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	04/07/2026

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** Based on observation, interview and record review, the facility failed to thoroughly assess resident risk for elopement and provide the level of supervision required to prevent residents from eloping (exiting the facility without the required supervision) for 1 of 4 residents (Resident 1) reviewed for accidents. This failure placed residents at risk for inadequate supervision, elopement and potential of life-threatening situations. Findings included.Review of the facility policy titled, Missing Resident, dated 08/23/2024, showed the facility would identify residents at risk for elopement and they would be monitored to ensure their safety. Review of the facility policy titled, Wandering, Unsafe Resident, Revised August 2014, showed the facility would identify residents at risk for wandering/elopement, assess for correctable risk factors, and assess residents at risk for appropriateness of the use of a wander guard (specialized, wearable-based security solution to protect residents with cognitive deficits from wandering). Review of the facility policy titled, Wander guard Wander Management System, dated 10/01/2024, showed that the device would be placed to protect residents as risk for elopement and/or unsafe wandering and would be reviewed quarterly. The procedure did not include a process of evaluating the potential discontinuance of the wander guard. Resident 1 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS), an assessment tool, dated 02/02/2026, showed Resident 1 had severe cognitive impairment, and was independent with dressing, sitting, standing, and was able to ambulate (walk) 150 feet without staff assistance. The care plan focus for elopement risk, dated 04/14/2025, showed the resident was at risk for elopement related to history of attempts to walk outside and unable to find way back and impaired safety awareness. Review of the Physician's Order, dated 04/14/2025, showed a wander guard was ordered for resident use for safety.Review of the Wander risk assessment, dated 08/05/2025 by Staff E, Registered Nurse (RN), showed Resident 1 was at moderate risk for wandering. Review of the progress note, dated 08/19/2025 at 1:37 PM by Staff C, RN, Resident Care Manager (RCM), showed that the wander guard alarm was discontinued.Review of the Wander Guard Event report for the bracelet #586896 in use for Resident 1 prior to being discontinued on 08/19/2025 showed 76 entries between 04/14/25 and 08/01/2025, with alarms at three different doors and the most recent entry was 08/01/2025. Review of the facility investigation report, dated 02/08/2026, showed that Staff F, RN, had observed a gentleman at the bottom of the hill entrance of the facility property at 11:55 AM, the staff member inquired if the man was ok and they replied they were just going for a walk. At 12:30 PM, the staff member inquired of Staff H, Nursing Assistant Lead (NAL), if the man observed was a resident. They confirmed it sounded like one of their residents and they attempted to locate him, and could not find them, the report also indicated Staff H, NAL, thought the resident had a wander guard. At 12:44 PM, Staff F, RN, left to attempt to locate the resident, stopping at local business along the way. The resident was located by Staff F, RN, at 1:15 PM in front of a music store (located 1.7miles away). The resident was safely brought back to the facility. The facility investigation report also showed that Resident 1 had a previous elopement on April 13, 2025.On 04/06/2026 at 1:05 PM, Staff E, RN, said they had completed the wander risk assessment on Resident 1 and that if the facility was going to (continued on next page)

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	discontinue the wander guard, they would expect them to review how many times the resident had exit seeking behaviors. Staff E said that Staff D (MDS RN) had reviewed that, and Resident 1 had not had any exit seeking behaviors for the previous six months and thought it was ok to DC the wander guard. On 04/06/2026 at 1:52 PM, Staff D, MDS RN, said wander risk assessments were completed on admission, quarterly, and as needed for changes. The care team revisited all devices in use by the residents quarterly and when they reviewed Resident 1 in August, the team felt it was appropriate to discontinue the wander guard. Staff D said that wandering and exit seeking would be similar risks and they were not aware of how they could determine if there had been exit attempts by the resident that were not part of the resident record. Staff D said they did not know how to attain the wander guard event report for a resident, and if they had that information available, they would not have recommended the wander guard to be discontinued. On 04/06/2026 at 2:09 PM, Staff C, RN/RCM said Resident 1 was observed by staff prior to lunch and staff became aware he was missing after lunch, but staff were able to locate the resident, and he was returned to the building. Staff C said that Staff D, MDS RN initiated the discontinuation of the wander guard and that the resident had not exited the building in months. She evaluated the residents' continued need for the wander guard by reviewing the progress notes. Staff C said they did not review the alarm event report to determine if the resident had exit seeking behaviors that were not part of the resident record, because they did not have access to that information, only Staff B, Director of Nursing (DNS) and Staff G, RN, Investigative Nurse, have access. Staff C said if the wander event report showed the resident was still exit seeking, the wander guard should not have been discontinued. On 04/06/2026 at 2:51 AM, Staff G, RN, Investigative Nurse, said the incident occurred on a weekend; one of the nurses was coming back to the facility and saw Resident 1 at the end of the driveway, and he told her he was just out for a walk, they asked other staff about the resident and they identified him as Resident 1, and began the search for them. Staff G did not believe staff were aware he was missing prior to Staff F, RN inquiring about the resident. Staff G believed there was enough staff to supervise the residents. Staff G said residents are assessed for wander risk on admission and quarterly and as needed for changes. Staff G was not aware of a way staff could assess for exit seeking that was not part of the resident record, if staff were hearing the wander guard alarm, they were not sure the resident was placed on alert, if they were exit seeking, they would expect them to be placed on alert. Staff G said sometimes the resident just walks by the door or gets too close and it will alarm. Staff G said reviewing the wander guard event report is not part of risk assessment, that they were aware of. Staff G said if the wander guard event report showed the resident was still triggering the alarms at various doors they should probably not have discontinued the wander guard. On 04/07/2026 at 4:42 PM, Staff A, Administrator said that residents are assessed at risk for wandering/elopement and they have a wander guard system in place. Staff A was not aware of the process for removal of the wander guard device for a resident identified at risk for wandering. Regarding Resident 1, he was not aware the device had been discontinued until after the event, it was reinstated after his safe return to the facility. Staff A said he thought it would make sems for staff to review the wander alarm event report as part of the decision process to discontinue the safety device. Staff A said they should have had a better system in place; they were evaluating that. Reference WAC 388-97-1060 (3)(g)