STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505516	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Soldiers Home	1301 Orting-Kapowsin Hwy E Orting, WA 98360

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to obtain or offer assistance in formulating or periodically checking if a resident had a healthcare advance directive (AD) for 1 of 17 sampled residents (Residents 78) reviewed for AD. This failure placed the resident at risk to be denied the opportunity to direct their health care if they were to become unable to make decisions or communicate their health care preferences. Findings included . An AD is a written instruction, such as a living will or durable power of attorney [DPOA] for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Resident 78 admitted to the facility on [DATE] and was able to make needs known. Review of Resident 78's electronic healthcare record (EHR) on 07/15/2024 showed that the resident had a DPOA for financial; however, there was no documentation of an AD for healthcare. During an interview on 07/17/2024 at 10:38 AM, Resident 78 stated they thought their sister was their DPOA for healthcare but if not, they wanted their sister to be their DPOA for healthcare. Review of Resident 78's advanced directive care plan, revision dated 03/13/2024, showed that Resident 78 had a DPOA for Financial only. During an interview on 07/17/2024 at 1:39 PM, Staff H, Psychiatric Social Worker, stated that they were unable to locate documentation in the EHR that Resident 78 was offered AD information for healthcare or that it had been reviewed and it should have been. Staff H stated they were unable to locate a healthcare AD for Resident 78. During an interview on 07/17/2024 at 2:02 PM Staff A, Administrator, stated that AD information was to be offered to residents, obtained, and reviewed upon admission, and on a quarterly basis, and the documentation should be in the resident's EHR. Staff A stated that it did not meet expectations that they were unable to locate Resident 78's AD for healthcare. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b)

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 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** 38344 Based on observation, interview, and record review, the facility failed to ensure an incident of potential abuse, such as misappropriation of personal property, was identified as such and reported to law enforcement and the State Survey Agency as required for 1 of 4 sampled residents (Resident 37) reviewed for abuse. Failure to report allegation/incident of abuse placed the resident at risk for additional abuse and a diminished quality of life. 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 37 readmitted to the facility on [DATE] and was able to make needs known. During an interview and observation on 07/17/2024 at 10:12 AM, Resident 37 stated staff were aware that they had personal items stolen before and that was why they had keys for the locks on their nightstand and closet. Resident 37 had six keys hanging from a lanyard around their neck. Review of Resident 37's Grievance form dated 06/10/2024 showed on 06/08/2024 Resident 37 had a concern that people were stealing their things, and they were extremely upset over not having a lock on their closet door. This was causing them emotional distress to the point of crying. It showed, Steps taken to investigate the grievance: Resident without a lock on closet. It showed that locks were installed on closets as per resident request on 06/12/2024 and Resident 37 was notified on 06/12/2024. This grievance did not address the concern of stolen items or of reporting allegations of misappropriation of personal property. Review of the facility's incident reporting log from February 2024 through July 12, 2024, showed no incidents logged for Resident 37's allegation of stolen items. During an interview on 07/18/2024 at 8:21 AM, after reviewing Resident 37's grievance form dated 06/10/2024, Staff B, Director of Nursing Services, stated the police and State Agency should have been notified and that did not happen. During an interview on 07/18/2024 at 8:41 AM, after reviewing Resident 37's grievance form dated 06/10/2024, Staff A, Administrator, stated it did not meet expectations and staff needed to follow the guidelines in the Purple Book. Staff A stated the police and abuse hotline should have been called. Reference WAC 388-97-0640(5)(a)(6)(a)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to identify and investigate possible misappropriation of personal property/abuse for 1 of 4 sampled residents (Resident 37) reviewed for abuse. Failure to thoroughly investigate an allegation/incident of abuse placed the resident at risk for additional abuse and a diminished quality of life. Findings included . Resident 37 readmitted to the facility on [DATE] and was able to make needs known. During an interview and observation on 07/17/2024 at 10:12 AM, Resident 37 stated staff were aware that they had personal items stolen before and that was why they had keys for the locks on their nightstand and closet. Resident 37 had six keys hanging from a lanyard around their neck. Review of Resident 37's Grievance form dated 06/10/2024 showed that on 06/08/2024 Resident 37 had a concern that people were stealing their things, and they were extremely upset over not having a lock on their closet door. This was causing them emotional distress to the point of crying. It showed, Steps taken to investigate the grievance: Resident without a lock on closet. It showed that locks were installed on closets as per resident request on 06/12/2024 and Resident 37 was notified on 06/12/2024. This grievance did not address the concern of stolen items or of investigating allegations of misappropriation of personal property. Review of the facility's incident report log from February 2024 through July 12, 2024, showed no investigation recorded for Resident 37's allegation of stolen items. During an interview on 07/18/2024 at 8:21 AM, after reviewing Resident 37's grievance form dated 06/10/2024, Staff B, Director of Nursing Services, stated they should have initiated an incident report investigation of what items Resident 37 thought was stolen and this did not meet expectations. During an interview on 07/18/2024 at 8:41 AM, after reviewing Resident 37's grievance form dated 06/10/2024, Staff A, Administrator, stated it did not meet expectations and staff needed to follow the guidelines in the Purple Book. Staff A stated an incident report investigation should have been initiated and completed. Please refer to F609 for additional information. Reference WAC 388-97-0640 (6)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessment was accurately completed upon or prior to admission for 1 of 7 residents (Resident 71) reviewed for PASRRs and/or unnecessary medications. This failure placed the resident at risk for unidentified mental health care needs and a poor quality of life. Findings included . Resident 71 admitted to the facility on [DATE] with diagnoses to include depression, adult failure to thrive, post-traumatic stress disorder (PTSD, difficulty recovering after experiencing or witnessing a terrifying event), and was able to make needs known. Review of Resident 71's PASRR assessment dated [DATE], completed by the hospital prior to Resident 71's admission on 05/07/2024, showed no serious mental illness indicators documented in section I on the form. This form showed, No Level II evaluation indicated. During an interview on 07/17/2024 at 11:57 AM, Staff H, Psychiatric Social Worker, stated Resident 71's 05/03/2024 PASRR was not accurate and should have been reviewed and a new one completed upon admission to include depression. During an interview on 07/17/2024 at 12:16 PM, Staff B, Director of Nursing Services, stated Resident 71's PASRR dated 05/03/2024 did not meet expectations and a new PASRR should have been completed upon admission and marked yes for depression and PTSD. Reference WAC 388-97-1915 (1)(2)(a-c)

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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** 38344 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 19 sampled residents (Resident 78) reviewed for quality of care. The failure to assess, obtain orders, monitor, and document the use of Resident 78's shrinker (an elastic sock used to control swelling, promote healing and assist in shaping an amputated/surgically removed leg) prior to use, placed the resident at risk for medical complications, unmet needs, and a poor quality of life. Findings included . Resident 78 admitted to the facility on [DATE] with a diagnosis of an amputation (surgical removal of a limb) of the left lower leg and was able to make needs known. Observation and interview on 07/15/2024 at 12:25 PM showed Resident 78 with a left above the knee amputated leg. Resident 78 stated they were waiting for their shrinker to arrive in the mail so they could use it and then eventually get their prosthetic (artificial body part) leg. Resident 78 stated staff were aware that they were waiting for the shrinker. During an interview and observation on 07/17/2024 at 10:38 AM Resident 78 stated they received two shrinkers in the mail yesterday (07/16/2024) and that an aide washed them by hand before they used it. There were two shrinkers hanging on a towel rack by the sink. Resident 78 stated that they were responsible to apply the shrinker and they tried it on yesterday. Resident 78 stated they would wear it as long as they could tolerate because they needed to shrink their left stump/amputated leg before they could get their prosthetic leg. During an interview on 07/18/2024 at 7:49 AM, Resident 78 stated they had talked to Staff F, Certified Nursing Assistant/ Restorative Aide this morning and was told that the shrinker should be put on for about an hour every day and to check their skin for redness or any allergic reaction to the material and if they had any issues they should talk to the wound nurse. Review of Resident 78's electronic health record (EHR) on 07/17/2024 showed no assessment or provider orders for the use of a shrinker and no care plan for the care or independent use of a shrinker. Review of Resident 78's progress notes from 06/01/2024 through 07/18/2024 showed one progress note dated 06/12/2024 that addressed that the shrinker had been ordered. There were no other progress notes that addressed the shrinker. During an interview on 07/18/2024 at 11:00 AM Staff D, Licensed Practical Nurse (LPN), stated Resident 78 has a new shrinker for their above the knee amputation (AKA) and they were able to put it on themself. Staff D stated that they were unable to locate a provider order or a care plan for the use of Resident 78's shrinker and there should have been. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/2024 at 11:29 AM, Staff F stated Resident 78 was on a restorative exercise program for the arms and right lower leg and was not being seen by therapy at this time. Staff F stated Resident 78 had asked how long they should wear their shrinker and they told Resident 78 that their nurse or physician should provide that information but, they knew it was a buildup process to wear it in order to tolerate it and eventually it would shape the stump to get ready for a prosthetic leg. Staff F stated that they had not applied the shrinker nor had they seen the shrinker on Resident 78. During an interview on 07/18/2024 at 11:47 AM, Staff B, Director of Nursing Services, stated they were not aware that Resident 78 had received a shrinker and that it had been in use. Staff B stated it should have been documented that Resident 78's shrinker had arrived, provider notified, orders obtained to assess and use the shrinker, referral for therapy as needed, and it should have been care planned. Reference WAC 388-97-1620 (2)(b)(i)(ii), (6)(b)(i)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observations, interviews, and record review, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident 57) when reviewed for ADL decline. Failure to obtain a wheelchair for Resident 57's use, placed them at risk for avoidable decline and a diminished quality of life. Findings included . Resident 57 admitted to the facility on [DATE] with multiple diagnoses to include severe malnutrition, large sacral (lower back) skin ulcer and diabetes. The resident was able to make needs known and was dependent on staff for transfers in and out of bed. Multiple observations on 07/15/2024 through 07/18/2024 showed Resident 57 laid in bed on his back. During an interview on 07/18/2024 at 8:39 AM, Resident 57 stated they had a wheelchair in [NAME] waiting for pick up. They had talked to therapy about it and the VA social worker. It drives me crazy; I have been in bed since March, I can't go outside and see the dentist or the eye doctor or other people. I get a bed bath and use the bed as a toilet. Review of the resident's electronic health record (EHR) showed no mentioning of a wheelchair or plans for Resident 57's mobility or ways to be out of bed. Review of Resident 57's care plan initiated on 03/26/2024 did not include instructions or plan for wheelchair mobility. During an interview on 07/18/2024 at 12:40 PM, Staff B, Director of Nursing Services stated the expectation was for the facility to provide a loaner wheelchair after admission till the residents get their personal wheelchair. Reference WAC 388-97-1060(2)(a)(ii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview and record review, the facility failed to consistently monitor and document bowel movements and implement the bowel program when needed for 1 of 1 resident (Resident 28) reviewed for bowel protocol. Additionally, the facility failed to initiate proper positioning, for 2 of 3 residents (Resident 12 and 52) when reviewed for positioning and mobility. These failures placed the residents at risk for worsening conditions, discomfort, and a decreased quality of life. Findings included . <Bowel Monitoring> Review of a document titled, Bowel (Lower Gastrointestinal Tract) Care - Nursing Operating Protocol, dated 02/01/2018 showed that to promote bowel movements in a pattern that was usual for the resident and to prevent complications associated with constipation (a condition in which dry, hard stool that's difficult to pass). The night (NOC) shift Licensed Nurse (LN) was responsible to review resident bowel records and compile a list of residents who had gone 2 days (midnight to midnight) without a bowel movement. This information was to be passed onto day shift LNs for the initiation of the bowel care protocol in addition to routine schedule bowel medication as applicable. RESIDENT 28 Review of the quarterly minimum data set (MDS, a required assessment tool), dated 04/22/2024 showed Resident 28 was admitted to the facility on [DATE] with diagnoses to include stoke with hemiplegia (paralysis that affects one side of the body) and constipation. The MDS further showed Resident 28 was able to make needs known. Review of Resident 28's care plan dated 10/16/2020 showed a focus area that the resident had the potential for constipation related to impaired mobility, medications, and diet, long standing bowel pattern of greater than three days without a bowel movement. The goal was for the resident to have a soft formed bowel movement at least every third day through the review date. Interventions included to monitor, document and report, when necessary, signs and symptoms of complications related to constipation and to record bowel movement patterns each day and describe amount, color and consistency. During an interview on 07/17/2024 at 8:53 AM, Resident 28 stated they had constipation and would go back and forth with the nurses and tell them if they needed something for constipation. Review of Resident 28's medication administration record (MAR) showed several providers orders dated 10/05/2020 for LNs to administered medications as needed for constipation to include sennosides tablet to be administered for no BM in conjunction with polyethylene glycol powder and to document any refusal. In addition, bisacodyl suppository was to be administered as needed on day four without a BM, and to document any refusals. (continued on next page)

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	505516	A. Building B. Wing	07/18/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 28's electronic health record (EHR) task section for BM results showed that the resident had a BM on 07/05/2024; however, no BM was documented for the following dates from 07/06/2024 to 07/15/2024. In addition, no documentation showed that Resident 28 was administered any ordered constipation medication within the (MAR) or documented any refusal in the residents' clinical progress notes during these dates. During an interview on 07/17/2024 at 11:53 AM, Staff G, Certified Nurse's Assistant stated Resident 28 was really particular about their BMs and did not always tell them of their BM's; however, if they needed something for their bowels, they would tell us, and we would inform the LNs'. During an interview on 07/17/2024 at 12:21 PM, Staff C, Registered Nurse/Residential Care Manager (RN/RCM) stated it was their expectation that if the resident did not have a BM for greater than 72 hours, then the LNs were to administer medications for constipation and to document any refusals in the progress notes. During an interview on 07/17/2024 at 12:33 PM, Staff B, Director of Nursing Services (DNS) stated it was their expectation that whenever the resident had a BM it was to be documented in the clinical records (TASK section) and if the resident did not have a BM within the required time frame then the LNs were to administer the bowel protocol (constipation medication) as ordered and to document any resident refusal. 46148 <Positioning> Resident 12 Resident 12 admitted to the facility on [DATE] with a diagnosis of Parkinsons disease (A brain disorder that effects movement). Review showed the resident was dependent on staff for bed mobility and was to be repositioned every two hours while in bed. A care plan entry dated 05/22/2024 showed for staff to place hand rolls in the residents' hands daily. Observation on 07/17/2024 at 9:56 AM showed Resident 12 laid in bed on their back, there was a pillow under their right shoulder for positioning. The resident was awake and had their arms extended above them grasping their fingers. There was no palm protector in the residents left hand. Observation on 07/17/2024 at 11:16 AM showed Resident 12 laid in bed with their eyes closed, they were positioned on their back with a pillow under their right shoulder. There was no palm protector in the residents left hand. Observation on 07/17/2024 at 12:18 PM showed Resident 12 laid in bed with a pillow under their right shoulder. There was no palm protector in the residents left hand. Observation on 07/17/2024 at 1:22 PM showed Resident 12 laid in bed with a pillow under their right shoulder. There was no palm protector in the residents left hand. The resident had their arms in the air holding their fingers. (continued on next page)

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	505516	A. Building B. Wing	07/18/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/17/2024 at 2:14 PM showed Resident 12 laid in bed with a pillow under their right shoulder. There was no palm protector in the residents left hand. The resident appeared stiff with their arms in the air holding their fingers. Their left leg was extended straight, and the right leg was bent at the hip and knee, the resident answered yes when asked if they were in pain. During an interview on 07/18/2024 at 8:48 AM, Staff E, Certified Nursing Assistant, stated resident 12 can't use the call light or move in the bed so staff should reposition them every 2 hours. Staff E stated the resident was resistive to care on their palms and had sores on their fingertips so they should always have on the palm protectors. During an interview on 07/18/2024 at 8:52 AM, Staff D, Licensed Practical Nurse (LPN) stated resident 12 should have palm protectors on at all times and that the resident had a wound on their bottom so they should reposition them every two hours from side to side. During an interview on 07/18/2024 at 9:44 AM, Staff B stated their expectation was that staff reposition Residents 12 every two hours or less and that Resident 12 should have had the palm protectors on at all times. 49926 Resident 52 admitted to the facility on [DATE] with multiple diagnoses to include stroke (damage to the brain from interruption of its blood supply) with inability to move left upper and left lower extremity, fracture of left lower leg and depression. Resident 52 was able to make needs known. Multiple observations on 07/15/2024 through 07/18/2024 showed Resident 52 laying in bed on the back. Left hand was flaccid and fingers were curled up in a fist, there was no air cast to support left leg fracture left foot was resting turned outward on the pillow without any covering. Foot cradle was on the floor between bed and wall. Resident 52 stated they don't do anything for my left hand and left leg. Review of EHR showed the following orders: ensure L foot is flat in air cast boot from 5/24/2024, Orthopedic supportive boot stays on day and night, off during shower from 5/24/2024, left hand palmar resting splint for contracture prevention and management from 3/10/2022, use Foot Cradle at the end of the bed every shift from 8/06/2023. Review of Resident 52's care plan, initiated 2/21/2024, showed instructions regarding use of Foot Cradle, to apply ted hose to left leg, when to remove air cast and when to use palm splint. Review of Resident 52's treatment administration record for July 2024 showed license nurse documenting every shift that the orthopedic boot is on left leg, that the foot cradle is at the end of the bed. There was no documentation found about the use of the left hand palmar resting splint. During an interview on 7/18/2024 at 10:44 AM, Staff B stated the expectation was to have clear documentation and the devices to be used as ordered. Reference WAC 388-91-1060(1)

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	505516	A. Building B. Wing	07/18/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34567 Based on observation, interview and record review, the facility failed to provide the necessary supervision and safety monitoring for 1 of 4 residents (Resident 28) reviewed for accidents. This failure placed the resident and the facility at risk for possible fire and serious injury related to an inaccurate smoking safety assessment. Findings included . Review of a policy titled, Smoking and Tobacco in WDVA Facilities, dated, 06/26/2023 showed the rights of all individuals was to provide an example of preventive healthy behavior, maintain a clean and healthful environment and ensure health and comfort of individuals whose tolerance for tobacco use was limited. The document also showed that all those who live, work, and visit the facilities would be provided with an environment that limits the risks of fire or exposure to smoke vapor, and other byproducts of tobacco products. Smoking assessments would occur for residents that smoked upon admission, quarterly and when warranted by circumstances as part of an on-going safety program. Review of the quarterly minimum data set (MDS, a required assessment tool), dated 04/22/2024 showed Resident 28 was admitted to the facility on [DATE] with multiple diagnoses to include heart, lung and kidney disease, stoke with hemiplegia (paralysis that affects one side of the body). The MDS further showed Resident 28 was able to make needs known and showed tobacco use by the resident. During an observation and interview on 07/16/2024 at 8:53 AM, Resident 28 sat up in a wheelchair within their room, the resident had a right-hand splint (a device used for prevention of contractures/frozen joint) was secured by Velcro strap which was placed and used throughout the day. In addition, the resident had a large, bushy, untrimmed, gray beard. When asked if they currently smoked, Resident 28 stated, Yes, I go by myself off the property after getting my cigarettes and lighter from the nurses station. Review of Resident 28's electronic health records (EHR) showed a document titled, WSH ([NAME] Soldiers Home), Smoking Safety Assessment, dated 06/11/2024. The document showed a registered nurse at the facility had conducted a smoking assessment to deem if Resident 28 was safe to smoke independently. The document had several questions to include, Does the resident have hand dexterity to safely hold a cigarette, the section was marked, No. The question, Does the resident extinguish smoking material in an unsafe manner? i.e. throwing butts in ground), the document was marked Yes. The section for whether the resident had facial hair and if it was trimmed in such a manner to avoid lit cigarette and/or ashes falling on it, the document was marked, Yes. Review of a care plan for Resident 28 dated 06/11/2024 showed the residents' safety may be at risk related to noncompliance with smoking policy. The care plan goal showed that the resident would abide by smoking policy while they resided at WSH nursing facility. (continued on next page)

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	505516	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Soldiers Home	1301 Orting-Kapowsin Hwy E Orting, WA 98360

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 12:26 PM, when asked whether Resident 28's smoking safety assessment was accurate, Staff C, Registered Nurse / Residential Care Manger (RN/RCM) stated that if the resident had a large untrimmed beard and if the document showed that they had a lack of dexterity to hold a cigarette than they would not be safe to smoke. Staff C stated that Resident 28 needed to be re-assessed for smoking. During an interview on 07/17/2024 at 12:38 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that the smoking safety assessment was accurate for Resident 28 and that the resident's beard should be trimmed if they wanted to continue to smoke safely. Reference WAC 388-97-1060 (3)(g)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview and record review the facility failed to monitor and manage issues with pain for 1 of 2 residents (Resident 67) reviewed for pain management. Failure to monitor Resident 67's pain levels placed the resident at risk for uncontrolled pain and a decreased quality of life. Findings included . Resident 67 was admitted to the facility on [DATE] with a diagnosis of left toe amputation (surgically removed toe), chronic pain syndrome, and post-traumatic stress disorder. The resident had a provider order dated 05/28/2024 for a narcotic pain medication three times a day. During an interview on 07/16/2024 at 11:47 AM, Resident 67 stated they were taking pain medications every eight hours, but they are never on time, and it was not enough and that the pain was out of control. Review of the electronic health record on 07/17/2024 showed there was no documentation of the resident's pain level to determine if the medications were effective or what the residents pain level was. During an interview on 07/17/2024 at 1:26 PM, Staff K, Resident Care Manager, stated if pain was an issue for a resident, we should document their pain level every shift and that Resident 67 should have his pain levels monitored and treated as appropriate. Review of the resident's care plan entry dated 03/22/2024 showed for staff to monitor/document pain management. Document frequency, duration, intensity of pain, phantom pain and report to physician if medications are not effective. During an interview and observation on 07/17/2024 at 1:53 PM Resident 67 stated they have pain at a level 9 of 10 most of the time now, and that it used to help but it's not working now. Also, the staff used to ask about my pain, but they do not anymore. My pain is higher than 10 right now, that's why I'm shaking. The resident was observed shaking. During an interview on 07/17/2024 at 1:40 PM, Staff B, Director of Nursing Services stated it was their expectation that Resident 67's pain be monitored every shift and the provider be notified if the interventions were not effective. Reference WAC 388-97-1060 (1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to ensure as needed (PRN) psychotropic medications (affecting the mind) were limited to 14 days for 1 of 5 sampled residents (Resident 59) when reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary psychotropic medication, avoidable medication side effects, and a diminished quality of life. Findings included . Resident 59 admitted to the facility on [DATE] with multiple diagnoses to include chronic respiratory failure, and anxiety. Resident 59 was able to make needs known. Review of Resident 59's provider's orders showed an order for lorazepam (an antianxiety medication) every four hours PRN which started on 02/21/2024 and had no stop date. Review of Resident 59's monthly pharmacy recommendations showed no recommendation to stop lorazepam PRN after 14 days. Review of Resident 59's medication administration record showed that Resident 59 was administered lorazepam tree times in the month of July 2024, seven times in June 2024 and nine times in May of 2024. During a phone interview on 07/17/2024 at 9:57 AM, Staff O, Pharmacist, stated PRN Lorazepam should have been discontinued or justified within 14 days. Sorry, we missed the boat. During an interview on 07/18/2024 at 12:27 PM, Staff B, Director of Nursing Services, stated the expectation was for the PRN psychotropic medications to be discontinued within 14 days or justified by the provider. Reference WAC 388-97-1060(3)(k)(i)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46067 Based on observation and interview, the facility failed to provide food at an appetizing temperature for 1 of 1 tray line when reviewed for Kitchen Services. This failure placed residents at risk of lower nutritional intake, potential weight loss, and a diminished quality of life. Findings included . On 07/15/2024 at 12:42 PM, Resident 71 stated Some of the food sucks because the meat is overcooked. On 07/15/2024 at 12:58 PM, Resident 37 stated, The food does not taste good here. On 07/15/2024 at 12:23 PM Resident 78 stated, The food is not very flavorful and could use some improvement. The chicken and other meat are over cooked and dry. Review of the lunch menu for 07/17/2024 showed the Regular diets would receive Italian Meatloaf, Lemon Herb Orzo, Garlic Bread, Roasted Asparagus and Marbled Cheesecake. The protein alternative was Tilapia. Observation on 07/17/2024 at 11:49 AM during lunch tray service showed Staff L, Food Service Worker Lead, plating meatloaf on resident trays and adding gravy to only select trays. Staff L said they were adding gravy to the meatloaf slices that looked dried out. Review of the lunch menu for 07/17/2024 showed gravy was not on the menu for those receiving Regular diets. During an interview on 07/17/2024 at 1:03 PM, when requested to take the temperature of a test food tray, Staff L, Food Service Worker Lead stated the orzo was 135 degrees Fahrenheit (F), the asparagus was 135 degrees F, the meatloaf was 136 degrees F, and the Tilapia was 125 degrees F. When asked if these temperatures were hot enough, Staff L, said No, the fish was not up to temperature. During an interview on 07/18/2024 at 9:03 AM, Staff M, Dietary Manager, said only altered texture diets should have received gravy and if a menu item was dried out it should not have been served. Staff M said the Tilapia temperature did not meet their expectation. Reference WAC 388-97-1100 (1), (2)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 46067 Based on observation, interview and record review the facility failed to ensure 22 of 90 sampled residents (Residents 2, 8, 13, 14, 18, 23, 30, 34, 37, 40, 48, 59, 60, 62, 64, 71, 73, 74, 82, 85, 86 and 140) received physician ordered therapeutic diets or portion sizes. This failure placed residents at risk for medical complications, nutritional deficits and a decreased quality of life. Findings included . <Therapeutic Diets> Review of lunch menu for 07/17/2024 showed the Regular diets would receive Italian Meatloaf, Lemon Herb Orzo, Garlic Bread, Roasted Asparagus and Marbled Cheesecake. Review of the lunch extension menu showed Easy to Chew, Soft and Bite Sized and Puree diets were to receive a wheat roll instead of garlic bread. Observation of the lunch tray preparation service on 07/17/2024 between 11:13 AM and 11:52 AM showed Staff L, Food Service Worker Lead, serving garlic bread to residents on Easy to chew, Soft and bite sized and Puree diets. Observation of the steam table during tray service showed no wheat rolls. During an interview on 07/17/2024 at 11:49 AM, Staff L said the main kitchen had only prepared garlic bread and garlic bread sticks. Staff L said they were unsure why wheat dinner rolls were not prepared. <Portion Sizes> Observation on 07/17/2024 at 11:31 AM showed the tray card for Resident 60 indicated Large Portion. Staff L provided one and a half portions of meatloaf and portion sizes consistent with the regular diet for the starch, vegetable and dessert. Observation on 07/17/2024 at 11:31 AM showed the tray card for Resident 48 indicated Double Protein. Staff L provided the portion sizes consistent with the regular diet (1 slice). During observation and interview on 07/17/2024 at 11:45 AM, Staff N, Food Service Supervisor reviewed Resident 48's tray card and said two slices of meatloaf should have been provided. Staff N requested Staff L plate an additional slice of meatloaf. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/18/2024 at 9:03 AM Staff M, Dietary Manager said tray cards that indicate Large Portion should have been provided one and a half portions of protein and starch. Staff M was unable to provide an explanation why the cook did not prepare wheat rolls; however, stated the expectation was that extension menus and tray cards were followed. Staff M said wheat rolls should have been provided as ordered or the dietician should have been notified to determine if an alternative could have been substituted. Reference: (WAC) 388-97-1200(1)