STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505517	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Veteran Home-Retsil	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 40914 Based on observation, interview and record review, the facility failed to ensure interventions were consistently implemented and monitored for effectiveness for 1 of 3 residents (Resident 1) reviewed for accidents and hazards. This failure placed residents at risk for falls, injury and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia, post-traumatic stress disorder (a mental condition caused by experiencing a traumatic event), and blindness. The Minimum Data Set (MDS), dated [DATE], documented Resident 1 has severe cognitive impairment and is dependent on staff with activities of daily living. The care plan, revised on 11/20/2024, documented Resident 1 was at risk for falls due to impulsivity and poor safety judgement, fierce determination to be independent, and decreased mobility. Care plan documented staff would toilet the resident every waking hour, place items within reach, invite to activities, and keep the resident's room door open for visibility. On 11/21/2024 at 2:35 PM, Resident 1 was observed in his bed. The resident had an indwelling catheter in place (long flexible tube inserted into bladder to drain urine into a drainage tube and bag). The resident said sometimes they would get up alone to go to the bathroom because the wait was too long. Facility incident report, dated 11/05/2024, documented Resident 1 was found in the bathroom up against the wall, next to the toilet. Resident 1 had disconnected their catheter tube from the drainage tube. The resident's call light was turned on. Staff assisted the resident to bed and noted three skin tears to the resident's arms. Progress notes, dated 11/06/2024, documented staff were unable to determine the root cause of the fall and they would investigate further and documented the cause may have been due to disconnection of catheter tubing. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility incident report, dated 11/08/2024, documented Resident 1 fell in bathroom and was found against the toilet and wall. Resident 1 said they were wanting to go to the bathroom. The resident was assisted back into the wheelchair and self-transferred onto the toilet. The report documented Resident 1 had been assisted to the bathroom [ROOM NUMBER] minutes prior and there were no injuries present. Progress notes, dated 11/12/2024, documented Resident 1 had received new shoes to help prevent falls and labs and a urine analysis were obtained to rule out contributing medical factors or infection. Facility incident report, dated 11/14/2024, documented Resident 1 was found on the floor in the bathroom while trying to get on [the] toilet and no injuries were sustained. Progress notes, dated 11/15/2024, documented Resident 1 would be on every hour toileting rounds during waking hours. Progress notes, dated 12/17/2024, documented Resident 1 fell in room outside of the bathroom. No injuries found. The resident had been assisted to the toilet about an hour prior. Progress notes, dated 12/18/2024, documented Resident 1 fell after they were taken to their room. Staff provided a call light and left to go to another room. When staff returned, the resident was on the floor. The note documented staff would not leave the resident up in wheelchair while alone in room. The facility tasks documentation, from 11/22/2024 to 12/20/2024, documented staff would offer to take [the resident] to the bathroom every hour while awake and staff had assisted Resident 1 to the bathroom every hour on four of 60 shifts. The resident refused assistance to the toilet on three out of 60 shifts. Two out of 60 shifts were noted as not applicable. Five shifts were documented as resident not available due to hospitalization . And 46 out of 60 shifts had no documentation showing Resident 1 was assisted to the toileting every hour. On 12/20/2024 at 3:43 PM, Staff B, Registered Nurse and Director of Nursing, said she would expect staff were documenting they were providing toileting to Resident 1 every hour. Staff B said this should be documented at least once, every shift. Staff B reviewed the documentation and said staff were not documenting each shift. Staff B said on the shifts documented as resident refusals, she could not tell if the resident's refused toileting all day or at times throughout the shift. Staff B said they had not determined interventions related to disassembling their indwelling catheter. Staff B said they should have been ensuring fall interventions are effective. Reference WAC 388-97-1060(3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914 Based on observation, interview and record review, the facility failed to monitor the efficacy for use of an indwelling urinary catheter (a small flexible tube inserted into the bladder to drain urine) for 1 of 3 sampled residents (1), reviewed for catheter use. This failure placed the residents at increased risk of a catheter associated urinary tract infections, pain, and urethral trauma. Findings included . Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia, post-traumatic stress disorder (a mental condition caused by experiencing a traumatic event), and blindness. The Minimum Data Set (MDS) dated , 10/14/2024, documented Resident 1 had severe cognitive impairment and was dependent on staff with activities of daily living. The care plan, dated 10/16/2024, documents Resident 1 had an indwelling foley catheter due to an enlarged prostate, bladder neck obstruction (a blockage of urine flow), and a neurogenic bladder (nerve damage to the muscles and nerves of the bladder). The resident frequently disconnected their catheter and spilled urine into bed. Staff would position the catheter below the bladder and monitor for signs and symptoms of a urinary tract infection (an infection in the bladder). Urology notes, dated 02/10/2023, documented Resident 1 had multiple urologic complaints including over 30 falls, 18 of which were due to toileting needs. The resident was found to have 831 millileters (normal is 0) of residual urine in the bladder. The resident said they had intermittent urinary urgency and frequency, which is why Resident 1 tried to toilet themselves. Urology provider documented Resident 1 likely had benign prostatic hyperplasia (an enlargement of the prostate gland reducing the flow of urine) with a bladder neck obstruction and a neurogenic bladder. The resident would likely a need long-term catheter. The resident was not a candidate for de-obstructing procedure. Resident 1 may desire to attempt a voiding trial in two to three months. The resident would not need to return to urology unless there were catheter issues or there was an interest in a supra-pubic catheter. There had been no further follow up with urology. Progress notes, dated 10/09/2024, documented Resident 1 continuously unhooks catheter from the bag. Progress notes, dated 10/11/2024, documented Resident 1 continuously unhooks catheter from the bag. Progress notes, dated 10/14/2024, documented Resident 1 continuously unhooks catheter from the bag. On 11/21/2024 at 2:35 PM, Resident 1 was observed in his bed. The resident had an indwelling catheter in place. The resident said sometimes he would get up alone to go to the bathroom because the wait was too long. Resident 1 said sometimes they do disconnect their catheter. Resident 1 could not explain why they do this. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility incident report, dated 11/05/2024, documented Resident 1 was found in the bathroom up against the wall next to the toilet. The resident's call light was turned on. Staff assisted the resident to bed and noted three skin tears to their arms. Resident 1 had disconnected their catheter tube from the drainage tube. On 11/08/2024, 11/14/2024, and 12/17/2024, the resident fell during attempts to use the bathroom. The hospital history and physical, dated 12/09/2024, documented Resident 1 was admitted to the hospital on 12/08/2024 with septic shock due to a urinary tract infection (UTI). The resident's blood pressure was 66/44 (normal 120/80) and white blood cells were 20.4/L (normal 4.5 to 11.0/L). On 12/20/2024 at 2:53 PM, Staff G, Nursing Assistant, said Resident 1 would often disassemble their indwelling catheter. Staff G said the resident attempted to self-transfer to the toilet frequently and would say they have to urinate, despite the catheter. Staff G said the resident would also disassemble the catheter when staff assisted the resident to the toilet and in bed. Staff G said they had not been given any specific instructions regarding the resident disassembling the catheter. Staff G said she knew from her background to clean off the catheter with alcohol. At 3:15 PM, Staff E, Licensed Practical Nurse (LPN), said Resident 1 disassembled the indwelling catheter frequently. Staff E said staff need to check on the resident frequently because he would go to the bathroom and disassemble the catheter. Staff E said there had been no discussions related to the catheter, risk for infection, or plans going forward. Staff D, LPN, said the resident disassembled the indwelling catheter frequently. Staff D said Resident 1 last saw urology on 02/10/2023. Staff D said the urology notes indicated the resident should return if there were problems with the resident's catheter. Staff D said she would consider the issues the resident was having to be a concern and Resident 1 should return to urology. At 3:43 PM, Staff B, Registered Nurse and Director of Nursing, said Resident 1 would often disassemble their indwelling catheter tubing. The resident typically did this in bed and in the bathroom. Staff B said there was no specific guidance for staff to manage this issue and could not find anything in the care plan. Staff B said there had been no urology referrals to see if they could help address this issue. There has not been a discussion regarding a potential suprapubic catheter. As the infection control nurse, Staff B said there had been no discussions how to best manage the infection risk to the resident. Staff B said Resident 1 had just returned from the hospital due to a urinary tract infection related to the catheter. Reference WAC 388-97-1060 (3)(c)