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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505517 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/22/2024 |
| NAME OF PROVIDER OR SUPPLIER Washington Veteran Home-Retsil | | STREET ADDRESS, CITY, STATE, ZIP CODE 1141 Beach Drive PT Orchard, WA 98366 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</p> <p>Based on observation, interview and record review, the facility failed to thoroughly investigate 3 of 4 allegations of abuse, neglect and/or misappropriation for 2 of 2 residents (Residents 97 and 105) whose investigation were reviewed. The failure to establish a timeline of events, ensure all staff who were present, involved and/or had knowledge of alleged incidents were reviewed, and to implement identified interventions to prevent reoccurrence, placed residents at risk for unidentified and/or continued abuse, neglect, and/or misappropriation of their property.</p> <p>Findings included .</p> <p>Resident 97 admitted to the facility on [DATE]. On 04/16/2024 at 11:35 AM, the resident said a little over a month ago, there was an incident with a prior roommate. The roommate allegedly came over to Resident 97's side of the room and threatened to shoot him. Resident 97 said they notified staff, and the roommate was moved to a different room.</p> <p>The facility's incident/accident reporting log showed the following entries for Resident 97:</p> <p>a) 02/25/2025- resident to resident incident.</p> <p>b) 03/16/2024- misappropriation (Missing money)</p> <p>c) 04/02/2024- resident to resident incident.</p> <p>1) Review of the 02/25/2024 resident-to-resident investigation showed Resident 97 reported their roommate came over to their side of the room twice the previous night. Staff noticed it and intervened, assisting the roommate back to his side of the room. The roommate was mean and threatening to the staff when they did this. Resident 97 said after the staff left, my roommate came back over and accused me of having his wife in my bed and said I will kill you. Resident 97 said he fell asleep around 10:00 PM only to be woken up around midnight to his roommate yelling at staff. After the staff left, he fell asleep again until around 8:00 AM the next morning when he awoke to his roommate threatening to kill him again.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the notes section of the investigation showed Resident 97 was placed on alert for psychological/social harm and the roommate was moved due to Resident 97's concern for his safety. In an interview Resident 97 reported that his roommate had also smeared feces and urine in the bathroom and a male housekeeper had to clean it up. The interviewer documented [Resident 97] was calm but is fearful of his safety. Further review showed staff documented Per MD [the roommate] hears staff and confuses it with hearing the voice of his wife. Especially on evening shift.</p> <p>The investigation concluded roommate's delusions were exacerbated by his new environment. Roommate's actions were projected on this resident because he was in close proximity. The roommate was moved to another unit and the following day felt bad about the incident and wanted to apologize. The verbal threats this resident received are abusive in nature.</p> <p>The investigation did not provide any information on how they arrived at the conclusion. There was no documentation or indication that the staff members who removed Resident 97's roommate from his side of the room twice on evening shift, the staff members who were allegedly yelled at by the roommate on night shift, the male housekeeper who allegedly cleaned up the urine and feces in the bathroom or the nurses on duty at the time of the alleged events were ever interviewed. The investigation also failed to establish if Resident 97 told the staff that removed the roommate twice on evening shift, that his life had been threatened, and if so, what action, if any, was taken to ensure Resident 97's safety.</p> <p>Additionally, Resident 97's care plan was updated to reflect that he hears staff and confuses it with hearing the voice of his wife. Especially on evening shift. That he likely has delusions/vivid dreams that he acts on and believes. Which is what the investigation concluded about the perpetrator, Resident 97's former roommate.</p> <p>On 04/19/2024 at 9:14 AM, Staff B, Director of Nursing (DNS), reviewed the investigation and acknowledged there was no documentation to show staff who were present, involved and/or had knowledge of the incident were interviewed. Staff B indicated this detracted from the ability to establish a timeline of events, including when staff were first notified of the verbal threats, and whether staff took immediate to protect Resident 97.</p> <p>On 04/19/2024 at 9:21 AM, when asked why Resident 97's care plan was updated to reflect he hears staff and confuses it with hearing the voice of his wife. Especially on evening shift. That he likely has delusions/vivid dreams that he acts on and believe when the investigation concluded it was Resident 97's roommate who had vivid nightmares and delusions, Staff B indicated the investigation was confusing and she would have to talk with the investigator to clarify. No further information was provided.</p> <p>2) Review of the 04/02/2024 resident-to-resident investigation showed Resident 97 reported his roommate threatened to come in and beat the s**t out of him. He also reported that his roommate called out things like God help me . all night long.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the investigative documents showed Resident 97 was placed on alert for potential psycho/social harm, was referred to mental health and offered a room change. In a follow up interview Resident 97 denied being fearful or wanting to change. Resident 97's roommate acknowledged calling out during the night because he was in a lot of pain but denied threatening Resident 97 and indicated they had got along ok. The investigation included Resident 97's mood care plan which indicated Resident 97 hears staff and confuses it with hearing the voice of his wife. Especially on evening shift. That he likely has delusions/vivid dreams that he acts on and believes. Which is was concluded about Resident 97's former roommate on the 02/25/2024 resident to resident investigation.</p> <p>The investigation concluded this incident is unsubstantiated. The resident has a history of exaggerating/embellishing events in conversations. This is likely what occurred during the social worker interview. The resident's roommate does call out and [resident] was in a verbal altercation one month ago with his former roommate. This resident is combining a previous interaction with the current interactions with his roommate due to cognitive impairments. No findings of abuse or neglect.</p> <p>The investigation did not include interviews of direct care staff to determine if they had any firsthand knowledge of the alleged events. There was no explanation why Resident 97's care plan indicated he hears staff and confuses it with hearing the voice of his wife. Especially on evening shift. That he likely has delusions/vivid dreams that he acts on and believes,' given that was attributed to the perpetrator in the conclusion of the 02/25/2024 resident to resident investigation, not Resident 97. Additionally, it was unclear how the facility determined the incident was unsubstantiated, from the information contained in the investigation.</p> <p>On 04/22/2024 at 8:31 AM, Staff B, DNS, said direct care staff should have been interviewed but acknowledged there was no documentation or indication that occurred. Staff B said she was confused/uncertain why the delusion/vivid dreams were care planned for Resident 97, given the previous investigation attributed that to Resident 97's perpetrator.</p> <p>On 04/22/2024 at 8:33 AM, when asked if the allegation was thoroughly and accurately investigated Staff B, DNS, stated, No.</p> <p>46067</p> <p>4) Resident 105's annual Minimum Data Set assessment (MDS) showed Resident 105 admitted to the facility on [DATE] and was able to make their needs known.</p> <p>Review of investigative documentation regarding an incident that occurred on 03/26/2024, under the section titled, physical, showed Resident 105 was punched in the upper torso by another resident during a witnessed altercation, was described as visibly upset and wanted to retaliate against the other resident and without injury. The section titled, root cause, dated 03/30/2024, showed neither resident has any recollection of the incident due to their cognitive impairment. This action is abusive in nature. Further review showed no documented interventions regarding the incident.</p> <p>During an interview and record review on 03/02/2023 at 12:11 PM, Staff CC, Neighborhood Coordinator, stated that although there were no documented interventions on the incident report for Resident 105 the other resident involved in the altercation was care planned to be put on behavior monitoring. Upon further review Staff CC stated the facility failed to implement and document the behavior monitoring for the resident.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 04/19/2024 at 3:08 PM, Staff B, Director of Nursing Services (DNS), said their expectation was not met as the resident was put on alert for behaviors however no behavior monitoring was documented. Staff B, DNS said the expectation was that interventions were implemented as soon as possible to keep residents safe and to ensure the care plan accurately reflected those interventions.</p> <p>Reference WAC 388-97 - 0640 (6)(a)(b)</p> | | |