

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505530 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>11/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Washington State Walla Walla Veterans Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>92 Wainwright Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 00242</p> <p>Based on observation, interviews and record review, the facility failed to provide the necessary adequate supervision for 1 of 3 residents (Resident 1) reviewed for elopement (leaving a facility without notice or supervision). This failure allowed Resident 1 to exit the facility unnoticed and placed the resident at risk for serious injury and/or exposure to the elements.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia. Review of Resident 1's comprehensive assessment, dated 09/19/2024, showed they had moderately impaired cognition. Review of Resident 1's plan of care, revised on 11/02/2024, showed they could walk from their room in [NAME] house outside to the Administration Building for activities or exercises, but on occasion would become disoriented to time and attempt to leave after hours or when offices were locked, believing it was time for an activity. The resident was not to leave their house unattended after business hours. In addition, the plan of care, dated 06/15/2023, showed the resident was independent with turning in bed, walking, transfers, dressing, personal hygiene and toileting.</p> <p>Review of the facility investigation report, dated 11/01/2024, showed at 4:40 AM Resident 1 rang the doorbell to the main entrance to [NAME] house to be let back into the house. When staff let Resident 1 into the house the resident immediately went to their room without answering any questions by staff as to where they went. Nursing Assistant (NA) staff did not know Resident 1 had left [NAME] house as there was a sign posted on the outside of the resident's</p> <p>door stating night shift staff was not to disturb the resident. The investigation showed it was unknown how long Resident 1 was out of the house or where they had gone. The resident's plan of care showed they were an elopement risk due to a history of wandering and exit seeking when they resided at their home prior to their admission to the facility. The resident was not to leave the [NAME] house unattended. Later, Resident 1 was unable to recall leaving [NAME] house during the night. The resident had significant impaired cognition with notable episodes of short-term memory deficits.</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 |
|---|-------|-----------|

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505530  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY COMPLETED<br><br>11/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Washington State Walla Walla Veterans Home   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>92 Wainwright Drive<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 11/18/2024 at 2:05 PM observation of a hand written sign posted on the outside of Resident 1's door stated, Please Do Not Disturb While Sleeping, Noc [night] Shift - Knock before Entering. The resident stated they were okay with staff peeking into their room at night to ensure their safety.</p> <p>On 11/18/2024 at 2:31 PM, Staff A, NA, stated they and Staff B, NA, were in a room providing care to another resident in [NAME] house, when they heard the door bell ring. Staff A went to the main entrance door to see Resident 1 standing outside the door wanting to be let in. After Staff A let the resident into the house the resident immediately went to their room without answering any questions. Staff A stated they were unaware Resident 1 had left [NAME] house and there were no audible alarms on the exit doors to alert them. The resident always kept their door closed and staff did not check on them due to the signage posted on the outside of their door. Following the elopement incident, Staff A stated they still did not check on Resident 1 during the night shift unless they were observed out of their room.</p> <p>On 11/18/2024 at 12:20 PM, Staff B stated there were no alarms on exit doors alerting staff when Resident 1 left [NAME] house and went outdoors. Staff did not check on the resident as there was a sign posted on the outside of their door stating not to disturb the resident. Staff B stated the resident would get upset if staff tried to open their door.</p> <p>On 11/18/2024 at 1:10 PM, Staff C, Registered Nurse (RN), stated there were no alarms on the exit doors to alert staff a resident had left [NAME] house. Staff on the night shift did not know Resident 1 had left [NAME] house during the night on 11/01/2024. Staff did not check on the resident at night as they had a do not disturb sign on their door. Staff C stated the elopement incident on 11/01/2024 was not the first time the resident had left [NAME] house at night. The door to the resident's room was closed during the day also.</p> <p>On 11/18/2024 at 1:20 PM, Staff D, RN, stated there was an incident that occurred approximately one year ago when they observed Resident 1 passing by them during the night around 2:00 AM. Staff D stated they tried to redirect the resident from going outdoors and was told by the resident to get out of the way. At that point Staff D walked with Resident 1 to the Administration building so the resident could see there were no activities going on at that time.</p> <p>Review of a concurrent Progress Note, dated 12/12/2023 at 1:50 AM regarding Staff D's interview, showed at 1:45 AM Resident 1 came out of their room and stated they were going to Bingo as it was scheduled at 2:00 PM. Staff tried to redirect the resident but they were ignored as Resident 1 continued to walk outside towards the Administration building. Staff D, who accompanied Resident 1 to the Administration building, tried to explain to the resident it was night time. Once Resident 1 arrived at the Administration building they stated, where is everyone? Resident 1 then returned to [NAME] house.</p> <p>Reference (WAC) 388-97-1060(3)(g)</p> |   |  |