled but did not respond verbally. There was a fall alarm clipped to the back of their shirt and connected to the back of Resident 15's wheelchair. Review of the 07/22/2025 fall incident report showed Resident 15 was left in their wheelchair in their room after an NA had assisted the resident to the bathroom. At 6:15 AM the NA called the LN to Resident 15's room. Resident 15 was on the floor and sustained a fall with a large hematoma (localized swelling with blood) to the back of the right side of their head. The 07/22/2025 fall interventions showed the resident was placed as a one-on-one staff observation, frequent checks when sleeping, and not to be left unattended. Review of the 08/01/2025 fall incident report showed Resident 15 was in the dining room without supervision when a dietary aide who had been cleaning up after breakfast, reported to nursing staff that Resident 15 was on the floor. A new fall intervention was Dycem (a non-slip mat) was placed in the resident's wheelchair, and the resident was not to be left unattended. An observation on 08/06/2025 at 10:16 AM, Resident 15 was left alone in the dining room by themselves in their wheelchair, unsupervised, and the resident had their eyes closed. Resident 15 was leaning forward with their head down until 10:50 AM when staff was notified Resident 15 was unsupervised in the dining room. During an interview on 08/07/2025 at 10:04 AM, Staff M stated Resident 15 had multiple falls at the hospital. The resident's 07/21/2025 admission time was delayed because the resident fell at the hospital while waiting for transfer to their facility. Resident 15 was admitted to the facility on [DATE] at 1:00 PM and the care plan at the facility, after Resident 15 arrived, was to not leave the resident unattended. The resident was left unattended in their room on 07/22/2025 at 6:00 AM that morning and fell out of their wheelchair sustaining a bump to the back of their head. During an interview on 08/07/2025 at 10:06 AM, Staff M stated that on 08/01/2025 at 8:58 AM, Resident 15 was in their wheelchair in the dining room unsupervised when a dietary aide who was cleaning up after breakfast, saw Resident 15 on the floor and notified nursing staff. ^ During an interview on 08/07/2025 at 10:30 AM, Staff Z, NA, stated they came to work on 07/22/2025 before their shift began on the day shift. Staff Z stated they did not know who Resident 15 was but assisted the resident to the bathroom. Staff Z stated they assisted the resident back to the wheelchair in their room and left the room to get information on the resident. Staff Z stated when they (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	returned to the room, Resident 15 was on the floor and had a large bump on the back of their head. Resident 28 Review of the resident's medical record showed Resident 28 was admitted to the facility on [DATE] with diagnoses to include atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), a hereditary bleeding disorder, and repeated falls. Review of the comprehensive assessment dated [DATE] showed the resident's cognition was moderately impaired and was on a toileting program. Resident 28 was dependent on staff for toileting hygiene and required substantial assistance from sit to stand. During an observation and concurrent interview on 08/05/2025 at 10:05 AM, Resident 28 was self-propelling their wheelchair and stated they were on the way to play games. The resident's bed had been made, a carpet mat was located in the front of their bed, and their call light was in the top drawer of the nightstand. During an observation on 08/06/2025 at 11:00 AM, Resident 28 stood up in their restroom facing their wheelchair, with their left hand grabbing the grab bar on the wall to their left. Then, Resident 28 with their right hand, on the right arm of their wheelchair, proceeded to push the wheelchair while ambulating to grab the door frame, then turned and sat down in the wheelchair. There were no staff members in the restroom to supervise the resident's transfer. This surveyor notified the staff that the resident needed assistance. During an observation and concurrent interview on 08/07/2025 at 3:28 PM, Resident 28 was standing up in their restroom holding onto the sink, their pants on the floor, and they had fecal matter all over themselves and their shirt. The resident stated they needed some assistance, and there were no staff members in the restroom to supervise the resident's transfer. This surveyor notified the staff that the resident needed assistance. Review of the facility incident log, dated from February 2025 through July 2025, showed Resident 28 had 12 fall incidents and two resulted in injury. During an interview on 08/06/2025 at 2:56 PM, Staff Y, Nursing Assistant, stated their procedure when a resident had a fall, was they notified the nurse, assisted the resident up and kept them safe until the nurse arrived. Staff Y stated they would document the incident on the computer and fill out an incident report. ^^ During an interview on 08/06/2025 at 3:30 PM, Staff M stated the fall process was the NA would notify a nurse, and the nurse would do their assessment. Staff M stated involved staff would complete a witness statement and the nurse would talk with the NA to assist with filling out the incident reporting. Staff M stated the nurse would complete an incident report, a progress note, and alert charting^for 72 hours. Staff M stated they had been working on streamlining the incident report process to make it easier for the staff to be compliant, but it was a work in progress. During an interview on 08/08/2025 at 1:05 PM, Staff B, Director of Nursing Services, stated their expectation was staff followed resident care plans to do what was best for the resident. Reference: WAC 388-97-1060 (3)(g)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on observation, interview, and record review, the facility failed to ensure visitation rights were protected for 1 of 2 residents (Resident 5) when their friend was restricted from talking to the resident without their knowledge. This failure placed the resident at risk of isolation, abandonment, and the ability to be independent regarding their own visitor choices. Findings included . Resident 5 Review of the resident's medical records showed they were admitted to the facility with diagnoses to include schizophrenia (a mental health condition where individuals experience periods of emotions ranging from joy to rage and hallucinations (false perceptions/or sensory experiences that are not real) or delusions (false beliefs that persist despite evidence that they are not real). Review of the 07/21/2025 comprehensive assessment showed Resident 5's cognition was moderately impaired and required staff supervision or touching assistance with most activities of daily living (ADLs). During an interview on 08/04/2025 at 4:02 PM, Resident 5 stated they enjoyed writing letters and would write their friend often, but their friend had just dumped them and did not understand why they had not heard from them or had seen them. Review of Resident 5's 06/25/2021 Care Profile (special instructions about the resident's care needs), showed [Resident 5's friend] is not to talk to [Resident 5] at this time per POA (Power of Attorney, a legal authorization that gives the agent or attorney-in-fact the authority to act on behalf of an individual) request. Review of Resident 5's POA document, dated 02/14/2014, showed the POA did not provide the authority to override personal and health care decision making by Resident 5, unless Resident 5 was determined to be incapacitated (a person who is unable to make decisions for themselves due to mental or physical limitations). Review of Resident 5's medical records showed no information that Resident 5 had been deemed incapacitated. During an interview on 08/05/2025 at 10:01 AM, the POA stated they had restricted Resident 5's friend from talking with them a long time ago because they were concerned the friend would take advantage of Resident 5 and would bum money or cigarettes from them. The POA stated the restriction could have been removed because Resident 5 had not smoked in a few years and they no longer left enough money to worry about with Resident 5. The POA stated they had not discussed restricting the resident's friend with Resident 5 prior to placing the restriction on their friend. During an interview on 08/06/2025 at 3:34 PM, Resident 5 stated they had not been talked to by the facility or the POA about restricting their friend from talking with them. Resident 5 stated their friend had dropped them like they were nothing and no longer came to see them and could not understand why. Resident 5 stated they would have wanted to see and talk to their friend and that restriction should not have been placed. During an interview on 08/07/2025 at 10:55 AM, Staff B, Director of Nursing Services, stated the restriction of Resident 5's friend was a long time ago, years ago and because they were a vulnerable adult with mental health issues, they felt the POA was acting in the best interests of Resident 5. Staff (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B stated the facility did not discuss the restriction with Resident 5 and assumed the POA had done that at the time the restriction was placed. Staff B stated the facility had not normally followed up on restrictions put into place periodically to see if they still applied to the residents' current situation/condition. Reference WAC: 388-97-0520 (1)(2)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents personal fund accounts were, A) deposited in an interest bearing account for 4 of 5 residents (Residents 25, 23, 8, and 28) reviewed for personal funds accounts, and B) made available to residents on the weekend for 2 of 5 residents (Residents 8 and 28) reviewed for personal funds. This failed practice caused residents not to receive or have access to monies owed to them. Findings included . Review of the facility's policy titled, Resident Personal Funds, dated 08/21/2023, showed the facility would deposit any resident's personal funds in excess of $100 ($50.00 for Medicaid residents) in an interest-bearing account. Review of the facility's undated guidelines titled, Trust Fund Petty Cash Instructions: (for when the business office is closed), showed, .residents must be allowed access to trust funds when the business office is closed. The nurse supervisor on duty will be responsible for maintaining the petty cash (a small amount of cash on hand by a facility to cover minor expenses) for residents when the business office is closed. Resident 25 Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions) and heart complications. The 04/21/2025 comprehensive assessment showed the resident had severely impaired cognition. Resident 23Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia and a history of a stroke (when blood flow to the brain is interrupted). The 07/15/2025 comprehensive assessment showed the resident had severely impaired cognition. Resident 8Review of the medical record showed the resident was admitted on [DATE] with diagnoses including heart and lung complications. The 06/30/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 08/04/2025 at 4:42 PM, Resident 8 stated the facility office staff were not working on the weekends so they would be unable to pull money out of their personal trust funds account. Resident 28 Review of the medical record showed the resident was admitted on [DATE] with diagnoses including history of a stroke. The 06/16/2025 comprehensive assessment showed the resident had moderately impaired cognition but was able to make their needs known. During an interview on 08/05/2025 at 9:42 AM, Resident 28 stated they had personal funds that the facility held onto and had used it to pay for haircuts but did not think they could pull out money on the weekend if they needed it. Review of the facility's personal resident funds account, provided by Staff I, Business Office Manager, showed on 08/04/2025 11 residents (including Residents 25, 23, 8 and 28) had funds in the account and eight of the residents had balances greater than $50.00. Review of the resident pooled funds account summary statements for January 2025 through July 2025 showed that no interest had been accrued (received in regular amounts over time) in June 2025 or July 2025 and the last time interest had been accrued for the resident pooled funds account was in May 2025. During an interview on 08/04/2025 at 11:00 AM, Staff I and Staff H, Chief Financial Officer, both in charge of managing the facility's resident funds account, stated that no interest had been allocated to the resident pooled personal funds account in June 2025 or July 2025. Staff H stated they would be contacting the bank to discuss why the personal funds account had not gained interest in those months. During an interview on 08/05/2025 at 3:50 PM, Staff H, stated they had talked with the facility's bank about the resident pooled funds account and were informed that the account had been switched and was not an interest-bearing account since May 2025. During an interview on 08/07/2025 at 9:58 AM, Staff G, Registered Nurse (RN), stated they had worked as a nursing supervisor on the weekends. Staff G stated residents who had funds in the pooled account were unable to get money on the weekends because the office staff did not work on the weekend. During an interview on 08/07/2025 at 10:01 AM, Staff K, RN, stated they had worked the weekends before. Staff K stated they were unaware if residents were able to get money from their personal funds account or what the process was. During an interview on 08/08/2025 at 10:48 AM, Staff A, (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, also present, Staff B, Director of Nursing Services, stated that resident funds needed to be in an interest-bearing account and the correct process wasn't followed. Staff B stated the residents should have access to funds even on the weekend and nursing staff should have been aware of how to get residents funds. Staff B stated the correct process was not being followed. Reference: WAC 388-97-0340(3)(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement 4 of 8 components (identify, protect, report, and investigate) of their abuse/neglect policy/procedure after allegations of abuse were reported as a grievance (a formal complaint that highlights a violation of contract terms or policy) to the facility for 2 of 3 residents (Residents 8 and 41) reviewed for abuse/neglect. This failure placed the residents at risk for further abuse, fear, and unmet care and services. Findings included . Resident 41 Review of Residents 41's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include anxiety (a feeling of worry, nervousness, or uneasiness), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired, able to understand, and make their needs understood. During an interview on 08/05/2025 at 10:15 AM, Resident 41 stated there had been a nursing assistant (NA) who had been very rude to them, had an attitude, and talked down to them (later identified as Staff BB, NA). Resident 41 stated they could not remember the NAs name, but that they had reported it to Staff S, NA, and they knew who they were. During an interview on 08/06/2025 at 10:23 AM, Staff S stated, the resident was very upset and the resident had told them that Staff BB had talked down to them and was very rude. Staff S stated they believed they had reported to the medication nurse. Staff S stated the incident happened last week. Staff S stated they were aware they were a mandated reporter. During an interview on 08/08/2025 at 10:55 AM, Staff BB stated they worked with Resident 41 the previous Wednesday. Staff BB stated they had a good rapport (close relationship)with the resident and were surprised by the resident's complaint. During an interview on 08/08/2025 at 11:07 AM, Staff AA, Licensed Practical Nurse, stated they were aware of the incident, and they had overheard the conversation in the dining room during dinner. Staff AA stated neither the resident nor the NA reported the incident to them, but that they had gone to Resident 41 after their dinner and asked if they were okay. Staff AA acknowledged they were a mandated reporter and stated they had not filled out an incident report because the resident stated they were okay. Staff AA did not recognize the incident as potential abuse. During an interview on 08/06/2025 at 3:55 PM, Staff B, Director of Nursing Services, stated the incident overheard by Staff AA was not reported to them, written up, or investigated as potential abuse. Resident 8 Review of the resident's medical records showed they admitted to the facility with diagnoses to include respiratory and heart failure. The 06/30/2025 comprehensive assessment showed Resident 8's cognition was intact, and they were dependent on staff assistance for toileting, personal hygiene, transfers, bathing, and dressing. During an interview on 08/04/2025 at 4:37 PM, Resident 8 stated they had issues with a few of the NAs being too rough and rushing me. Resident 8 stated they reported the issue to the facility, and the facility told them there was education provided to the nursing assistants and it was taken care of but (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then continued to happen. Resident 8 was able to identify two staff by name and possibly a third with a partial name (later identified as Staff CC, NA, Staff DD, NA, and Staff EE, NA). Review of the grievance log showed on 07/16/2025 a concern was reported to the Social Services Director (SSD) that the night NAs were rushing with [Resident 8]. The concern showed there was education provided to the NAs during their mandatory meeting on 07/22/2025. The grievance did not identify staff involved. During an interview on 08/07/2025 at 3:56 PM, Staff N, SSD, stated Staff F, Registered Nurse, had received a concern via an electronic mail (email) from Resident 8's Resident Representative (RR) on 07/08/2025. Staff N stated they were not sure what came out of that concern but was told education was going to be provided to the NA staff. Staff F entered the office during this interview and stated they did not identify the staff involved in the concern, nor did they investigate the concern, and they stated they had forwarded the email to the Director of Nursing Services (DNS) for them to handle. Review of the 07/08/2025 through 07/10/2025 emails showed: The RR emailed the facility on 07/08/2025 at 9:16 AM. The email showed the RR reported that Resident 8 had an incident involving three NAs the day prior (07/07/2025) or possibly the day before that (07/06/2025) that involved three named NAs. The email showed the staff were rude and rushed [Resident 8] when the resident requested help with toileting. The RR reported that during this time, Resident 8 had dribbled urine onto the floor while being transferred with a mechanical lift (a machine used to transfer a person from one surface to another surface) and asked to be placed on the toilet. The email showed that when Resident 8 asked that question, one of the NAs replied with why do you need the toilet you already went on the floor? The email showed Resident 8 had felt humiliated and had been very upset about it. The email showed Resident 8 wanted the RR to contact the State Ombudsman (a government employee who investigates and tries to resolve complaints, usually through recommendations or mediation) but the RR wanted to give the facility the chance to resolve the situation first. On 07/08/2025 at 9:36 AM, Staff F replied to the RR and informed them they would be forwarding the concern to the DNS and the Administrator for them to take action on this matter. On 07/10/2025 at 8:23 AM, the RR emailed Staff F to follow up with the reported concern because Resident 8 had not heard anything and was pretty anxious about it. On 7/10/2025 at 11:04 AM, Staff F replied to the RR that they had added Staff N to the email because they were the staff that followed up with Resident 8 and that the DNS and the scheduler had followed up with the NAs. Staff F wrote Resident 8 did not want [Staff CC, NA] to provide them care any longer and was removed from their care. On 07/10/2025 at 11:48 AM, Staff N replied to the RR and stated they had spoken with Resident 8 and informed them that Staff CC would no longer be their NA. During a review of the incident investigation log, for July 2025 showed no incident had been logged regarding Resident 8's concern or investigated as a possible allegation of abuse. During review of the staff meeting minutes on 07/22/2025 showed no education had been provided to NAs regarding being rude or rushing residents during care, nor did the signatures of the staff present (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during that meeting show the three named staff (Staff CC, Staff DD, and Staff EE) that were involved in the incident. During an interview on 08/08/2025 at 12:12 PM, Staff B, DNS, stated the person who received the reported concern was responsible for investigating the concern. Staff B stated upon receiving the email, they did not interview the resident or the staff themselves and would have expected Staff F or Staff N to complete those interviews. Staff B stated they would investigate a reported concern as a possible allegation of abuse if the concern caused the resident psychological harm, such as if they were distraught [deeply upset and agitated] or still dwelling.or worked up about it [the incident]. Staff B stated they would have expected a follow-up with Resident 8 by Staff N and for that follow-up to be documented. Staff B stated the follow up was usually verbal, but they were working on improving that process. Staff B also stated Staff N was responsible for writing up the grievance and ensuring the process was followed. Staff B stated they would have expected education to be completed as the grievance report showed, and was unaware that did not happen. Staff B stated if they would have read the notes for Resident 8 and seen they were still having issues regarding the treatment received by the NAs, they would have investigated it deeper. Reference WAC: 388-97-0640 (2)(a-b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent showers for 2 of 5 residents (Residents 6 and 41) reviewed for activities of daily living (ADLs) care provided for dependent residents. This failed practice placed the residents at risk for unmet care needs, impaired skin integrity, and embarrassment. Findings included . Resident 6Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses including dysfunction of the bladder, muscle weakness, and cervical spondylotic myelopathy (a condition where age-related wear and tear on the spine in the neck causes spinal cord compression). Review of the comprehensive assessment dated [DATE] showed the resident's cognition was intact and required assistance of two staff members for toileting hygiene, showering, and lower body dressing. Review of Resident 6's care plan dated 07/21/2025, showed the resident preferred two showers per week. Review of the facility's undated shower schedule showed Resident 6's shower days were Sunday and Wednesday. An observation on 08/06/2025 at 8:17 AM, showed Resident 6 was lying in their bed, dressed in a pink gown, with their hair greasy and their legs covered with a sheet. During an observation and concurrent interview on 08/07/2025 at 9:45 AM, Resident 6 was lying in bed, their hair greasy, disheveled (unkempt), wearing a gray t-shirt, a brief, and blue socks. The resident stated they were unsure when their last shower was and they were to get a shower the day prior, but they had not received their shower. During an observation and concurrent interview on 08/07/2025 at 12:07 PM, Resident 6 was up in their wheelchair, and they stated they were coming back from their exercises. The resident's hair was greasy, uncombed and they were wearing the same gray t-shirt as observed at 9:45AM earlier that day. Review of Resident 6's June 2025 nursing task sheet, showed no documentation of a shower from 06/09/2025 through 06/14/2025 (six days without a shower). Further review showed no documentation of a shower from 06/23/2025 through 06/29/2025 (six days without a shower). Review of Resident 6's July 2025 nursing task sheet, showed no documentation of a shower from 07/01/2025 through 07/12/2025 (12 days without a shower). Further review showed no documentation of a shower from 07/17/2025 through 07/23/2025 (seven days without a shower). Resident 41Review of the medical record showed Resident 41 admitted to the facility on [DATE] with diagnoses to include heart disease, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of worry, nervousness, or unease) and intervertebral disc degeneration (a condition caused by the breakdown of one or more discs that separate the bones of the spine). The comprehensive assessment dated [DATE] showed Resident 41's cognition was intact and dependent on staff for toileting hygiene, showering, and transfers. During an interview on 08/05/2025 at 10:36 AM, Resident 41 stated they were scheduled to have showers two days a week. The resident stated that last week they only received one shower, and the week before they did not have a shower. Resident 41 stated that it was not their choice to go without a shower but that there was no one to give them a shower.ˆThe resident stated they thought that their last shower was a week ago on Tuesday (07/29/2025).ˆ Review of Resident 41's care plan dated 05/06/2025, showed the resident preferred two showers a week. Review of the facility's undated shower schedule showed Resident 41's shower days were Tuesday and Friday. Review of Resident 41's June 2025 nursing task sheet, showed no documentation of a shower from 06/01/2025 through 06/10/2025 (ten days without a shower). Review of Resident 41's July 2025 and August 2025 nursing task sheet, showed no documentation of a shower from 07/01/2025 through 07/08/2025 (eight days without a shower). Further review showed no documentation of a shower from 07/26/2025 through 08/03/2025 (nine days without a shower). During an interview on 08/08/2025 at 9:37 AM, Staff V, Nursing Assistant, stated they were assigned to do the showers but at times would also be pulled from that task to work on the floor. Staff V stated they had a shower schedule for residents that they used as a guide. Staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V stated they offered bed baths when a resident did not get their shower. Staff V stated if a resident were to refuse a shower they reported to their floor nurse. During an interview on 08/08/2025 at 1:05 PM, Staff B, Director of Nursing Services, stated the expectation for staff were to follow the residents' shower schedule, care plans, and the showers were to be documented even if refused or not given. Reference: WAC 388-97-1060 (2)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Trauma-Informed Care related to assessing trauma and identifying trigger-specific (a psychological stimulus that prompts recall of a previous traumatic event) interventions for residents with a history of trauma for 1 of 1 resident (Resident 41) reviewed for trauma informed care. Findings included . Review of the facility's undated policy titled, Trauma Informed Care showed the facility would identify a resident's history of trauma, as well as cultural preferences. The facility would identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions would identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to decrease the effect of the trigger on the resident and the triggers would be added to the care plan. Resident 41 Review of Resident 41's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart disease, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of worry, nervousness, or unease), and intervertebral disc degeneration (a condition caused by the breakdown of one or more discs that separate the bones of the spine). The comprehensive assessment, dated 07/07/2025, showed Resident 41's cognition was moderately impaired, required extensive assistance from two staff members for transfers. Review of a provider progress note dated 12/16/2024 showed Resident 41 had a history of Post Traumatic Stress Disorder (PTSD, a mental disorder that develops from experiencing a traumatic event). The progress note showed the resident experienced PTSD symptoms such as flashbacks, nightmares, and increased anxiety when triggered. The progress note showed Resident 41 could be triggered by yelling and screaming, Review of Resident 41's care plan, dated 04/01/2024, showed no focused areas, goals, or interventions related to Resident 41's PTSD. ˆ During an interview on 08/08/2025 at 9:53 AM, Resident 41 stated they had experienced childhood sexual and mental abuse. The resident stated that yelling and screaming increased their PTSD triggers of anxiety. Review of the Trauma Informed Care assessment dated [DATE], showed the resident had PTSD with triggers when they heard yelling and screaming. During an interview on 08/08/2025 at 11:46 AM, Staff N, Social Services Director, stated the TIC assessments were done on admission, and they did not recognize Resident 41 had a diagnosis of PTSD. Reference: WAC 388-97-1060(3)(e)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to implement and ensure their system of records for controlled substances (categories of drugs, regulated and classified based on their potential for abuse, potential to cause physical or psychological dependence) disposition (the process of returning and/or destroying unused medications) and accurate reconciliation (a system of recordkeeping that ensures an accurate inventory of controlled substances received, administered or destroyed) was completed in sufficient detail to enable the accurate accounting with these types of medications for 1 of 2 medication carts reviewed and 1 of 1 narcotic (a type of medication for pain relief or sedation and is a category within controlled substances) destruction logbook reviewed for storage/disposition of controlled medications. This failure placed residents at risk for potential financial loss, uncontrolled pain, and possible drug diversion (the abuse of prescription drugs used for purposes other than intended by the prescriber). Findings included .During an interview on 08/06/2025 at 3:25 PM, Staff F, Registered Nurse (RN) and Staff B, Director of Nursing Services, stated the facility's process for the disposition of residents controlled substances was to place them in the Drug Buster (a medication disposal system designed to safely/effectively deactivate and dispose of unwanted medications) and document the specific resident/medication information in their narcotics destruction logbook. Staff B stated that two RNs would sign together in the narcotics destruction logbook to show that an accurate reconciliation was documented/completed regarding the disposition of the controlled substance. Review of January 2025 through August 2025 controlled substance shift count verification logbooks showed 24 nursing shifts on 20 different days did not have the required two nursing staff signatures in order to verify that the narcotics count was completed and accurate. Additionally, the logbook showed that on 03/11/2025 no count had been completed by any staff. During an interview on 08/06/2025 at 3:42 PM, Staff G, RN, stated that two nurses completed a narcotics count of all the controlled substances in the medication cart every shift and both nurses would sign a shift count verification logbook (a book that showed a complete and accurate count of narcotics by two nurses). Staff G stated that nursing staff signatures were missing throughout the logbook, .they should be signing off with another nurse every time they are working . Review of the facility's narcotics destruction logbook showed that on 04/02/2025, five controlled substances from three residents were destroyed, with one staff nursing signature noted and a blank spot where the second staff nurse was supposed to sign but had not. During an interview on 08/06/2025 at 4:09 PM, Staff B and Staff A, Administrator, stated that the controlled substance shift count verification logbook was not filled out correctly and that the process of having two nurses verify that the controlled medication count was not being followed. Additionally, Staff B stated the correct process for the accurate accounting of the three resident's narcotic disposition, done 04/02/2025, was not followed. Reference: WAC 388-97-1300(1)(b)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop/implement components of their infection prevention and control precautions regarding, A) Legionella (a bacteria that can cause a severe respiratory disease) testing protocols, identification of areas at risk and procedures for when control measures (actions or steps taken), adopted to reduce the potential growth/spread of pathogens (bacteria, virus or other microorganisms that can cause diseases) in water, were not met for 1 of 1 water management program (WMP) reviewed for infection control, and B) Nursing Staff hand hygiene and glove change for 1 of 3 residents (Resident 3) reviewed for infection control. The failure to implement the infection control components placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of the facility's policy titled, Legionella Management Program, dated 06/03/2025, showed the facility identified two areas at risk for legionella growth, the ice machines and hot water storage (which was monitored at a set temperature). The policy showed the ice machines routine control measures were to have the machines cleaned/sanitized weekly with a full deep clean/filter change completed every three months. No other control measures were identified. The policy did not include documentation of what corrective actions would be taken when the facility's control measures were not maintained or within acceptable ranges and stated .refer to appendix (a section or table of additional matter at the end of a book or document). Review of the Center for Disease Control and Prevention (CDC) toolkit titled, Developing a WMP to Reduce Legionella Growth and Spread in Buildings, dated 06/24/2021, showed a facility's WMP should identify areas or devices in the building where Legionella might grow or spread to people so the risk can be reduced. The toolkit showed that parts of a building water system that were a risk for spreading contaminated water included water storage tanks, water heaters, shower heads/hoses, infrequently used equipment like eye wash stations, ice machines, and decorative fountains. Additionally, the toolkit showed that water stagnation (something that does not change or move) encouraged biofilm (a community of bacteria that stick together and to a surface forming a protective layer) growth, which can protect Legionella from heat/disinfectants and was common in water devices that went unused or infrequently used. During an interview on 08/05/2025 at 2:20 PM, Staff D, Director of Environmental Services, stated they took part in the development of the WMP for the facility along with the facility's Infection Preventionist (IP). Staff D stated the water management team identified two control measures for the facility. Staff D stated the facility decorative water fountain, nor the residents' infrequently used bathtub, were identified as areas of risk. When inquired about the facility's policy to reference an appendix for intervention when control limits were not met, Staff D stated that it referenced the CDC legionella toolkit. Staff D stated they were unsure of the facility's process when control measures were not met. During a concurrent observation and interview on 08/06/2025 at 10:29 AM, Staff E, Maintenance Supervisor, stated that dietary staff were responsible for the weekly cleaning/disinfection of the ice machines and maintenance staff were responsible for quarterly (every three months) deep cleaning and changing of the water filter on the ice machines. When Staff E and the surveyor observed the ice machines, one showed a date of 03/05/2025 (62 days past the quarterly control measures scheduled change) and the second showed a date of 02/12/2025 (86 days past the quarterly control measures (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled change). Staff E stated the maintenance staff did not flush the facility's eye washing stations routinely and that it was not part of their process. Staff E stated the eye washing stations were infrequently used and would be a potential risk for spreading contaminated water. During an interview on 08/06/2025 at 11:40 AM, Staff C, Infection Preventionist/Treatment Nurse, and Staff D stated the WMP's team did not identify flushing of the infrequently used devices like the eye washing stations or the resident's bathtub nor that control measures were not within acceptable ranges with the facility's ice machines. Staff D stated the WMP should have developed/implemented what corrective actions would need to be taken when the facility's control measures were not maintained, and the correct process was not being followed. During an interview on 08/06/2025 at 11:45 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, stated the facility should be identifying where legionella could grow like the decorative water fountain and areas of water stagnation. Staff A and Staff B were unaware that the ice machines' control measures were not being completed quarterly. Staff A and Staff B stated the process needed to be fixed. Hand Hygiene and Glove Change Resident 3 Review of the medical record showed Resident 3 had been admitted to the facility on [DATE], with diagnoses to include heart disease, diabetes, foot ulcer and depression. The comprehensive assessment dated [DATE] showed the resident cognition was intact and dependent on staff transfers. During an observation on 08/05/2025 at 11:52 AM, Resident 3was sitting up in their wheelchair in the dining room. The resident was fully dressed, wound dressings to both feet, and both covered with boot heel protectors. In an interview on 08/06/2025 at 9:46 AM, Resident 3, stated on Tuesdays they went to a local wound clinic for dressing changes and an evaluation by a physician. Resident 3 stated the nurses completed dressing changes twice a week; Thursdays and Saturdays. During an observation on 08/07/2025 at 10:06 AM, Staff C, IP/TN with their clean gloves began to remove Resident 3's right foot wound dressing and then removed the left foot dressing. Staff C removed their gloves after use, sanitized their hands and applied clean gloves. Staff C then grabbed gauze, sprayed the gauze with wound cleanser and then began wiping the resident's left side of the foot wound with the same gauze and cleansed the left big toe wound. Staff C did not remove their gloves or performed hand hygiene. With their contaminated gloves, Staff C grabbed clean gauze, soaked it with wound cleanser and placed the soaked gauze to the resident's left heel. Staff C in their soiled gloves grabbed clean gauze, soaked it with wound cleanser and placed the soaked gauze to the resident's right heel. Staff C then grabbed clean gauze with their contaminated gloves, sprayed the gauze with wound cleanser and began wiping the resident's right foot on the side where there were two wounds. During an interview on 08/07/2025 at 12:13 PM, Staff C, IP/TN, acknowledged their infection control break during Resident 3's wound care. Staff C stated they were nervous with someone watching them. Staff C stated they realized their breach once they went from the left foot to the right foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/2025 at 1:05 PM, Staff B, Director of Nursing Services, stated the expectation was that staff follow the orders, policies and procedures. Staff B stated they were aware of the infection control breach with Resident 3's wound care. Reference: WAC 388-97-1320(1)(a)(2)(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a clean sanitary environment for 1 of 1 Kitchen floor area that had an uncleanable surface. This failed practice of an uncleanable surface could potentially placed staff and residents at risk of illness. Finding included . During an interview and concurrent observation on 08/04/2025 at 9:25 AM, Staff O, Dietary Supervisor, observed in the thresh hold entryway to the dry goods food storage room, the flooring had cracked, damaged and missing linoleum.^^Staff O stated the floor had been that way for some time and difficult to clean.^ An observation on 08/04/2025 at 9:35 AM, the tilt skillet/stove (commercial cooking equipment used to prepare large batches of food for grilling and braising), which stood three feet above some broken tiled floor. The tile floor, under the tilt skillet showed a four-foot by three-foot area of broken/loose tile with missing and loose grout (mortar poured between cervices to consolidate and seal areas) in between several individual tiles. The tiles were wet due to the steam produced from the heated tilt skillet when in use. The area was uncleanable and there was an accumulation of water between the broken tiles and the missing grout.^ During an interview on 08/04/2025 at 9:40 AM, Staff O stated the tiles had been coming up and there were places of missing grout between the tiles, and they needed to be replaced and repaired.^ During an interview on 08/08/2025 at 11:36 AM, Staff D, Director of Environmental Services, stated they were unaware the tile under the tilt stove in the kitchen needed repaired/replaced or the linoleum in the entryway to the dry goods room was in disrepair. ^Reference WAC 388-97-3220(1)

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	08/08/2025

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

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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 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 4 of 5 days (08/04/2025 through 08/07/2025) of the survey period. This failed practice prevented residents, family members, and visitors from knowing the facility's actual number of available nursing staff.ˆ ˆ Findings included .ˆ Observations on 08/04/2025 at 11:40 AM, 08/05/2025 at 8:44 AM, and 3:31 PM, and 08/06/2025 at 8:50 AM, showed inaccurate postings for actual nursing staff hours worked. On 08/07/2025 at 10:02 AM, the nursing staff posting across from the nurses' station showed it was dated 08/03/2025 (four days prior) and did not show any actual adjustments or changes to the nursing staff hours posted. ˆ During an interview on 08/07/2025 at 12:20 PM, Staff S, Nursing Assistant (NA), stated they were responsible for the daily staff posting. Staff S stated they were off on 08/04/2025 and 08/06/2025, and that the second lead NA was responsible for the posting on the weekends. Staff S stated if any changes were needed, the changes were entered into the computer and re-posted. During an interview on 08/07/2025 at 12:45 PM, Staff T, Staffing Coordinator, stated the staffing levels were based on the facility census and Staff S was responsible for the daily nursing staff postings. ˆ During an interview on 08/07/2025 at 1:07 PM, Staff A, Administrator, and Staff B, Director of Nursing, acknowledged the daily nurse staff postings were outdated and incorrect.ˆ ˆ Reference: WAC 388-97-0020ˆ

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	08/08/2025

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

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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 0572 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to periodically inform residents of their rights after residents were admitted to the facility for 7 of 10 residents (Residents 2, 5, 8, 10, 16, 28, and 31) and 1 of 1 Resident's Representative (RR, Resident 19) reviewed for resident rights. This failure placed residents at risk of not being informed of their rights and/or to make informed decisions regarding their rights. Findings included. During a Resident Council meeting on 08/06/2025 at 2:30 PM, Resident 19's RR stated they would be asked to leave the room while staff cared for Resident 19. The RR stated they never asked Resident 19 if that's what they wanted or if that was okay. The RR stated they had not had Resident Rights reviewed with them since admission, nor did they know where they could access them or find them. Residents 2, 5, 8, 10, 16, 28, and 31 were all in attendance at the Resident Council meeting and all agreed with Resident 19's RR. Review of the resident council meeting minutes for January 2025 to August 2025 showed there had been no review of Resident Rights, written or verbally, during the resident council meetings. During an interview on 08/06/2025 at 3:19 PM, Staff W, Activities Director, stated they did not review Resident Rights with the residents during the monthly resident council meetings or periodically after admission, nor did they discuss where they could be found or accessed. During an interview on 08/08/2025 at 12:12 PM, Staff B, Director of Nursing Services, stated they reviewed Resident Rights with staff during [NAME] Hall Meetings but had not with the residents. Reference WAC: 388-97-0300 (1)(a)

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	08/08/2025

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

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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 0574 Level of Harm - Potential for minimal harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview, and record review, the facility failed to provide the required contact information to resident advocacy resources (ombudsman, State Agency (SA), Aging and Long Term Care), or how to file a complaint with the SA for 7 of 11 residents (Residents 2, 5, 8, 10, 16, 28, and 31) and 1 of 1 Resident Representative (RR, Resident 19) reviewed for required notices and contact information. This failure placed the residents at risk of abuse, neglect, and not having resources available to them. Findings included. During a resident council meeting on 08/06/2025 at 2:37 PM, Resident 8 stated they had wanted to get in contact with the ombudsman regarding some concerns they had but did not know where to find that information. Residents 2, 5, 10, 16, 28, and 31 and Resident 19's RR all agreed. The Residents also did not know how to file a complaint with the SA, nor did they know that was an option. During an interview on 08/06/2025 at 3:19 PM, Staff W, Activities Director, stated they did not know where the information for the resident advocacy resources was posted. During an interview on 08/06/2025 at 3:55 PM, Staff A, Administrator, stated Staff W had access to the Ombudsman information hung up in their cubicle but was not visible to all residents, RRs, or visitors. An observation on 08/07/2025 at 10:40 AM showed upon entrance into the main door of the facility, a sign with contact information for the resident advocacy resources but not visible to the residents in the long-term care area of the facility where the residents resided. During an interview and concurrent observation on 08/07/2025 at 10:51 AM, Staff B, Director of Nursing Services, stated the only signage they were aware of were the Mandatory Reporter [contact information for staff when they have a suspicion of abuse/neglect, misappropriation, or exploitation) signs. The signs did not include contact information for the resident advocacy resources. Reference WAC: 388-97-0300 (7) (c-d)