

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 03/14/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interview and record review, the facility failed to report to the state agency and log allegations of abuse/mistreatment by staff on the reporting log within five working days for 8 of 14 residents (1, 2, 3, 7, 8, 10, 14, & 15) reviewed for abuse and neglect. This failure placed residents at risk for repeated incidents, unmet care needs and unidentified abuse and/or neglect.</p> <p>Findings included .</p> <p>Facility policy, Abuse and Neglect, dated 12/01/2022, documented all alleged or suspected incidents of abuse, neglect, and misappropriation of property will be reported and investigated in accordance with State and Federal rules.</p> <p><Resident 1 & 14></p> <p>Resident 1's quarterly Minimum Data Set (MDS/an assessment tool) dated 01/09/2025, showed Resident 1 was admitted to the facility on [DATE] with intact cognition.</p> <p>Resident 14's quarterly MDS, dated [DATE], showed Resident 14 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 11/22/2024, documented Resident 14 wandered into to Resident 1's room. Resident 1 was observed to hit Resident 14 in the forearm with a closed fist.</p> <p>Incident Log, dated November 2024, did not show any entries related to incident on 11/22/2024. The Log showed the 11/22/2024 allegation was not reported to the State Agency.</p> <p><Resident 7 & 15></p> <p>Resident 7's quarterly MDS, dated [DATE], showed Resident 7 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Resident 15's annual MDS, dated [DATE], showed Resident 15 was admitted to the facility on [DATE] with moderately impaired cognition.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress notes, dated 12/05/2024, documented staff heard yelling and cursing, witnessing Resident 7 and Resident 15 fighting in Resident 15's room. A nursing assistant intervened but Resident 15 continued to strongly grab Resident 7's arm and elbow. Resident 7 was observed to have blood stains on the sleeves of their shirt. A 2 x 2 fresh skin tear on the right upper arm was observed.</p> <p>The Incident Log, dated December 2024, showed no evidence the 12/05/2024 allegation was reported to the State Agency.</p> <p><Resident 7></p> <p>Resident 7's quarterly MDS, dated [DATE], showed Resident 7 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 12/06/2024, documented an unknown resident shouted at and nearly hit Resident 7. The incident required staff intervention to separate the 2 residents.</p> <p>Progress notes, dated 02/18/2025, documented there was a resident to resident physical altercation between Resident 7 and an unnamed resident. The unnamed resident was heard denying theft of belongings. The resident was heard asking do you want me to whoop your ass? Resident 7 was heard hitting the resident.</p> <p>The facility's Incident Logs did not show any entries related to incident on 12/06/2024 and 02/18/2025 incidents. The allegations were not reported to the State Agency.</p> <p><Resident 1 & 2></p> <p>Resident 1's quarterly MDS, dated [DATE], showed Resident 1 was admitted to the facility on [DATE] with intact cognition.</p> <p>Resident 2's annual MDS, dated [DATE], showed Resident 2 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 12/07/2024, documented Resident 1 and Resident 2 were observed to have a physical altercation. Staff separated the resident. Resident 1 stated they hurt [Resident 2] because he was a killer.</p> <p>The Incident Log, dated December 2024, showed the facility did not report the 12/07/2024 incident until 12/10/2024.</p> <p><Resident 7 & 8></p> <p>Resident 7's quarterly MDS, dated [DATE], showed Resident 7 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Resident 8's quarterly MDS, dated [DATE], showed Resident 8 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress notes, dated 12/06/2024, documented staff heard a distressful noise into Resident 7's room. Staff found Resident 7 holding Resident 8 in a headlock. Staff broke up the altercation. Resident 8 was found with bruising to the right eye lid and superficial abrasions to their nose and forehead.</p> <p>The Incident Log, dated December 2024, showed no evidence the 12/31/2024 allegation was reported to the State Agency until 01/02/2025.</p> <p><Resident 1 & 15></p> <p>Resident 1's quarterly MDS, dated [DATE], showed Resident 1 was admitted to the facility on [DATE] with intact cognition.</p> <p>Resident 15's annual MDS, dated [DATE], showed Resident 15 was admitted to the facility on [DATE] with moderately impaired cognition.</p> <p>Progress notes, dated 12/31/2024, documented staff were alerted to a resident-to-resident altercation between Resident 1 and Resident 15. Resident 1 had demanded Resident 15 give them their watch. When Resident 15 refused, Resident 1 hit Resident 15 three times.</p> <p>The Incident Log, dated December 2024, showed no evidence the 12/31/2024 allegation was reported to the State Agency.</p> <p><Resident 3></p> <p>Resident 3's quarterly MDS dated [DATE], showed Resident 3 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 01/01/2025, documented Resident 3 was sitting in front of the television and an unnamed resident leaned towards Resident 3's face. Resident 3 pushed the other resident.</p> <p>The Incident Log, dated January 2025, did not show the incident 01/01/2025 logged. The Log did not show evidence the 01/01/2025 incident was reported to the State Agency.</p> <p><Resident 10></p> <p>Resident 10's annual MDS, dated [DATE], showed Resident 10 was admitted to the facility on [DATE] with intact cognition.</p> <p>Progress notes, dated 01/24/2025, documented Resident 10 reported they were missing \$10. The resident reported they had two \$5 bills in their pants pocket and accused the nursing assistant of taking the money.</p> <p>Incident Log, dated January 2025, showed the 01/24/2025 allegation was not reported to the State Agency until 01/28/2025.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/14/2025 at 2:23 PM, Staff C, Registered Nurse and Investigation Nurse, said the incidents were not reported timely, reported at all, and were not logged on the Incident Log. Staff C said some logging was missed when they received some erroneous information, and some incidents did not need to be logged. Staff C said some incident reporting was missed when she was out on leave. Staff C said she felt the direct care staff needed support to report incidents rather than waiting for Staff C to report. Staff C said staff would be educated on the reporting process.</p> <p>At 3:25 PM, Staff B, RN and Director of Nursing (DNS), said she was unaware of issues with reporting and investigating. Staff B said she expected incidents were investigated and reported timely.</p> <p>At 3:30 PM, Staff A, Administrator, said staff should be reporting and investigating timely. Staff A said he did not want staff to fear reporting and wanted staff to feel empowered to report.</p> <p>Reference WAC 388-97-0640(5)(a) (6)(c)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40914</p> <p>Based on interviews and record review, the facility failed to thoroughly investigate an allegation for 2 of 14 residents (3 & 7) reviewed for accidents. Facility failure to complete investigations placed residents at risk for ongoing neglect and abuse, unmet needs, and decreased quality of life.</p> <p>Findings included .</p> <p>Facility policy, Abuse and Neglect, dated 12/01/2022, documents all incidents of alleged or suspected abused, neglect, personal and/or misappropriation of property and reported and investigated in accordance with State and Federal rules.</p> <p><Resident 7></p> <p>Resident 7's quarterly Minimum Data Set (MDS/an assessment tool), dated 02/28/2025, showed Resident 7 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 12/06/2024, documented an unknown resident shouted at and nearly hit Resident 7. The incident required staff intervention to separate the 2 residents.</p> <p>Progress notes, dated 02/18/2025, documented there was a resident to resident physical altercation between Resident 7 and an unnamed resident. The unnamed resident was heard denying theft of belongings. The resident was heard asking do you want me to whoop your ass? and Resident 7 was heard hitting the resident.</p> <p>The facility could not provide investigations for the incidents on 12/06/2024 and 02/18/2025.</p> <p><Resident 3></p> <p>Resident 3's quarterly MDS, dated [DATE], showed Resident 3 was admitted to the facility on [DATE] with severely impaired cognition.</p> <p>Progress notes, dated 01/01/2025, documented Resident 3 was sitting in front of the television and an unnamed resident leaned towards Resident 3's face. Resident 3 pushed the other resident.</p> <p>The facility could not provide investigations for the incidents on 01/01/2025.</p> <p>On 03/14/2025 at 2:23 PM, Staff C, Registered Nurse and Investigation Nurse, said these incidents should have been investigated. Staff C could not find evidence of an investigation.</p> <p>Reference WAC 388-97-0640 (6)(a)(b)</p>		