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	07/02/2025

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 - 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** . Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines during the use of a mechanical lift and the lift sling for 2 of 3 residents (Residents 1, 5) reviewed for falls. The facility failed to assess, evaluate the root cause, and implement fall prevention interventions specific to resident needs for 4 of 6 sampled residents (Residents 1, 2, 3, and 4) reviewed for accidents. In addition, the facility failed to follow manufacturer instructions for routine, documented inspection of the mechanical lift slings. Resident 1 experienced harm when they sustained a hip fracture when transferred with a mechanical lift and sling in a manner inconsistent with the manufacturer instructions. These failures placed all residents that required mechanical lift transfer at risk for avoidable falls, physical injuries, functional decline, and diminished quality of life. Findings included . <Mechanical lift sling> <Resident 1> Resident 1 was admitted to the facility on [DATE]. The quarterly minimum data set (MDS), dated [DATE], documented that the resident had no cognitive impairment and was dependent on staff for activities of daily living (ADLs). Resident 1 had no recent history of falls. The care plan, dated 12/21/2023, documented Resident 1 was at risk for falls due to chronic debility and decreased sensation to bilateral low extremities. Staff would use a two-person transfer with a mechanical lift and a medium red toileting sling, ensuring flaps were not bunched underneath the resident. On 06/17/2025 at 10:25 AM, Resident 1 was observed in their room, in bed. In a concurrent interview at that time, the resident reported they were recovering from a hip fracture and things were going well so far. The resident said they remembered the fall. Resident 1 said they didn't hook it up to the Hoyer [mechanical lift] the right way. Resident 1 did not see how the staff hooked her up because she was not watching but felt that way because there was never a problem with the sling before. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	The facility investigation, dated 06/01/2025, documented Resident 1 fell during a transfer with the mechanical lift. The staff were transferring the resident from the bed into the wheelchair when the resident slid through the mechanical lift sling, bottom first, falling to the floor. Resident 1 hit their head on the bar of the mechanical lift resulting in a head laceration. Resident 1 was transported to the hospital. Witness statements noted staff used the red toileting sling to transfer the resident. The resident was noted to be secured appropriately with the legs crossed underneath both resident's legs. The investigation conclusion was noted as unable to determine the root cause of this fall and found the resident was transferred out of bed according to the care plan. Review of the Vancare Hygiene Sling Instruction Sheet, undated, documented strap of the legs should be crisscrossed between the legs of the resident and in front of the resident. Progress notes, dated 06/11/2025, documented Resident 1 was found to have a right hip fracture from the fall to the floor. During an interview on 06/04/2025 at 2:25 PM, Staff F, nursing assistant (NA), said she assisted Resident 1 with the transfer which resulted in the fall out of the mechanical lift. Staff F said they were getting the resident up into the wheelchair. They hooked the resident up like they normally did. They used the red toileting sling, hooking both straps to the top of the mechanical lift. They bucketed the straps on the resident's legs describing this as both straps going under the legs but not crisscrossed in-between the legs. As they lowered the resident into the chair, the resident slid through the straps and fell to the floor. One of the resident's legs remained hanging in the sling and the other fell to the floor. Staff F said it was like the resident fell through a trap door. Staff F said she used the sling how she was trained. She said, the sling is not safe, but did not know of any other incidents with the sling, just close calls. During an interview on 06/04/2025 at 3:00 PM, Staff K, NA, and Staff L, NA, said they bucket the red toileting sling when transferring residents. Both Staff K and Staff L said they were trained to use the red toileting sling this way. Staff K said the sling is safe if you use it right. During an interview on 06/04/2025 at 3:33 PM, Staff H, NA, said he was trained to bucket the red toileting sling when transferring residents. Staff H said there were no safety issues with the sling if you use it right. During an interview on 07/02/2025 at 4:19 PM, Staff C, Registered Nurse and Investigation Nurse, said the staff reported they crisscrossed the straps under the legs but not between the legs. Staff C did not investigate the manufacturer instructions to determine if the leg straps were used appropriately. Staff C could not state how the red toileting sling should be used. Staff C said the care plan did not note how the leg straps should be placed. Staff C said she was unsure if this was the appropriate sling for the resident due to the resident's lack of core strength and weight carried in their midsection. Therapy had recommended the red toileting sling at some point, but a recent reassessment was conducted, and a new sling was chosen. During an interview on 07/02/2025 at 5:29 PM, Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN), said she did not know the correct way to use the red toileting sling and could not say if staff used the red toileting sling appropriately. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	During an interview on 07/30/2025 at 5:04 PM, an email communication from Staff B documented training and education was started related to the proper use of the red toileting sling. <Resident 5> Resident 5 was admitted to the facility on [DATE] with diagnosis of renal failure and multiple sclerosis. The annual MDS, dated [DATE], documented Resident 5 had no cognitive impairment and was dependent on staff for ADLs. During an observation on 06/04/2025 at 3:37 PM, Staff H positioned the red toileting sling around Resident 5's back with the assistance of Staff L. The staff adjusted the sling and wrapped it around Resident 5's waist and clipped it. They positioned the chair in a reclining position to position leg straps under the resident. The sling's straps were bucketed under both legs, not in-between the resident's legs. Staff H opened the legs of the mechanical lift and positioned the chair between legs. The staff hooked the straps on the top hook and the bottom hooks. Both staff support the resident as they lifted and transferred the resident into bed. They lowered the resident into bed and remove the lift, then sling. During an interview on 07/02/2025 at 4:19 PM, Staff C could not state how the red toileting sling should be used. During an interview on 07/02/2025 at 5:29 PM, Staff B, DNS and RN, said she did not know the correct way to use the red toileting sling. During an interview on 07/30/2025 at 5:04 PM, an email communication from Staff B documented training and education was started related to the proper use of the red toileting sling. <Fall investigation & Assessment of Preventative Measures> <Resident 1> Resident 1 was admitted to the facility on [DATE]. The quarterly minimum data set (MDS), dated [DATE], documented the resident had no cognitive impairment and was dependent on staff for ADLs. Resident 1 had no recent history of falls. The facility investigation, dated 06/01/2025, documented Resident 1 fell during a transfer with the mechanical lift. The staff were transferring the resident from their bed into their wheelchair when the resident slipped out of the mechanical lift sling, falling to the floor. Resident 1 hit their head on the bar of the mechanical lift resulting in a head laceration. Resident 1 was transported to the hospital. Witness statements noted staff had used the red toileting sling to transfer the resident. The resident was noted to be secured appropriately with the legs crossed underneath both resident's legs. The investigation conclusion is noted as unable to determine the root cause of this fall and found the resident was transferred out of bed according to the care plan. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	During an interview on 07/02/2025 at 4:19 PM, Staff C, said she completed the investigation on Resident 1's fall. The staff reported they crisscrossed the straps under the legs but not between the legs. Staff C did not investigate the manufacturer instructions to determine if the leg straps were used appropriately. Staff C could not state how the red toileting sling should be used and was not aware the manufacturer guidelines directed staff to crisscross between their legs. Staff C said the care plan did not note how the leg straps should be placed. Staff C said she did not evaluate other residents using the sling and did not watch residents transferred with the sling. <Resident 2> Resident 2 was admitted to the facility on [DATE]. The annual MDS, dated [DATE], documented the resident had moderate cognitive impairment and required substantial/maximal assistance from staff for ADLs. Resident 2 had two or more falls in the recent past/look back period with no injury and two or more falls with injury. The care plan, dated 06/29/2025, documented Resident 2 had actual falls due to Huntington's disease (a neurological disease which affects thinking ability, movements, and mental health) and an unsteady gait. The resident is noted as having 15 falls since January 2025. On 06/17/2025 at 11:05 AM, Resident 2 was observed lying in bed. The wheelchair was observed to have no anti-roll device. The fall investigation, dated 03/13/2025, documented Resident 2 fell on the floor in front of his wheelchair. The resident sat in wheelchair without waiting for staff to sit. Intervention included an anti-roll back wheelchair. The fall investigation, dated 03/13/2025, documented Resident 2 was sitting on the floor at the entrance of his room. Water was on the floor. It appeared he had been washing his hands. Poor lighting and improper footwear were noted. No documentation of prior toileting assistance was noted. No staff interviews related to the fall were noted. The care plan, dated 03/14/2025, documented the resident would be assisted with washing their hands. The investigation did not assess for prevention interventions related to the poor lighting, improper footwear, or the last time the resident was assisted with toileting. The fall investigation, dated 03/14/2025, documented Resident 2 fell when they stood up abruptly from the chair in their room then fell and hit their head. Staff were present in the room. The resident pointed to their fingernails and staff determined they wanted their fingernails cut. Portions of the investigations fall assessment were left blank. The root cause was gait imbalance. No interventions were documented. The fall investigation, dated 03/14/2025, documented Resident 2 had an unwitnessed fall in their room. The resident was found on the floor by the recliner. The resident wanted to use the bathroom. Portions of the investigations fall assessment were left blank. The investigation did not determine the last time the resident was assisted with toileting or if the resident fell from the bed, recliner, or wheelchair. The care plan, dated 03/14/2025, documented a referral for therapy to consider an anti-roll back wheelchair. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	The fall investigation, dated 04/12/2025, documented Resident 2 was found on the floor next to the bed. The investigation noted the resident did not use a call light. Portions of the investigations fall assessment were left blank. The investigation did not determine the last time the resident was assisted with toileting and what type of footwear the resident was wearing. The root cause determined is Resident 2's impulsiveness and self-transfers. The intervention was to add a soft touch call light to Resident 2's room. The fall investigation, dated 04/16/2025, documented Resident 2 was found sitting next to their bed on the floor. The resident did not use the call light. The care plan, dated 04/14/2025, documented Resident 2 needed a soft touch call light. The fall investigation, dated 06/03/2025, documented staff heard a loud bang and found Resident 2 on the floor next to the recliner. The resident sustained a cut to the right temple measuring 1.5 centimeters (cm) x 0. 5 cm. A predisposing factor was listed as furniture but did not include how the furniture contributed to the fall. The resident had improper footwear on at the time of the fall. The investigation did not determine the last time the resident was assisted with toileting, whether the resident used the call light or within reach, or where the resident was prior to the fall. The root cause determined Resident 2 may have taken themselves to the bathroom or may have been sleeping and fallen out of bed. No care plan interventions were noted in the investigation or care plan. The fall investigation, dated 06/04/2025, documented Resident 2 was found sitting in the hall in front of his room with the food cover from their food tray next to him. The investigation did not determine the last time the resident was assisted with toileting, whether the resident used the call light or within reach, or where the resident was prior to the fall. The root cause determined the resident was trying to return the food cover to staff. The care plan, 06/05/2025, document staff will remove the food cover from the food trays. During an interview on 07/02/2025 at 4:19 PM, Staff C said the staff did not place the soft touch call light timely. <Resident 3> Resident 3 was admitted to the facility on [DATE]. The annual MDS, dated [DATE], documented the resident had severe cognitive impairment and required substantial/maximal assistance from staff for ADLs. Resident 2 had no recent falls. The care plan, dated 06/27/2025, documented Resident 3 was at risk for falls due to Parkinson's disease, generalized weakness and decreased mobility. Resident 3 had 11 falls since January 2025. On 06/17/2025 at 11:48 AM Resident 3 was observed in their wheelchair. No anti-roll devices were noted on the wheelchair. The fall investigation, dated 03/20/2025, documented Resident 3 was found on the floor in the hallway holding their shoe. The assessment of the fall was blank in some sections and there were no staff interviews related to the fall. The root cause of the fall was self-shoe removal. The resident was to be assessed for anti-roll back wheelchair. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	The fall investigation, dated 04/28/2025, documented Resident 3 was in the shower area of the bathroom, on the floor and was likely standing using [shower] bar when lost balance. The resident's cell phone was on the ground. One brake was locked on the wheelchair. The investigation assessment was blank in some sections and there were no staff interviews related to the fall. The section noting last time toileted or brief check or change was left blank. The root cause and interventions included follow up for a urinary tract infection (UTI). The care plan, dated 04/28/2025, documented request urine analysis. The fall investigation, dated 05/23/2025, documented Resident 3 was found sitting on the floor facing the sink. The resident had toileted themselves. The investigation did not include interviews from staff or the last time the resident was assisted with toileting. Portions of the investigation assessment were incomplete or missing. The root cause was attempting to toilet on his own. The care plan, dated 05/27/2025, documented Resident 3 was sent the resident to the emergency room (ER). The fall investigation, dated 05/24/2025, documented Resident 3 attempted to grab a coke out of their fridge and fell. The wheelchair brakes were not locked. The assessment of the fall was blank in some sections and there were no staff interviews related to the fall. The intervention noted was to continue the same plan of care. The fall investigation, dated 05/24/2025, documented Resident 3 fell out of bed. The investigation assessment was blank in some sections and there were no staff interviews related to the fall. The investigation does not mention when staff last saw the resident or when they last toileted the resident. The intervention was to send to the ER. The investigation lacked a root cause of the fall. During an interview on 07/02/2025 at 4:19 PM, Staff C said Resident 2 and Resident 3 did not currently have an anti-roll back chairs and there was a long wait to get one. Staff C said no other interventions were implemented in its place. Staff C said there were pieces missing in each Resident's investigations. The unit coordinators were supposed to be gathering all the information, but it was done inconsistently. All fall investigations should be thoroughly investigated including an assessment of the fall and details before and after, root cause of the fall, and a care plan intervention. <Resident 4> Resident 4 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident had no cognitive impairment and was dependent on staff for ADLs. Resident 2 had one recent fall with no injury. The care plan, dated 05/27/ 2025, documented Resident 4 was at risk for falls due to a disease of the nervous system causing muscle weakness and loss of control. The resident would be reminded to use the call light, encouraged to be active, and ensure they are wearing the proper footwear. The fall investigation, dated 05/24/2025, documented Resident 1 fell to the floor while reaching their glasses. The investigation noted staff will assess for an eyeglasses strap. No follow up in the investigation or care plan noted if the eyeglasses strap was obtained. During an interview on 07/02/2025 at 4:19 PM, Staff C said the resident did get an eyeglass strap but was not in the care plan. (continued on next page)

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	07/02/2025

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 - Actual harm Residents Affected - Few	<Sling care> Review of the Vanderlift Operating Manual, November 2017, documented that nurse or professional rehabilitation staff must inspect all slings at least once a month for signs of damage, lose and missing stitching and/or tears or excessive wear that may cause the sling to fail. Slings that are damaged or excessively worn must be removed from service. A permanent record of each inspection and action taken should be kept by the facility. During an interview on 07/02/2025 at 5:29 PM, Staff B said they did not keep a record of the sling inspections. Reference WAC 388-97-1060(3)(g) .