| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to manage his or her financial affairs.<br><br>Based on interview and record review, the facility failed to ensure all residents with personal funds accounts had access to their accounts after business hours and on the weekends for 7 of 10 sampled residents (Resident 121, 135,15, 3, 232, 4 & 14) reviewed for personal funds accounts. This failure placed residents at risk of not having access to their accounts during non-banking hours, a decreased sense of autonomy and a diminished quality of life. Findings included.On 05/05/2026 at 12:34 PM, Resident 121 said I can get money whenever I want except Saturday and Sunday. The doors were locked on the weekends.On 05/04/2026 at 3:08 PM, Resident 135 said they were told they could withdraw money on the weekend and get up to $100 by going to the front desk, but no one's ever there on the weekend so you really can't and during the week you could only withdraw money before 3 pm.On 05/04/2026 at 10:53 AM, Resident 15 said they could withdraw their money only during normal business hours because there was no one in the administrative area to withdraw money at night. Resident 15 said, they don't need the money at night and would withdraw earlier if they think they would need money after hours.On 05/05/2026 at 10:27 AM, Resident 3 said they could only access their money Monday through Friday from 8 AM to 4 PM and when asked about access to their money on Saturday and Sunday, Resident 3 said the office door was closed and there was no access.On 05/04/2026 at 2:20 PM, Resident 232 said, I can plan ahead if I need money on the weekend.On 05/04/2026 at 2:24 PM, Resident 4 said they could not access their money on Saturday or Sunday because the cashier doesn't work weekends and if they go up there on a Friday night, they could not get money after 3:00 PM. On 05/04/2026 at 11:26 AM, Resident 14 said they could only withdraw money during business hours, and they could plan ahead if they needed money on the weekends. On 05/07/2026 at 6:10 AM, Staff N, Registered Nurse 2, was asked what their process was when a resident came to them on their shift at night and wanted to withdraw money from their personal fund account and Staff N said, we don't have access. We used to have access but now lately we don't. Staff N said they would have to inquire more about it and would advise the resident to talk to social work to withdraw money.On 05/07/2026 at 6:09 AM, Staff O, Licensed Practical Nurse 2, was also asked the procedure to withdraw money out of a trust account at night and they said, We don't have access on night shift [to the trust money]. I would tell them to wait until morning when the office opens. Unfortunately, I am pretty new still and I have not had that happen.On 05/07/2026 at 9:12 AM, Staff P, Administrative Assistant 5, said the evening and night shift supervisors were aware of the process for accessing resident personal funds after hours. Staff P said we need to do more training. The staff needed to know how and where the funds were kept and how to check to see if a resident has money in their account. Staff P said there were new nurses and they would coordinate with the Director of Nursing Services to train the new staff, so they were aware of the process.On 05/11/2026 at 9:09 AM, Staff A, Administrator, said the residents should have access to their funds after hours and on weekends. Staff A said the evening and night shift supervisors were aware of the process and he wanted to make sure all the staff know what to do. Staff A said they have already provided staff training, on the evening and night shifts, to make sure the residents have access to their funds if they requested it.Reference WAC 388-97-0340(1)(2)(3) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a system that ensured copies of advanced directives (written instruction, such as a living will or durable power of attorney for health care) were requested from residents who indicated they had one, and/or to provide information and assistance to residents who expressed an interest in formulating one for 6 of 6 residents (Resident 105, 121, 135, 148, 10 & 232) reviewed for advanced directives. These failures placed residents at risk of not having their healthcare choices honored and/or detracted from residents' ability to have their healthcare preferences known. Findings included .Resident 105Resident 105 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed they had a durable power of attorney (DPOA) for healthcare but had not provided a copy to the facility.Review of the electronic health record (EHR) showed there was not a copy of Resident 105's DPOA for healthcare, nor was there documentation of staff attempts to obtain a copy. Resident 121Resident 121 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed the resident did not have an advanced directive but wanted further information and/or assistance formulating one. Review of the EHR showed there was no documentation that staff provided the resident with further information about advanced directives or assisted the resident with the process of formulating one.Resident 135Resident 135 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed the resident did not have an advanced directive but wanted further information and/or assistance with formulating one. Review of the EHR showed there was no documentation that staff provided the resident with further information about advanced directives or assisted the resident with the process of formulating one.Resident 148Resident 148 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed they had a DPOA for healthcare but had not provided a copy to the facility.Review of the EHR showed there was not a copy of Resident 105's DPOA for healthcare, nor was there documentation to show staff attempted to obtain a copy. Resident 10Resident 10 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed they did not have an advanced directive but wanted more information and/or assistance with formulating one. Review of the EHR showed there was no documentation that staff provided the resident with further information about advanced directives or assisted the resident with the process of formulating one.Resident 232Resident 232 was admitted to the facility on [DATE]. Review of the resident's admission agreement showed the resident had a durable power of attorney (DPOA) for healthcare but had not provided a copy to the facility.Review of the EHR showed there was not a copy of Resident 105's DPOA for healthcare, nor was there documentation of staff attempts to obtain a copy. On 05/07/2026 at 8:20 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, were asked to provide documentation of staff attempts to obtain copies residents' advanced directives who indicated they had them, and/or documentation showing facility staff provided further information about advanced directives and/or assisted with the process to formulate one for the above identified residents who had requested it. On 05/07/2026 at 10:53 AM, Staff A, Administrator, confirmed the above requested documentation was not present in the residents' records. Staff A explained that there had been some confusion with the advanced directive process and indicated facility staff social services were following up with the identified residents who had a DPOA for healthcare to obtain a copy and were in the process of providing further information about advanced directives and/or assistance with formulating one for the above residents that had requested it.Reference WAC 388-97-0300(1)(b)(3)(a)-(c) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) included adverse side effects and target behaviors were thoroughly documented and monitored, that as needed psychotropic medications limited to 14 days was reassessed, and Abnormal Involuntary Movement Scale (AIMS, a standardized, clinician-administered assessment designed to observe, quantify, and track involuntary movements in patients, especially those taking long-term antipsychotic medications) testing was completed within required timeframes for 4 of 5 sampled residents (Resident 19, 2, 121 & 13) reviewed for unnecessary medications. This failure placed residents at risk of unnecessary medication usage, increase in side effects without interventions, and a diminished quality of life. Findings included.Resident 19<br><br>Resident 19 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbances and anxiety (the specific type of dementia cannot be clearly identified, despite the presence of cognitive decline and memory loss), bipolar disorder (a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes), and generalized anxiety (intense, excessive and persistent worry or fear). The Quarterly Minimum Data Set (MDS, an assessment tool) dated 03/20/2026, documented Resident 19 was unable to complete interviews, was severely cognitively impaired and relayed on staff for some cares.<br><br>A physician's order, dated 07/04/2025, documented Resident 19 was prescribed quetiapine (an antipsychotic) for bipolar with psychosis daily at bedtime.<br><br>A physician's order, dated 11/04/2025, documented Resident 19 was prescribed sertraline (an antidepressant) for depression (persistent feelings of sadness and loss of interest) daily in the morning. Resident 19 had no diagnoses of depression.<br><br>A physician's order, dated 02/11/2026, documented Resident 19 was prescribed lorazepam (an antianxiety) every 4 hours as needed (PRN) for terminal anxiety for 90 days.<br><br>A physician's order, dated 02/04/2026, documented Resident 19 was ordered to have an Abnormal Involuntary Movement Scale (AIMS, a standardized, clinician-administered assessment designed to observe, quantify, and track involuntary movements in patients, especially those taking long-term antipsychotic medications) test completed on the 16th of the month.<br><br>Resident 19's Mood State care plan, dated 03/03/2025, documented Resident had one target behavior listed under Behavior Tracking for quetiapine; paranoid statements (no details provided) and one target behavior under Behavior Tracking for sertraline; tearfulness (no other details provided).<br><br>AIMS testing<br><br>Review of the electronic health record (EHR), on 05/05/2026, showed no documentation an AIMS test was completed on 02/16/2026 or thereafter.<br><br>Psychotropic medication over 14 days<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An encounter (physician's) note, dated 02/12/2026, documented Resident 19 was on comfort focused care, after they returned to the hospital with a diagnosis of non-ST-segment elevation myocardial infarction (NSTEMI, where a coronary artery is partially blocked, leading to reduced oxygen supply to the heart muscle). The encounter note documented to start comfort care orders including pain medication and antianxiety as needed, discontinue nonessential mediations. The EHR showed no 14-day reassessment for the antianxiety medication.<br><br>Monitoring of side effects and target behaviors<br><br>Review of the EHR on 05/05/2026, showed no documentation of side effect monitoring for the antipsychotic, antidepressant or the antianxiety PRN. The EHR also showed no documentation of target behaviors for the antianxiety medication.<br><br>On 05/08/2026 at 9:08 AM, Staff G, Licensed Practical Nurse (LPN), said Resident 19 was mostly nonverbal, needed cueing for some tasks and liked to be independent with care. Staff G said Resident 19 originally had a lot of behaviors including exit seeking, yelling out and crying, but Resident 19 had a decrease in all his behaviors, and they have not seen any of those behaviors in about 3-4 months. Staff G confirmed Resident 19's behaviors had decreased enough last month the facility assessed the resident no longer require a wander guard (a wearable or system-based solutions designed to prevent wandering and elopement in residents with dementia or cognitive impairments) and it was removed.<br><br>On 05/08/2026 at 9:21 AM, Staff H, Registered Nurse/Neighborhood Coordinator, said in order to administer any psychotropic medication the facility must obtain a diagnosis (justification for use), consent and an order from the physician. The facility must also monitor target behaviors and side effects of the medication(s). Staff H reviewed the EHR and confirmed there was no side effect monitoring for any of the antipsychotic or antidepressant and no side effect or target behaviors for the antianxiety medication. Staff H said there should have been side effect monitoring and target behaviors for all the psychotropic medications. Staff reviewed Resident 19's Medication Administration Record (MAR) and said the target behaviors were listed there and under tasks. Staff H reviewed the MAR and the tasks and confirmed only one target behavior was associated with the antipsychotic (paranoid statements) and the antidepressant (tearfulness). When asked if tearfulness met the criteria for justification on use for an antidepressant, Staff H could not answer. Staff H said there should have been more target behaviors listed for Resident 19 and it was undetermined what target behavior correlated to what medication, it should have been more specific. Staff H was asked to find the AIMS test completed in February 2026. Staff H was unable to locate the AIMS test in February 2026 and confirmed no AIMS test had been completed since. Staff H said the AIMS should have been completed. When asked about psychotropic medication as a PRN, Staff H said, Resident 19 was located on another hall, he had experienced a lot of behavior issues and then was transferred to the memory care unit for a higher level of care. Staff H said earlier this year, Resident 19 received a diagnosis of cardiac disease and started displaying behaviors that included anxiousness, pacing, nervousness, facial grimacing/concerns, tearfulness and crying out (none of these were listed as target behaviors on the MAR or care plan, except tearfulness). When Resident 19 was diagnosed with the cardiac disease the physician placed Resident 19 on comfort care and ordered antianxiety medication. Staff H said PRN psychotropic medications were to be prescribed for 14 days and then reassessed for continual use. Staff H confirmed the medication was prescribed for 90 days, no 14-day reassessment was completed. Staff H said the antianxiety should have been assessed if needed. Staff H said over the past few months Resident 19 had shown a decrease in target behaviors.<br><br>On 05/08/2026 at 12:22 PM, when asked to locate the side effect and target behavior monitoring<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | orders, Staff B, Director of Nursing Services (DNS), confirmed there was no side effect monitoring for any of the psychotropic medications, no target behaviors listed for the antianxiety medication and said there should have been. Staff B reviewed the MAR, tasks and care plan for target behaviors related to the antipsychotic and antidepressant. Staff said there was one target behavior listed for each medication, antipsychotic-paranoid statements, and the antidepressant -tearfulness. When asked if tearfulness met the criteria for justification on use for an antidepressant, Staff B stated, I see where you are going with this and acknowledged that all of Resident 19's associated target behaviors should have been listed under each medication type on the MAR and on the care plan and it was not person centered. Staff B was asked to locate the AIMS test completed in February 2026. Staff B was unable to locate the AIMS test in February 2026, confirmed no AIMS test had been completed since and said the AIMS should have been completed. When asked about PRN psychotropic medications, Staff B said if psychotropic medication was being used PRN it required a 14-day order, then to be reassessed by the provider for continual use. If the medication was extended past the original 14 days, it needed justification for use. Staff B reviewed the antianxiety medication ordered (for comfort care) and confirmed there was no original 14-day order and the provider had not reassessed the need for the medication, only prescribed the 90-day PRN. When it was explained that Resident 19 had a decrease in target behaviors and never received a dose of the antianxiety medication, Staff B said it should have been reassessed.<br><br>Resident 2<br><br>Resident 2 was admitted on [DATE] with diagnoses that included major depressive disorder, unspecified dementia, unspecified severity with agitation, anxiety disorder and unspecified psychosis not due to substance or known, physiological conditions (a diagnosis given when a person exhibits clear psychotic symptoms, such as hallucinations or delusions, but the symptoms do not fully match any specific psychotic disorder). The Quarterly MDS, dated [DATE], documented Resident 2 was severely cognitively impaired and able to make needs known.<br><br>A physician's order, dated 02/18/2026, documented Resident 2 was prescribed Lorazepam every 4 hours PRN for terminal anxiety for 90 days.<br><br>On 05/08/2026 at 9:21 AM, Staff H, Registered Nurse/Neighborhood Coordinator, reviewed the EHR and confirmed there was no side effect monitoring or target behavior for the antianxiety said there should have been side effect monitoring and target behaviors.<br><br>On 05/08/2026 at 12:22 PM, when it was explained Resident 2 had been prescribed an anxiety medication and there was no side effect monitoring or target behaviors, Staff B, DNS, said there should have been. Staff B also confirmed there was no original 14-day order, and the provider had not reassessed the need for the medication, only prescribed the 90-day PRN.<br><br>Resident 121<br><br>Resident 121 was admitted to the facility on [DATE] with diagnoses of major depressive disorder and anxiety disorder. The Quarterly MDS, dated [DATE], documented Resident 121 was cognitively intact.<br><br>Resident 121 had two orders for psychotropic medications as follows:<br><br>1) Buspirone (anti-anxiety medication) two times daily for anxiety, dated 10/29/2025.2) Fluoxetine (antidepressant medication) every morning for Major Depressive Disorder (MDD), dated 10/29/2025. (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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the MAR and the Treatment Administration Record (TAR) from 04/01/2026 through 04/30/2026 and 05/01/2026 through 05/05/2026, showed that adverse side effects were not monitored for the medication Buspirone.<br><br>Review of Resident 121's care plan, initiated 10/29/2025, listed target behaviors as 1. Psychomotor agitation (restlessness, fidgetiness, calling out, etc.) 2. Self-report or observed sad affect. The care plan did not differentiate which of the target behaviors were to be observed for which medication prescribed.<br><br>Review of the Certified Nursing Assistant task documentation showed there were two different behavior monitors where nursing assistant staff could document behaviors exhibited by Resident 121. One monitor was for psychomotor agitation (restlessness, fidgetiness, calling out, etc.). The second monitor was for self-report or observed sad affect. The documentation did not specify which target behavior was being monitored for which medication.<br><br>On 05/08/2026 at 10:57 AM, Staff B, DNS, when asked their expectations for identifying target behaviors for psychotropic medications said that they were to be given for behaviors and staff would be monitoring for those behaviors. Staff B said behavior monitoring should be in place for each psychotropic medication. After reviewing the two medications Resident 121 was prescribed, Buspirone for anxiety and fluoxetine for MDD, Staff B was asked what specific target behaviors were being monitored and for which medication. Staff B said the target behaviors were not specific to the medications and the target behaviors overlapped for Resident 121. When asked how it would be determined if the medications were necessary if the target behaviors were not specific to the medications, Staff B said I see what you are going with that and said the EHR was not set up to differentiate between the specific medications and the target behaviors. When asked which medication sad affect was treating Staff B said it had not been indicated. When asked if documented target behavior of sad affect met criteria for MDD, Staff B said it was part of Resident 121's symptoms, Staff B did not elaborate on what other symptoms of MDD Resident 121 displayed.<br><br>During this same interview Staff B said she expected adverse side effects to be monitored for psychoactive medications. When asked if adverse side effect monitoring was in place for Resident 121's Buspirone, Staff B looked in the EHR and said she did not see adverse side effect monitoring in place, and it should have been.<br><br>Resident 13<br><br>Resident 13 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment, diagnoses of dementia with behavioral disturbance, anxiety disorder and depression, received antipsychotic and antianxiety medication, and there was physician documentation, dated 02/25/2026, that a gradual dose reduction (GDR) of the resident's antipsychotic medication was contraindicated. Record review showed Resident 13 had orders for the following psychotropic medications.a) Quetiapine (an antipsychotic medication) which the resident received from 09/19/2025- 03/16/2026 for a diagnosis of psychosis with hallucinations. On 03/17/2026 the diagnosis for the use of quetiapine was changed to dementia with behavioral with other behavioral disturbance.b) Buspirone (an antianxiety medication) initiated on 03/03/2025 for anxiety.c) Lorazepam (an antianxiety medication) initiated on 03/20/2025 for advanced dementia with severe agitation. Review of Resident 13's EHR showed an AIMS assessment was completed on 02/16/2026. There was no documentation to show staff completed a baseline AIMS assessment at the time Resident 13 was started on quetiapine (09/19/2025). In an interview on 05/11/2026 at 9:58<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | AM, Staff B, DNS, said an baseline AIMS assessment should have been completed when Resident 13's was started on quetiapine. When asked if one was completed Staff B stated, No. A Behavioral Symptom care plan, revised 01/22/2026, showed Resident 13 had diagnoses of dementia, depression, post-traumatic stress disorder (PTSD) and anxiety disorder. It documented a history of the resident using abusive language, such as yelling, screaming and threatening others, as well as a history of physical behaviors towards staff that included kicking, hitting, pushing and grabbing. Interventions included administering anti-anxiety medication for the target behaviors (TB) of restlessness, agitation, and aggression (verbal or physical), non-pharmacological interventions/approaches included: 1. Ensure safety of the resident and peers, creating space if needed and reapproaching after a few minutes. 2. Identify possible needs (pain, toileting, hunger, discomfort, overstimulation) and offer assistance. 3. Provide reassurance and supportive presence, allowing the resident to talk or express distress as needed. 4. Listen calmly and validate feelings, helping reduce fear, confusion, or frustration. 5. If agitation escalates, step back briefly to reduce stimulation and allow the resident space. 6. Reapproach calmly after a short interval, using reassurance and simple communication. A Mood care plan, revised 04/07/2026, documented the resident had issues with mood secondary to diagnoses of dementia, depression and PTSD which manifested as sleep challenges. A goal of will continue to function at current level with no signs and symptoms of depression was identified and the interventions were to encourage the resident to express feelings, provide support and reassurance, and perform psychotropic medication reviews per facility policy. Resident 13 comprehensive care plan did not identify or address the resident's psychosis, hallucinations, use of antipsychotic medication, or indicate what behaviors the quetiapine was initiated to target. Review of the March, April and May 2026 MAR showed there was no identification or monitoring of target behaviors or adverse side effects related to Resident 13's use of quetiapine, buspirone or lorazepam. During an interview on 05/11/2026 at 10:30 AM, when asked for documentation to show nurses were monitoring for adverse side effects associated with the use of lorazepam, buspirone and quetiapine Staff B, DNS, said no, not that's documented. When asked if the specific TBs each medication was initiated to treat, had been identified and were being monitored Staff B indicated agitation was a TB for all three medications and behavior monitoring was done by nurse aides in Point of Care (POC, a computer program where nurse aides chart). Review of Resident 13's behavior monitor in POC for May 2026 showed the following behavior monitors were in place.a) TB 1- Notice 1st signs: agitation &/or aggression: verbal or physical.b) TB 2- Upset, pacing, accusatory to staff.c) TB 3- Anxious mood exhibited by poor safety awareness (interacting w/ others) -Aggressive speech/ actions.d) TB 4- Resident pushing items: moves chairs, tries to push (fellow residents) in wheelchairs, or carts.e) TB 5- Target Behaviors: 1. Restlessness 2. Agitation (verbal or physical) 3. Aggression 4. Worsening symptoms in late afternoon or evening.f) TB 6- Notice 1st signs: pacing &/or irritability. The behavior monitors did not identify what TBs were associated with which medications. During an interview on 05/11/2026 at 12:30 PM, Staff B, DNS acknowledged staff did not identify specific TBs for the use of each psychotropic medication. When asked how the facility could assess the effectiveness of each medication and the need for continued use if all three psychotropic medications had the same TBs Staff B, said I see your point. Gradual Dose ReductionsReview of Resident 13's falls care plan, revised 01/22/2026, documented 4/5/26 Intervention- failed GDR will be placed back on prior dosage. The care plan did not indicate what medication had a failed GDR, or how it was determined (e.g. increased TB behaviors etc.) A 03/16/2026 provider note documented Gradual dose reduction of the patient's antipsychotic medication was recommended or ordered during this visit.Decrease Seroquel 12.5 mg to once daily for paranoia and agitation 2/2 [secondary to] dementia. A 04/03/2026 provider note documented, Decreased Seroquel 12.5 mg to once daily for paranoia and agitation 2/2 dementia, tolerating well, continue current dose and follow up in 2 weeks. A 04/06/2026 provider note documented, Seen and examined per nurse supervisor request for potentially failed Seroquel GDR. He has advanced dementia and does not answer questions appropriately. Nurse manager reports he has (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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | been extremely agitated and ramming his wheelchair into things, combative with care, and hard to redirect, all since Seroquel dose reduction. She does not believe he is hallucinating but hard to tell. He's calm at the moment, but I have seen him easily agitated and somewhat confrontational at times. The provider wrote an order to increase Resident 13's quetiapine to 25 mg every afternoon for paranoia and agitation secondary to dementia. Review of Resident 13's EHR showed no documentation to support the resident had demonstrated any increased agitation, combativeness, or difficulty being redirected. Nor was there documentation to support the resident had rammed his wheelchair into anything since 03/16/2026, when the quetiapine dose was reduced. Review of the progress notes from 03/16/2026 - 04/05/2026 showed no behaviors were documented. During an interview on 05/11/2026 at 4:12 PM, when asked if there was any documentation to support Resident 13 demonstrated increased behaviors or any behaviors at all after the GDR of the quetiapine on 03/16/2026 to support the determination that it was a failed GDR Staff B, DNS, indicated she saw one behavior documented in a progress note. Staff B said the documentation Does not support a failed GDR.<br><br>Reference WAC 388-97-0620 (1)(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on observation and interviews, the facility failed to have sufficient staff to ensure residents received timely call light responses during mealtimes. This failure placed residents at risk for accidents, injuries and diminished quality of life.Findings included .Staff InterviewsObservation and interview on 05/11/2026 at 11:01 AM, showed no Certified Nursing Assistants (CNA) on the A hall. Five residents were observed in their rooms. Staff G, LPN (Licensed Practical Nurse), stated during mealtimes CNA's were assisting with feeding residents in the dining room and on the hall. Staff G stated they were responsible for responding to call lights for the duration of the mealtimes (approximately an hour). Staff G stated a resident who required two staff for care during that time were told they would need to wait until mealtime was over.During an interview on 05/11/2026 at 1:03 PM, Staff S, CNA, stated I leave my hall at 11:35 AM to assist with dining in the dining room, that leaves one CNA on the hall to pass trays and then they come to assist with feeding in the dining room. The nurse on the hall answers lights and if a resident requires cares in pairs or two-person assist during that time they tell them they will have to wait until additional staff is back on the floor which is between 12:45-1:30 PM.Observation and interview on 05/11/2026 at 12:45 PM, showed no CNA's on the B-hall. Staff R, LPN, stated, We currently don't have any CNAs on the hall they are assisting with feeding in the dining room. The CNA's leave at 11:45 AM and usually get back on the hall at 12:40 PM, I answer all the call lights during that time.During an interview on 05/11/2026 at 1:08 PM, Resident 126 stated, I have waited over an hour and a half for a brief change at times. I turned on my call light at 12:30 PM and as you can see my light is still on. I think there is usually one staff on the hall from 11:45 AM until who knows when.Resident InterviewsResident 5During an interview on 05/05/2026 at 11:04 AM, Resident 5 stated in the past two weeks the longest amount of time they had to wait for their call to be answered was a couple hours.Resident 98During an interview on 05/04/2026 at 1:11 PM, Resident 98 stated, One time I thought I was having a heart attack, and I went to the end of the hallway, and nobody was around. I even called 911 and they arrived before staff responded to my call light. Sometimes the nurse on my hall has to take care of another hall, they are short staffed.Resident 105During an interview on 05/05/2026 at 10:29 AM, Resident 105 stated, During meals it can take staff some time to respond to my call light.Resident 135During an interview on 05/04/2026 at 3:11 PM, Resident 135 stated, I have waited an hour many times, I got back from lunch put on my call light and waited an hour. There is only one person on the hallway during mealtimes.Resident 4During an interview on 05/04/2026 at 2:04 PM, Resident 4 stated, I have waited over an hour for my call light to be answered on more than one occasion because they were waiting for staff from another floor or the staff were in training. JustDuring an interview on 05/11/2026 at 4:57 PM Staff B, Director of Nursing, stated during mealtimes the licensed nurse (LN) was the only member of staff on the halls and was responsible for answering call lights. Staff B stated CNA's were assisting with feeding in the dining rooms during mealtimes. Staff B stated the expectation was if a resident required 2 members of staff during mealtime the LN would go to the dining room to request assistance from a CNA.Reference WAC 388-97-1080(1), 1090(1). |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to maintain proper refrigerator, freezer and dishwasher temperatures logs for 1 of 1 kitchen and 4 of 4 serveries (AC, ABCD, EG, EFGH serveries) and prevent contamination during meal preparation services for 1 of 1 serveries (AC) reviewed for food service safety. The failure to maintain documented refrigerator/freezer and dishwasher temperature logs and prevent cross contamination placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life. Findings included .Cross contaminationOn 05/06/2026 at 12:00 PM, Staff J, Lead Food Services worker, started plating lunch meals in the AC servery with gloves on. Staff J reviewed the resident's meal card tickets, that were wrapped in a plastic sleeve, before they grabbed a plate warmer and a plate. Staff J placed the hot food required by meal type on the plate and then placed the meal card on the tray and then retrieved the required items like pea salad cup, ambrosia cup or requested meal items. Staff J then would pass the meal tray to the Certified Nursing Assistant standing on the other side of the steam table and proceed with the next tray. On 05/06/2026 at 12:04 PM, Staff J, with a gloved hand, touched the pork to cut it and then wiped their hand on the rag sitting on the steam tray table next to them and continued to dish lunch meal plates. On 05/06/2026 at 12:06 PM, Staff J, with a gloved hand, touched the pork to cut it and then wiped their hand on the rag sitting on the steam tray table. Staff J plated multiple more plates before changing their gloves at 12:07 PM and started dishing plates again. On 05/06/2026 at 12:08 PM, Staff J, with a gloved hand, touched the pureed vegetables and mashed potatoes. Staff J immediately donned (put on) a new pair of gloves. On 05/06/2026 at 12:10 PM, the alternative meal, liver and onions, arrived at the servery. Staff J took the temperature of the liver and onions (touching the thermometer and did not change their gloves) and continued to dish lunch meal plates. On 05/06/2026 at 12:14 PM, Staff J, donned a new pair of gloves, touched the vegetarian patty to cut it, and continued to dish more plates. On 05/06/2026 at 12:16 PM Staff J, wiped down the steam table countertop with the rag, that they had been using to wipe their hand with after touching the meat/protein. Staff J was still wearing the same gloves from previous meat touching and continued to dish lunch meal trays. On 05/06/2026 at 12:24 PM, Staff J, with gloved hand, touched a vegetarian hotdog to cut it. Staff J then wiped their gloved hand on rag (used previously to wipe down countertop). Staff J was still wearing the same gloves from previous meat touching and continued to dish lunch meal trays. On 05/06/2026 at 12:26 PM, Staff J, with a gloved hand, touched the pork on the plate, to move it back on the plate. On 05/06/2026 at 12:27 PM, Staff J, with a gloved hand, touched the pork to cut it and then wiped their hand on the same rag sitting on the steam tray table. Temperature LogsOn 05/06/2026, Staff M, Food Services Manager, provided a stack of refrigerator, freezer and dishwasher logs about 5-6 inches tall. The top two pieces of paper were reviewed: AC Refrigerator/Freezer temp log and AC Dish Machine Temperature Log March 2026 AC Refrigerator/Freezer Temperature Log was missing entries on the 6th, 7th, 8th, 9th, 20th, 21st, 22nd, 27th, 28th-no temp recorded, only an X marked. March 2026 AC Dish Machine Temperature Log was missing entries on the 4th dinner, 5th dinner, 6th lunch and dinner, 7th lunch and dinner, 10th dinner, 11th dinner, 12th breakfast, lunch and dinner, 14th lunch and dinner, 17th, lunch and dinner, 18th dinner, 19th dinner 20th lunch, 21st lunch and dinner, 22nd breakfast and lunch, 23rd dinner, 24th dinner, 25th lunch and dinner, 27th breakfast and lunch. On 05/06/2026 at 1:15 PM, when asked the process for missing dates on temperature logs, Staff K, Food Services Manager, with Staff L, Administrative Assistant and Staff M, Food Services Manager present, said if there were missing dates, they would contact the staff working that day and question them why it was not filled out. Reviewing March 2026 AC Refrigerator/Freezer Temperature Log and March 2026 AC Dish Machine Temperature, all three staff members acknowledged the missing entries on the March 2026 refrigerator/freezer and dishwasher temperature logs and said the missing entries should have been<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | filled in. When asked if touching food was allowed, Staff K said food was not supposed to be touched with bare hands, staff should be using gloves or utensils for Ready to Eat foods. When observations were explained about Staff J, Lead Food Services worker, touching the food, cleaning supplies (dirty rag) and environmental surfaces (meal ticket cards, thermometer, refrigerators), Staff K, Staff L and Staff M said Staff J should not have touched the food, they should not have touched the food (purposely repeated themselves), the cleaning rag or other environmental surfaces. Staff K said Staff J should have changed their gloves, washed their hands before touching anything else and should not have used the same rag. Reference WAC 388-97 -1100 (3), -2980 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personal privacy was protected for 2 of 2 sampled residents (Residents 25 and 75) reviewed for resident rights. This failure placed the residents at risk for embarrassment, a violation of their privacy, and a diminished quality of life.Findings included .Resident 25Review of the electronic health record (EHR) showed Resident 25 was admitted to the facility on [DATE] with diagnoses that included chronic pain, diabetes (too much sugar in the blood) and hypokalemia (low potassium). Resident 28 was able to make needs known.Observation on 05/04/2026 at 11:01 AM, showed Resident 25 had an [NAME] (electronic virtual assistant device) on their bedside table. Review of Resident 25's EHR showed no documentation of consent to the recording device in their room.Review of the Care Plan showed no documentation related to the [NAME].Resident 75Review of the EHR showed Resident 75 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (movement disorder of the nervous system), high blood pressure and Aphasia (impairs ability to communicate due to damage to the language areas of the brain). Resident 75 had unclear speech and sometimes understood others.Observation on 05/04/2026 at 12:56 PM, showed Resident 75 had an [NAME] with a screen (electronic virtual assistant device) on their bedside table. Review of Resident 75's EHR showed no documentation of consent to the recording device in their room.Review of Resident 75's Care Plan showed an intervention to encourage resident to call family member on their Alexa device.During an interview on 05/07/2026 at 8:51 AM, Staff T, Licensed Practical Nurse (LPN), stated Resident 75 had an [NAME] in their room because family liked to look in on the resident. Staff T stated they were unaware if there was a special process staff followed when providing care to ensure the resident had privacy.During an interview on 05/11/2026 at 2:33 PM, Staff B, Director of Nursing Services, stated the expectation was for a consent to be signed by the resident or resident representative and roommate if applicable prior to the use of the recording device. Staff B stated the electronic device should have been care planned so staff were aware to turn the screen when providing care to the resident.Reference WAC 388-97-0360, 0500(1) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to initiate a grievance for 1 of 2 sampled residents (Resident 215) reviewed for missing personal property. This failure placed the resident at risk of unmet needs, personal loss and a diminished quality of life. Findings included. Review of the facility policy titled Missing Items, effective date 04/03/2025, showed the process for reporting and handling residents' missing property, including money was when a resident and/or resident's representative brought to the attention of a staff member a concern that money or a personal possession is missing the staff member to whom the loss was reported should check areas the item may have been misplaced. If the item could not be located, the staff member to whom the concern was reported was instructed to complete a grievance on the same day. Resident 215 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/03/2026, documented Resident 215 was moderately cognitively impaired. On 05/04/2026 at 11:10 AM, Resident 215 told Staff C, Registered Nurse, that their stereo equipment was missing in an elevated voice. Staff D, Certified Nursing Assistant, entered the room, and Resident 215 said their stereo was gone. Staff D asked what was missing and Resident 215 said in a loud voice it was a Bose Stereo. At 11:18 Staff D, looked in the cupboard for the missing item, but did not locate it. Resident 215 said the stereo looked like an old-fashioned stereo, but it was new, they had told staff that morning it was missing and they were not sure when it went missing. On 05/06/2026 at 10:57 AM, Staff E, Registered Nurse/Neighborhood Coordinator, said when a resident reports a missing personal item staff would talk with the social worker and the social worker would talk with the resident and fill out a grievance if needed. Staff E said it was her expectation that staff would alert the neighborhood coordinator and the social worker. On 05/06/2026 at 11:10 AM, Staff F, Social Worker, said her expectation of staff, if a resident reported missing property, was for them to look for the item and if not found to initiate a grievance, and if it was a valuable item to initiate the grievance immediately. Staff F said whoever took the complaint should initiate the paperwork. Regarding Resident 215's report of a missing stereo to 2 staff members, Staff F said this had not been reported to her and that the staff should have told her even if only by email. Staff F said she was in charge of resolving missing items but whoever heard about it should have initiated a grievance. When asked if she had received an email or grievance regarding Resident 215's reported missing stereo, Staff F looked in the electronic health record and said she did not see a progress note, email, or grievance about the reported missing stereo. Staff F said Resident 215 would make allegations because of a previous head injury, but that should not stop staff from following procedure. On 05/07/2026 at 1:24 PM, Staff F, when asked if it met her expectations that staff had not reported the missing stereo and had not filed a grievance, said it did not meet her expectations, that there should have been a note under her door, or an email or the charge nurse should have said something, staff should have followed up. Reference WAC 388-97-0460 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify allegations of abuse or neglect for 2 of 4 sampled residents (Resident 11 and 98) reviewed for abuse. This failure placed residents at risk for unidentified and repeated potential abuse, neglect, or mistreatment, and a diminished quality of life.Findings included .Review of the facility's policy titled, Abuse and Neglect-Resident Abuse Prevention, revised December 18, 2024, showed, NEGLECT: A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult. In a Washington State Veterans Home, neglect also means a failure to provide a resident with the goods and services necessary to avoid physical harm, mental anguish, or mental illness. All incidents of alleged or suspected abuse, neglect, personal and/or financial exploitation, abandonment, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported and investigated in accordance with established federal and state rules.Resident 11Review of the electronic health record (EHR) showed Resident 11 admitted to the facility on [DATE] with diagnoses that included overactive bladder, depression (mood disorder), chronic right heart failure and hemiplegia and hemiparesis affecting right side (partial loss of strength and near complete loss of voluntary movement). Resident 11 was able to make needs known.During an interview on 05/04/2026 at 12:02 PM, Resident 11 stated they were often left in a soiled (feces and urine) brief for long periods of time during mealtimes which started when they became a hoyer transfer requiring two staff. Resident 11 stated they had developed sore areas that were painful. Resident 11 stated they purchased their own wipes for facility staff to use because washcloths had become too painful.During an interview on 05/07/2029 at 11:10 AM, Staff B, Director of Nursing Services (DNS), was made aware of the information Resident 11 provided about incontinent care.Review of a progress note, dated 05/08/2026, documented the Social Work met with the resident that day related to wellbeing post discussion the day prior about sitting in feces and long wait times for toileting. A date was set to meet again the following day to address a formal grievance related to staffing.During an interview on 05/11/2026 at 9:13 AM, Staff U, Registered Nurse/Investigation Nurse, stated Resident 11 reported during breakfast staff were not available to assist the resident with timely transfers and incontinent care. Staff U stated Resident 11 was not concerned about abuse or neglect and was urged to complete a grievance related to the situation which would be handled by the Social Work department.Review of the facility's updated Accident and Incident Log provided on 05/11/2026 for May 2026, showed no incident logged related to Resident 11's allegations related to incontinent care or rough handling.During an interview on 05/11/2026 at 9:41 AM, Staff B, DNS, stated based on Resident 11's response in the interview of not feeling abused or neglected the facility did not believe the incidents were allegations of abuse or neglect.During an interview on 05/11/2026 at 11:04 AM, Staff F, Social Work, stated Resident 11 was interviewed 48 hours after the incident was reported to the Administrator. Staff F stated during the interview Resident 11 reported their brief was not changed timely due to Certified Nursing Assistants (CNAs) not being available during mealtimes. Resident 11 also reported on their shower day staff requested the resident to stay in bed in a soiled brief until a shower could be provided. Resident 11 additionally reported rough handling by staff to Staff F during the interview. Resident 98Review of the facility's policy titled, Abuse and Neglect-Resident Abuse Prevention, revised December 18, 2024, showed, Mental abuse means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing. All incidents of alleged or suspected abuse, neglect, personal and/or financial exploitation, abandonment, or mistreatment, including injuries of unknown source and misappropriation of resident<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | property, are reported and investigated in accordance with established federal and state rules.Review of the EHR showed Resident 98 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), heart failure and chronic obstructive pulmonary disease (damaged lungs). Resident 98 was able to make needs known.During an interview on 05/04/2026 at 1:04 PM, Resident 98 stated they were recently involved in a verbal altercation with another resident who threatened to whip my a**. Resident 98 stated staff intervened and there were no further issues with the resident.During an interview on 05/06/2029 at 9:43 AM, Staff A, Administrator was made aware of the information Resident 98 provided related to the altercation.Review of a progress note dated 05/06/2026, showed Staff F, Social Work documented Resident 98 reported another resident yelled at them on their hall. Resident 98 reported two CNAs were present and did their best to break up the disagreement. Resident does not wish to file a grievance stating, there's not much you can do. Resident requested that staff communicate better as the event took place about 1.5 weeks ago.Review of the facility investigation dated 05/06/2026, showed the verbal altercation took place on 04/15/2026. Staff member X, CNA, was interviewed as a witness and one of the staff present during the altercation.Review of the facility's Accident and Incident Log for April 2026, showed no incident logged related to Resident 98's resident to resident altercation.During an interview on 05/11/2026 at 5:09 PM, Staff B, DNS, stated when staff witnessed a resident-to-resident altercation the expectation was to keep the residents safe, complete an incident report, complete an investigation and report to the hotline when there was abuse or neglect.Reference WAC 388-97-0640(5)(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure minimum data set (MDS) assessments accurately reflected residents' health status and/or care needs for 1 of 34 sample residents (Resident 13) reviewed. The failure to accurately code resident active diagnoses, placed residents at risk for unidentified and unmet psychosocial and/or behavioral care needs. Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI, a manual that directs staff on how to accurately assess and code the status of residents) version 1.20.1, dated October 2025, once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have been documented in the last 60 days and have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look back period. Nursing Monitoring includes clinical monitoring by a licensed nurse. Listing a disease/diagnosis on the resident's medical record problem list is not sufficient for determining an active diagnosis. Resident 13 was admitted to the facility on [DATE]. Review of the hospital history and physical and Discharge summary, dated [DATE], showed the resident had provisional diagnoses (temporary or working diagnoses made by a healthcare professional based on an initial evaluation. It represents their best educated guess of a patient's condition at the current time, used when there is not yet enough information to make a final or definitive diagnosis.) of psychotic disturbance, mood disturbance and anxiety. No diagnosis of depression was found.Review of Resident 13's electronic health record (EHR) showed the following orders:a) Quetiapine (an antipsychotic medication) for psychosis with hallucination, from 09/19/2025 - 03/16/2026. On 03/16/2026 the diagnosis for the use of quetiapine was changed to unspecified dementia with behavioral disturbance.b) Melatonin at bedtime for insomnia, with nurse monitoring of the resident's hours of sleep, dated 01/23/2025.c) Trazadone (an antidepressant) for insomnia from 02/01/2025 - 03/03/2025. Resident 13's EHR showed after 03/03/2025 they received no further antidepressant medications and no behavior monitoring for target behaviors for depression had occurred since the resident was admitted . Review of all mood assessments completed with the resident's MDSs since admission (three by resident interview on 01/20/2025, 07/08/2025 and 10/16/2025, and one completed by staff assessment on 04/21/2025) assessed the resident had a depression score of 0.Review of Resident 13's 10/16/2025 Quarterly, MDS showed the resident had diagnoses of anxiety and depression and received antipsychotic and antianxiety medications during the assessment period. Resident 13 did not receive an antidepressant medication, and psychosis and insomnia were not coded as active diagnoses. Review of Resident 13's 01/16/2026 Annual MDS showed the resident had diagnoses of anxiety and depression and received antipsychotic and antianxiety medications during the assessment period. Resident 13 did not receive an antidepressant medication, and psychosis and insomnia were not coded as active diagnoses. Review of Resident 13's 04/14/2026 Quarterly MDS showed the resident had active diagnoses of anxiety, depression and unspecified dementia with behavioral disturbance, and received antipsychotic and antianxiety medications during the assessment period. Resident 13 did not receive an antidepressant medication and insomnia was not coded. On 05/13/2026 at 10:08 AM, Staff Y, MDS Coordinator, indicated they did not see Resident 13's psychosis diagnosis for the use of quetiapine and said it should have been coded 10/16/2025 and 01/16/2026 MDSs. On 05/11/2026 at 10:18 AM, when asked if Resident 13 was actively being treated with medication for insomnia and if nurses were monitoring the resident's hours of sleep at the time of the above referenced MDSs Staff Y, MDS Coordinator, said yes, and acknowledged insomnia was a active diagnosis. On 05/13/2026 at 10:32 AM, when asked why depression was coded on the 10/16/2026, 01/16/2026 and 04/14/2026 MDSs Staff Y said depression was listed as a diagnosis in provider notes within 60 days of each MDS. Staff Y acknowledged Resident was not being treated for depression (e.g. medication, counseling, behavior monitoring etc.)<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Documentation was requested to show how depression affected Resident 13's care or functional, cognitive, mood or behavior status during the assessment periods. No documentation was provided. Reference WAC 388-97-1000 (1)(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop, implement and/or ensure residents' comprehensive care plans accurately reflected care needs for 3 of 34 sampled residents (Resident 19, 13 & 4) reviewed for care plans. These failures placed residents at risk for unidentified and/or unmet care needs, medical complications and a diminished quality of life.Findings included .Resident 19<br><br>Resident 19 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbances and terminal anxiety (the specific type of dementia cannot be clearly identified, despite the presence of cognitive decline and memory loss), Bipolar disorder (a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes), and generalized anxiety (intense, excessive and persistent worry or fear). The Quarterly Minimum Data Set (MDS, an assessment tool) dated 03/20/2026, documented Resident 19 was unable to complete interviews, was severely cognitively impaired and relied on staff for some cares.<br><br>A physician's order, dated 07/04/2025, documented Resident 19 was prescribed quetiapine (Seroquel, an antipsychotic) for Bipolar with psychosis daily at bedtime.<br><br>A physician's order, dated 11/04/2025, documented Resident 19 was prescribed sertraline (an antidepressant) for depression (persistent feelings of sadness and loss of interest) daily in the morning. Resident 19 had no diagnoses of depression.<br><br>A physician's order, dated 02/11/2026, documented Resident 19 was prescribed lorazepam (an antianxiety) every 4 hours as needed (PRN) for terminal anxiety for 90 days.<br><br>Resident 19's Mood State care plan, dated 03/03/2025, documented Resident 19 had one target behavior listed under Behavior Tracking for quetiapine; paranoid statements (no details provided) and one target behavior under Behavior Tracking for sertraline; tearfulness (no other details provided). Resident 19 had no Comfort Care care plan, only a mention under Nutrition care plan that documented, weights are at risk to decrease.<br><br>On 05/08/2026 at 12:22 PM, when asked to locate the side effect and target behavior monitoring orders for Resident 19, Staff B, Director of Nursing Services, confirmed there was no side effect monitoring or no target behaviors listed for the antianxiety medication and said there should have been. Staff B said there was one target behavior listed for each medication, antipsychotic-paranoid statements, and the antidepressant -tearfulness on the care plan. Staff B acknowledged that all of Resident 19's associated target behaviors should have been listed under each medication type on the Medication Administration Record and on the care plan and the care plan was not person centered.<br><br>Resident 4 Resident 4 was admitted to the facility on [DATE]. Record review showed a provider order, dated 09/17/2024, that directed staff to assist with the application of Resident 4's bilateral wrist splints every morning (donning) and to assist with the removal (doffing) of the wrist splints at bedtime. An alteration in musculoskeletal status care plan, revised 04/14/2026, documented that the resident would wear bilateral wrist splints at night and that Staff will assist resident in donning black wrist braces when he goes to bed and doffing braces when he gets up in the morning. A potential for<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pressure ulcers care plan, revised 04/14/2026, documented The resident is dependent upon one person to apply protective splints to hand/wrist at night (bilateral) Check skin when donning and doffing. Both care plans indicated Resident 4 was to wear bilateral wrist splints at night, in direct conflict with the provider order, which directed staff to assist with application in the morning and removal at bedtime. On 05/04/2026 at 2:08 PM, 05/06/2026 at 10:48 AM and 05/07/2026 at 11:58 AM, Resident 4 was observed without wrist splints in place. On 05/07/2026 at 12:00 PM, when asked about the wrist splints, Resident 4 stated, I don't wear wrist splints. Several years ago, I did. They had me wear them for a short period after I got my casts off. I don't even remember what they look like, that's how long it has been. Resident 4 allowed this writer to look in drawers to see if there were wrist splints present in the resident's room. None were found. On 05/08/2026 at 3:13 PM, Staff E, Registered Nurse/Neighborhood Coordinator, said she did not recall ever seeing Resident 4 wearing wrist splints. When informed of Resident 4's report that he wore the splints several years prior, Staff E said Resident 4's care plans needed to be updated/revised. Resident 13Resident 13 was admitted to the facility on [DATE]. Record review showed the resident received quetiapine (an antipsychotic medication) from 09/19/2025 - 03/16/2026 for a diagnosis of psychosis with hallucinations. Review of the resident's comprehensive care plan, initiated 01/13/2025, showed it did not address the residents use of an antipsychotic medication, diagnosis of psychosis, the history of hallucinations/what was hallucinated. Nor did the care plan identify what specific behaviors the quetiapine was initiated to target or identify and instruct staff that an Abnormal Involuntary Movement Scale (AIMS, a standardized, clinician-administered assessment designed to observe, quantify, and track involuntary movements in patients, especially those taking long-term antipsychotic medications) was required at least every six months. On 05/11/2026 at 9:58 AM, Staff B, Director of Nursing Services (DNS), said the residents use of quetiapine, diagnosis of psychosis, history of hallucinations and what the hallucinations were of and the specific target behaviors the quetiapine was implemented to treat should have been care planned but acknowledged they were not. A 03/16/2026 provider note, documented Decrease Seroquel 12.5 mg to once daily for paranoia and agitation 2/2 [secondary to] dementia A 04/06/2026 provider note, documented Increase Seroquel 25 mg to in the afternoon/evening time, daily for paranoia and agitation 2/2 dementia.<br><br>Review of Resident 4's comprehensive care plan, initiated 01/13/2025, showed the facility failed to develop and implement a plan that addressed the resident's paranoia and associated behavioral manifestations.<br><br>On 05/11/2026 at 10:24 AM, Staff B, DNS, said a plan that addresses Resident 4's paranoia and associated behavioral manifestations should have been care planned.<br><br>Reference WAC 388-97 -1020(1), (2)(a)(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 3 residents (Residents 4) reviewed for limited range of motion. Facility nurses demonstrated a pattern of falsely documenting the application of bilateral wrist splints, that were not applied. This failure resulted in a resident losing trust in assigned nursing staff and placed residents at risk of contracture formation/progression, loss of independence and/or increased dependence on staff and a diminished quality of life. Findings included .Resident 4 Resident 4 was admitted to the facility on [DATE]. Record review showed a provider order, dated 09/17/2024, that directed staff to assist with the application of Resident 4's bilateral wrist splints every morning and to assist with the removal of the wrist splints at bedtime.On 05/04/2026 at 2:08 PM, 05/06/2026 at 10:48 AM and 05/07/2026 at 11:58 AM, Resident 4 was observed without wrist splints in place.On 05/07/2026 at 12:00 PM, when asked about the wrist splints Resident 4 stated, I don't wear wrist splints. Several years ago, I did. They had me wear them for a short period after I got my casts off. To clarify, in the past three months you have not worn or had your wrist splints applied? Oh, no. It's been much longer than that. I don't even remember what they look like, that's how long it has been. Resident 4 allowed this writer to look though the dresser drawers to see if any wrist splints present in the resident's room. None were found.Review of the March, April and May 2026 Treatment Administration Records (TARs) showed from 03/01/2026 - 05/08/2026 (69 days) Resident 4's bilateral wrist splints were signed off as having been applied as ordered on all 69 days by 17 of 17 nurses who worked. On 05/08/2026 at 3:13 PM, when asked about Resident 4's bilateral wrist splits Staff E, Registered Nurse/Neighborhood Coordinator, said she did not recall ever seeing Resident 4 wearing wrist splints since she started working at the facility (hire date 10/16/2024). Staff E reviewed Resident 4's TAR and confirmed facility nurses had signed they assist with application of Resident 4's bilateral wrist splints daily as ordered and stated, That's concerning. Staff E said it was the expectation that nurses only sign for tasks that they completed or validated was complete. Reference WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timely incontinent care for 1 of 2 residents (Resident 11) reviewed for activities of daily living (ADL) for dependent residents. This failure placed dependent residents at risk for skin breakdown, poor hygiene and diminished quality of life.Findings included .Review of the electronic health record (EHR) showed Resident 11 admitted to the facility on [DATE] with diagnoses that included overactive bladder, depression (mood disorder), chronic right heart failure and hemiplegia and hemiparesis affecting right side (partial loss of strength and near complete loss of voluntary movement). Resident 11 was dependent on staff for toileting hygiene.During an interview on 05/04/2026 at 12:02 PM, Resident 11 stated they were often left in a soiled (feces and urine) brief for long periods of time during mealtimes when they became a Hoyer transfer requiring two staff. Resident 11 stated they had developed sore areas that were painful. Resident 11 stated they purchased their own wipes for facility staff to use because washcloths had become too painful.Observation and interview on 05/11/2026 at 11:01 AM, showed no Certified Nursing Assistants (CNA) on the A hall. Five residents were observed in their rooms. Staff G, LPN (Licensed Practical Nurse), stated during mealtimes CNA's were assisting with feeding residents in the dining room and on the hall. Staff G stated they were responsible for responding to call lights for the duration of the mealtimes (approximately an hour). Staff G stated a resident who required two staff for care during that time were told they would need to wait until mealtime was over.During an interview on 05/11/2026 at 1:03 PM, Staff S, CNA, stated, I leave my hall at 11:35 AM to assist with dining in the dining room, that leaves one CNA on the hall to pass trays and then they come to assist with feeding in the dining room. The nurse on the hall answers call lights and if a resident requires cares in pairs or two-person assistance during that time they inform the resident they will have to wait until additional staff were back on the hall which is between 12:45-1:30 PM.Review of a Revision to Care Plan Order, dated 04/02/2026, signed by Physical Therapy showed, Resident 11 was downgraded from using a sit to stand to a Hoyer lift for transfers from bed to chair.Review of the providers orders showed Resident 11 was prescribed Ozempic (a medication used for blood sugar regulation) on 03/26/2026 which has a common side effect of diarrhea.Review of Weekly Skin assessment dated [DATE] showed, no open areas or redness.Review of Weekly Skin assessment dated [DATE] showed, no open areas or redness.Review of Weekly Skin assessments dated 04/11/2026, 04/18/2026, 04/25/2026, 05/02/2026 showed, Multiple red rashes on buttocks, inner thighs, and peri-area. No open areas noted. Applied Calmoseptine + Vit [vitamin] A&D ointment.Review of Weekly Skin assessments dated 05/09/2026 showed, On-going with multiple red rashes on buttocks, inner thighs, and peri-area. No open areas noted. Dimethicone applied as ordered. On-going with discoloration bilaterally, redness/rash on upper thighs.Review of a progress note, dated 05/09/2026, showed, Resident entire peri area front and back, inner thigh and abdominal folds with red rashes and sensitive to touch, peri area, vaginal area, labia very red raw, painful to touch when powder and cream applied. Right inner thigh with open area 2cm [centimeters] long x 0.3cm.Review of the EHR showed on 05/09/2029, Resident 11 requested to go to the emergency room for increased pain, burning, itching and rash to vaginal area. Resident 11 was diagnosed with a urinary tract infection and prescribed antibiotics for ten days.During an interview on 05/11/2026 at 4:57 PM, Staff B, Director of Nursing Services, stated during mealtimes the licensed nurse (LN) was the only member of staff on the hall and was responsible for answering call lights. Staff B stated the expectation was if a resident required two members of staff during mealtime the LN would go to the dining room to request assistance from a CNA.Reference WAC 388-97-1060 (2)(c) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bowel care in accordance with the facility's bowel protocol for 3 of 8 residents (Resident 3, 8 & 29) reviewed for bowel management. This failure placed residents at risk for nausea/vomiting, abdominal pain/discomfort, decreased appetite, and other negative health outcomes associated with untreated constipation.Findings included . Resident 3 Resident 3 was admitted to the facility on [DATE]. Review of the Quarterly minimum data set (MDS, an assessment tool), dated 02/11/2026, showed the resident was cognitively intact. On 05/05/2026 at 10:47 AM, Resident 3 said he had been struggling with constipation. Review of the April 2026 bowel record showed Resident 3 went from 04/15/2026 - 04/21/2026 (7 days), without a bowel movement (BM). Record review showed Resident 3 had the following as needed bowel care orders:a) Miralax as needed, for no BM for 48 hours, dated 02/25/2022.b) Milk of Magnesia once daily as needed for constipation, dated 01/04/2026c) Bisacodyl- administer two tablets once daily, as needed, for constipation not relieved by milk of magnesia, dated 03/20/2025.d) Bisacodyl Suppository every 24 hours, as needed for constipation not relieved by milk of magnesia, dated 02/25/2022.e) Mineral Oil Enema administer every 24 hours, as needed for Constipation, dated 02/25/2022. Review of the April 2026 Medication Administration Record (MAR) showed Resident 3 was not provided as needed bowel medication until 04/20/2026, the sixth day without a BM. On 05/11/2026 at 4:44 PM, when asked if Resident 3 was provided as needed bowel care in accordance with provider orders or the facility's bowel protocol Staff B, Director of Nursing Services (DNS), stated, No.<br><br>Resident 8Resident 8 was admitted to the facility on [DATE]. A review of the Annual MDS, dated 03/092026, showed the Resident 8 was cognitively intact. A review of Resident 8's electronic medical record showed the following orders: a) Lactulose Solution given every 24 hours as needed for constipation Once daily dated 04/07/2026 b) Lactulose Solution given every 12 hours as needed for constipation dated 09/12/2025c) Senna Tablet Give 2 tablet by mouth at bedtime for prevent constipation dated 03/05/2025d) Docusate Sodium Give 1 capsule by mouth three times a day for Bowel Management ordered dated 03/14/2025e) Milk of Magnesia Suspension Give 30 ml by mouth as needed for constipation once daily dated 03/12/2025f) Bisacodyl Give 2 tablet by mouth as needed for constipation not relieved by milk of magnesia. Once daily dated 03/21/2025 g) MiraLax Oral Powder Give 1 scoop by mouth in the morning for constipation dated 07/11/2025h) Bisacodyl Suppository give 1 suppository rectally as needed if no Bowel movement after Miralax (notify provider if no results from suppository) dated 07/06/2025<br><br>A review of Resident 8's bowel record from 04/07/2026 - 05/05/2026 showed no bowel movement from 04/12/2026 – 04/16/2026 (5 days). A review of April 2026 MAR showed Resident 8 refused:-Miralax on 04/13/2026-Senna on 04/12/2026-Docusate sodium on the evening of 04/12/2026 And no other as needed bowel medications were documented as given or refused on the April 2026 MAR during that time peiod.<br><br>On 05/08/2026 at 9:40 AM, Staff Q, Registered Nurse 3, said they would liked to see more documentation on the medication refusals, specifically that the staff went back to check in and offer again to Resident 8. Staff Q said Resident 8 had the right to refuse.<br><br>On 05/11/2026 at 9:29 AM, Staff B, DNS, said the nursing staff should have initiated the bowel protocol on the 15th. Staff B said after 72 hours of no Bowel Movement the Bowel Protocol should have been initiated.<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 29<br><br>Review of the electronic health record (EHR) showed Resident 29 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), depression (mood disorder) and constipation. Resident 29 was able to make needs known.<br><br>Review of Resident 29's task section in the EHR for bowel and bladder elimination showed no BM on 04/22/2026, 04/23/2026, 04/24/2026, 04/25/2026, 04/26/2026, 04/27/2026 and 04/28/2026. The EHR showed documentation that the resident was administered Milk of Magnesia Suspension, Dulcolax Suppository (Bisacodyl) and MiraLAX on 04/29/2026.<br><br>During an interview on 05/11/2026 at 9:41 AM, Staff B, DNS, stated the expectation was that the facility's bowel protocol should have been implemented within the stated time frame and documented whenever a resident had no BM for 3 days.<br><br>Reference WAC 388-97-1060(1)<br><br>. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents (Residents 11) was consistently offered/received services to maintain or prevent declines in mobility when reviewed for range of motion (ROM). This failure placed the residents at risk of decreased motion, mobility and a diminished quality of life.Findings included.Review of the electronic health record (EHR) showed Resident 11 admitted to the facility on [DATE] with diagnoses that included overactive bladder, depression (mood disorder), chronic right heart failure and hemiplegia and hemiparesis affecting their right side (partial loss of strength and near complete loss of voluntary movement). Resident 11 was able to make their needs known.During an interview on 05/04/2026 at 12:14 PM, Resident 11 stated they recently requested to start participating in restorative or physical therapy due to declining mobility. Resident 11 stated in the past they had medical issues that interfered with their ability to participate in therapy but said they were never reapproached by staff and restorative was not offered consistently.Review of a progress note dated 03/11/2026 showed, Resident requested to see LN to raise concern of increasing weakness of bilateral lower extremity, it's more difficult to stand and move now. I don't want to be stuck on sit-to-stand, I'm scared. Referral sent to PT/OT to assess and treat bilateral lower extremity weakness affecting ability to transfer.Review of a progress note from a different licensed nurse, dated 03/12/2026, showed resident was feeling like they were losing strength, a review of the restorative program was completed and resident was agreeable for more aggressive form of exercise that in room exercises and LN was awaiting guidance from restorative nurse. Review of a progress note, dated 04/04/2026, showed resident was transferred via hoyer.During an interview on 05/07/2026 at 9:27 AM, Staff V, Restorative Coordinator, stated Resident 11's restorative program was discontinued on 03/23 due to refusals. Staff V stated Resident 11 requested to restart her program and had been evaluated by therapy on 04/02/2026. Staff V stated Resident 11's restorative program was restarted on 05/06/2026.During an interview on 05/08/2026 at 1:57 PM, Staff W, Rehabilitation Director, stated Resident 11's evaluation was completed on 04/02/2026. Resident 11 was assessed to participate in therapy three times per week for four weeks. Staff W stated Resident 11's insurance required a steep copay/participation fee which Resident 11 stated they were unable to pay and therefore did not receive therapy. Staff W stated the business office was responsible for obtaining authorization and had not communicated with the therapy department on the status of the approval. Staff W stated they should have referred Resident 11 back to restorative therapy while waiting for the insurance approval but did not. Staff W stated the lack of coordination between the business office, therapy and restorative did not meet their expectations.During an interview on 05/11/2026 at 2:58 PM Staff B, Director of Nursing Services stated the expectation was that Resident 11 was offered some type of functional maintenance program or restorative program in the process of waiting for the approval. Staff B stated there was a communication breakdown between restorative and therapy and ultimately the facility realized Resident 11 had double coverage and was never responsible for a participation fee.Reference WAC 388-97-1060(3)(d) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505517 | A. Building<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure non-pharmacological interventions (NPIs, non-medication interventions) were attempted prior to the administration of as needed (PRN) pain medications for 2 of 5 residents (Residents 2 & 121) reviewed for unnecessary medications. This failure placed residents at risk of unnecessary medication usage and a diminished quality of life.<br>Resident 2<br><br>Resident 2 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 05/01/2026, documented Resident 2 was severely cognitively impaired and was able to make needs known.<br><br>A physician's order, dated 03/23/2021, documented, Pain Non-Pharmacological Codes: 1) Remove to calmer space 2) Ambulate resident 3) Refer to nurses note 4) Read material/coloring 5) Return to room [ROOM NUMBER]) Toileting 7) Provide food/snack 8) Give fluids 9) Change position 10) Adjust room temp 11) Back rub 12) 1 on 1 Conversation 13) Send to activities 14) Other were to be attempted prior to PRN pain medication administration.<br><br>A physician's order, dated 04/28/2026, documented Resident 2 was prescribed oxycodone PRN every 6 hours for chronic pain.<br><br>Review of the April and May 2026 Medication Administration Record (MAR), documented Resident received oxycodone on 04/30/2026 pain level 9; 05/02/2026 pain level 0; 05/03/2026 pain level 10, 05/06/2026 pain level 5. No NPI's were attempted prior to the administration of the PRN pain medication.<br><br>On 05/08/2026 at 9:21 AM, Staff H, Registered Nurse/Neighborhood Coordinator, said NPI's were to be attempted prior to the administration of the PRN pain medication. Staff H reviewed the listed dates above in the electronic health record (EHR), confirmed no NPI's were attempted and said they should have been.<br><br>On 05/08/2026 at 12:22 PM, Staff B, Director of Nursing Services (DNS), reviewed the EHR and confirmed Resident 2 had received PRN pain medication without NPI's having been attempted and said NPI's should have been attempted prior to administration.<br><br>Resident 121<br><br>Resident 121 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/04/2026, documented Resident 121 was cognitively intact.<br><br>Review of Resident 121's orders for April and May 2026, showed they had orders in place for acetaminophen-codeine (narcotic pain medication) to be given PRN for pain.<br><br>Resident 121 had another order, dated 10/29/2025, for monitoring and assessing pain instructing staff to document what non-prescription (non-medication) interventions were provided with 0=none, 1-verbal reassurance, 2- change in location/environment, 3- warm blanket, 4 – reposition, 5- food and/or drink, 6- rest, 7- heat, 8-cold, 9- music, and 10- massage. This order was not associated with the PRN acetaminophen-codeine orders.<br>(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<br>B. Wing | 05/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Washington Veteran Home-Retsil | 1141 Beach Drive<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the MAR, from 04/01/2026 through 04/30/2026, documented the PRN acetaminophen-codeine had been given 26 times in April with no NPIs attempted.<br><br>Review of the MAR from 05/01/2026 through 05/05/2026, showed acetaminophen-codeine had been administered six times with no NPIs attempted.<br><br>On 05/08/2026 at 10:57 AM, Staff B, DNS, said her expectations for NPIs as they related to PRN pain medications were that NPIs be offered prior to pharmacological (medication) interventions. Staff B reviewed the 04/2026 and 05/2026 MARs and confirmed that NPIs had not been attempted prior to the administration of PRN pain medication on the dates reviewed. Staff B said she did not see anything in Resident 121's progress notes regarding NPIs being attempted. Staff B said this did not meet her expectations.<br><br>Reference WAC 388-97-1060 (3)(k)(i) |