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	07/11/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse/neglect/mistreatment for 1 of 6 residents (Resident 3) reviewed for allegations of abuse/neglect. Failure to thoroughly investigate the allegations of abuse/neglect placed the residents at risk for continued mistreatment, unmet needs, and diminished quality of life.Findings included .According to the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), all incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. A thorough investigation is a systematic collection of review/evidence/information that describes and explains an event or a series of events to determine what occurred and make necessary changes to resident's plan of care and services to prevent reoccurrence. The investigation should include the who, what, when, where, why and how, of the incident and establish a reasonable cause within 24 hours of the incident.Review of the facility's policy titled, Resident Abuse Prevention, dated 12/18/2024, showed that staff were trained regarding how to report allegations of abuse and that an investigation would be conducted for reported allegations. Resident 3 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 05/05/2025, showed the resident had moderate cognitive impairment, displayed rejection of care, and was medically complex. A progress note, dated 05/22/2025 at 11:47 AM, by Staff L, RN, Neighborhood coordinator, showed that during a visit to update the resident about upcoming appointments the resident continued to have multiple complaints about staff not caring for his needs pertaining to his wound/skin treatment.Review of Resident 3's Treatment Administration Record for May 2025 showed Staff I, Registered Nurse (RN), was the nurse who performed the dressing change on 05/22/2025.Review of Resident 3's progress note, dated 05/24/2025 at 1:19 PM, showed that the resident was upset with multiple care related concerns and the administrator, nurse practitioner, management, supervisor and social worker was notified. Review of Resident 3's progress note, dated 05/25/2025 at 6:41 AM, by Staff I showed that the Staff I was told by Staff J, Licensed Practical Nurse (LPN) that the resident did not like him and reported if Staff I came in there ever again he would punch him. Staff I could no longer provide care to Resident 3. Review of Resident 3's progress note, dated 05/29/2025 at 5:21 AM, by Staff I showed Staff I attempted to assist Resident 3, and the resident was quoted as saying, Get f*ck out of here or I will bust your ass. Shift supervisor was notified, and email was sent to manager and social worker.Review of Department records on 05/29/2025 at 1:33 PM, showed a State Agency Complaint Intake was reported that during the early morning of 05/22/2025, a male night shift nurse allegedly treated Resident 3 rough during an abdominal dressing change and the dressing was placed on a windowsill and then replaced the same dressing back on. The resident reported this to the charge nurse, the social worker, and the Director of Nursing. During an interview on 06/11/2025 at 1:22 PM, Resident 3 said that on the early morning of 05/22/2025, a male nurse treated him rough during a dressing change. Resident 3 said the staff member asked if the resident could hold his abdomen up while they cleaned and redressed the area. Resident 3 said he could not assist him, and the nurse manipulated his abdomen in a painful way and placed the dressing which included previously placed ointment on it, on the windowsill and then replaced it back to his groin. Resident 3 said after the shift change, he requested to speak to the nurse and reported it to her. Resident 3 said he reported the incident to multiple nurses and multiple nursing assistants, and he asked that Staff A come speak with him. He believed multiple staff were aware and no one had done anything to follow up. The situation left him feeling, uncomfortable and questions the care every time someone comes in. Resident 3 said he had not seen the same staff member again.Review of a Social Worker Note, dated 05/30/2025, by Staff N, Social Worker, showed that a referral from nursing was received and reported that Resident 3 was planning on going to the nearest police station to file a complaint that he was not being properly cared for. Staff N met with Resident 3 to ask about his concerns and the resident reported he did not need any follow up, it was being taken care of.Review of a Social Worker Note, dated 05/31/2025 at 11:10 AM, by Staff M, Social Worker, showed they received an email at 9:40 AM from Resident 3 asking to see him, when they arrived the resident reported he no longer needed to speak with them. Review of the facility incident log for 05/17/2025 to 06/11/2025 showed no entry for reported care concerns to being rough handled and treatment care concerns on 05/22/2025. The facility was unable to provide an investigation/incident report for the alleged allegations from 05/22/2025. Review of

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the level of supervision required to prevent residents from eloping (exiting the facility without the required supervision) or attempting to exit the facility for 2 of 6 sampled residents (Resident 1 and 2) reviewed for accidents and failed to timely correct the wander guard system in place. These failures placed residents at risk of significant injury and a decreased quality of life.Review of the facility policy titled, Missing Resident/Elopement, dated 09/22/2023, showed that residents would be identified for risk of wandering and/or elopement and those at risk would be monitored and staff were to take necessary precautions to ensure resident safety. Resident 1 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS) an assessment tool, dated 05/05/2025, showed Resident 1 had severe cognitive impairment, required the partial/ moderate assistance with the use of a manual wheelchair, and a wander/elopement alarm was used daily. The care plan focus for elopement, initiated 11/06/2024, showed Resident 1 was an elopement risk related to previous attempts to leave the facility and interventions included that staff were to distract the resident from wandering by offering diversion, activities, food, television or books and Wander guard (an electronic alarm system that alerts staff when the resident approaches a door) placement. The wandering risk assessment, dated 05/06/2025, indicated Resident 1 was at low risk of wandering.Resident 2 was admitted to the facility on [DATE], the MDS dated [DATE], showed the resident was cognitively intact, independent with ambulation, and was careplanned to ambulate outside on the extensive campus independently. The wandering risk assessment, dated 02/11/2025, indicated Resident 2 was a low risk of wandering.A facility investigation report, dated 06/11/2025, showed Resident 1 triggered the alarm on floor 2 at door 8 (F2 courtyard) at 5:20 PM and the alarm was turned off at 5:25 PM. The resident then triggered the alarm on floor 2 at door 6 (main lobby) at 5:28 PM and the alarm was turned off at 5:29 PM. The resident then triggered the alarm on floor 1 at door 20 at 5:32 PM and the alarm was turned off at 5:33 PM. At 5:50 PM, Resident 1 was observed in his wheelchair being pushed by Resident 2 off of facility property, approximately 0.25 miles from the front entrance of the facility. The residents were observed on the side of the road by Staff E, Transportation, as he was returning to the facility. Staff E arrived at the facility and contacted Staff C, Registered Nurse and they both intercepted the residents who had made it approximately 0.50 miles from the main entrance of the facility. Staff C remained with the residents, while Staff E returned with the facility van. Resident 2 reported he was helping Resident 1, who reported he was going to another town.On 07/02/2025 at 4:22 PM, Resident 1 approached and asked if The Department staff could help him, to go someplace. Resident 1 was asked where he needed to go and he replied, across the street. Facility staff intervened and escorted the resident to the outside courtyard. In an interview on 07/09/2025 at 11:50 AM, Staff D, Registered Nurse (RN), Memory Care Neighborhood Coordinator, said that when a resident triggered the door alarm, staff should turn off the alarm and redirect the resident. Some redirection techniques could be to offer to go outside with them or activities or possibly assess if they needed to be toileted. Staff D said Resident 2 now resided in the memory care unit and had access to locked outside space. In an interview on 07/09/2025 at 1:19 PM, Staff F, Nursing Assistant (NA), said that they knew what residents were at risk of wandering/elopement by the use of a wander guard or if it was identified on the run sheets. Staff F said that if a resident was exit seeking, and triggering the alarm, staff should redirect the resident, maybe offer a snack and let the nurse know. Staff F said she was not aware Resident 1 had left the facility property. In an interview on 07/09/2025 at 2:17 PM, Staff G, RN, Neighborhood Coordinator, said when residents triggered the wander guard alarm, staff should reset the alarm and redirect the resident back to their unit.In an interview on 07/09/2025 at 2:33 PM, Staff C, RN, said she was in her office when Staff O came to her and reported he saw Resident 1 and 2 off of facility property. They went in staff O's private vehicle, and she stayed with the residents while Staff O returned with the facility van. Staff C said that Resident 1 stated he wanted to go home, and Resident 2 said he was taking him home. Staff C said she was not sure how Resident 1 exited the building, or if Resident 2 helped, but believed it was on the first floor. In an interview on 07/11/2025 at 4:38 PM, Staff C said nursing staff were not aware Resident 1 was missing on 06/11/2025. In an interview on 07/11/2025 at 1:40 PM, Staff H, RN, Investigative Nurse, said when a resident triggered the alarm staff were to respond to the alarm and redirect the resident or determine if they had any unmet needs; if they were not able to locate the residents, they should call all of the units to do a head count. Staff H said there was only one door that did not lock when the