

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2024
NAME OF PROVIDER OR SUPPLIER  Washington State Walla Walla Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 92 Wainwright Drive Walla Walla, WA 99362	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45117</p> <p>Based on observation, interview and record review, the facility failed to ensure the medication cart was locked when left unattended by 2 of 4 staff (Staff B and C) reviewed for medication storage. This failure placed the residents, staff, and visitors at risk for unauthorized access to medications resulting in negative health outcomes.</p> <p>Findings included .</p> <p>Review of a policy titled, Administering Medications, revised 12/2012, showed during the administration of medications, the medication cart would be kept closed and locked when out of sight of the medication nurse.</p> <p>A concurrent observation and interview on 09/13/2024 at 9:56 AM, showed Staff B, Registered Nurse (RN), standing at the medication cart located in the main hallway, outside of the resident rooms. Staff B proceeded to prepare medications for the resident in room P10, placed the medication cards in the medication cart drawer, and closed the drawers. At 9:58 AM, Staff B, without locking the medication cart, entered the resident's room and closed the door. Staff B returned to the medication cart at 10:02 AM, four minutes after leaving the medication cart unlocked. Staff B moved the medication cart to the doorway of resident room P09 and parked it at an angle to entrance of their room. At 10:03 AM, with the cart still unlocked, Staff B entered resident room P09, faced the resident (their back to the entrance to the room), and assessed the resident. Staff B returned to the unlocked medication cart, prepared a medication and placed it into a cup of applesauce. They re-entered room P09 and assisted feeding the applesauce/medication to the resident with their back to the unlocked medication cart. At 10:09 AM, Staff B returned to the medication cart (still unlocked) obtained a plastic cup, walked down the hall to the kitchen area, filled the plastic cup with water, and returned to resident room P09. Staff B assisted the resident with their water, again with their back to the unlocked medication cart. At 10:12 AM, Staff B returned to the unlocked medication cart, that had been left unlocked and unattended for nine minutes. Staff B stated their process was to lock the medication cart only when they were gone for longer periods. Staff B stated they were not sure what training they received for securing the medication cart.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 09/16/2024 at 11:48 AM, Staff C, RN, was standing at the medication cart in front of resident room U05. The cart was at an angle, with the drawers directed towards the entrance of the room. Staff C prepared medications for the resident and entered the resident room without locking the medication cart. At 11:50 AM, Staff C returned to the medication cart, obtained supplies to test the resident's blood sugar level, and returned to the resident's room without locking the medication cart. Staff C, with their back to the door, completed the blood sugar test, rearranged the resident's bedside table, performed meal set up, then returned to the medication cart at 11:54 AM, leaving the cart unlocked and unattended for four minutes. Staff C stated their normal process would have been to lock the medication cart when leaving it unattended, especially if they were in a resident room. They stated their process was to leave the medication cart unlocked if they kept it in sight. The Staff C stated they were trained by the facility to always lock the medication cart if it was unattended.</p> <p>During an interview on 09/13/2024 at 9:19 AM, Staff A, Administrator, stated leaving the medication cart unlocked was not the expected process. They stated administrative staff routinely checked the carts to see if the drawers were locked. Staff A stated the medication cart should always be locked when it was left unattended.</p> <p>Reference: WAC 388-97-1300(2)</p>