

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  11/17/2025
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)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review the facility failed to provide supervision to prevent elopement (leaving the facility unsupervised and undetected) for 1 of 3 residents (Resident 1) reviewed for accidents. This failure placed the residents at risk for exposure to the elements, serious harm and/or death. Findings included. Review of the facility policy titled Missing Resident/Elopement, dated 09/22/2023, showed residents who were at risk for wandering and/or elopement would be monitored, and staff would take necessary precautions to ensure their safety. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive brain disease that destroys memory and thinking skills), Dementia (a progressive disorder that impairs memory, thinking, language, and decline in cognitive abilities that affect daily life) and Post-Traumatic Stress disorder [(PTSD) a mental health condition that's caused by an extremely stressful or terrifying event]. The 08/05/2025 comprehensive assessment showed Resident 1 was independent for ambulation and required the assistance of one staff member for ambulation greater than 150 feet and activities of daily living. The assessment also showed Resident 1 had a severely impaired cognition. Record review of the facility investigation dated 08/30/2025, showed Resident 1 had attended a city parade (off campus) with facility staff and residents. When the parade ended, Resident 1 had wandered away from the group. The investigation showed staff were assisting other residents on the bus, they did not keep Resident 1 in their line of sight. Minutes had passed before staff members realized Resident 1 was missing. Record review of Resident 1's revised care plan dated 08/20/2024, showed they had wandering behaviors, were at risk for elopement and was to be kept in line of sight when they were out of the memory care unit (a unit that has enhanced security). During an interview on 09/24/2025 at 1:53 PM, Staff A, Nursing Assistant (NA), stated they were the only NA that accompanied the residents to the parade. Staff A stated when the parade had ended, they were assisting other residents back onto the bus and Resident 1 was left sitting on a bench. Staff A stated when they turned back around, Resident 1 was gone. Staff A stated they asked the other staff members where Resident 1 was, and they did not know. During an interview on 09/25/2025 at 12:19 PM, Staff B, Recreation Specialist, stated the process for taking residents on an outing included gathering a list of residents that were interested in attending. On the day of the parade some of the residents had cancelled. The activities department put an announcement on the facility radio asking if there were additional residents that wanted to attend. Staff B stated Resident 1 was brought to the lobby to attend with the group. Staff B stated they were aware that Resident 1 had a history of and current wandering behavior, however they were not concerned as the group had a NA accompanying the group to the parade. Staff B stated when the parade was over, they went to get the bus and returned to the area where they were watching the parade to begin loading residents onto the bus. Staff B stated that was when they noticed Resident 1 was missing. Staff B further stated they normally did not take residents from memory care unit as they should be observed one-on-one with a staff member when they were known to be at risk of wandering. During an interview on 09/24/2025 at 1:07 PM, Staff C, Director of Nursing Services, stated when planning to take a resident from the memory care unit the facility needed to ensure a plan for safety which could include a one-on-one supervision. Staff C stated Resident 1 had wandering behaviors and should have been kept in line of sight. Reference WAC: 388-97-1060(3)(g)</p>		