STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505530	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington State Walla Walla Veterans Home	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide notification of injury to the Resident's Representative (RR) for 1 of 3 residents (Resident 1) reviewed for notification. This failure placed the resident at risk of not having their representative involved in health care decision making for timely care and services.Findings included. Review of a policy titled, Incident Report - Resident, dated 04/02/2018, showed when the facility became aware of an incident that involved a resident, a Resident Incident Report would be initiated by the person that first became aware of the incident. The report should include family notification. The notification should be completed in a timely manner and contact attempts should be recorded on the Incident Report and in the nursing progress notes. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including heart failure, dementia with behavioral disturbance (distressing personality and behavior changes that occur alongside cognitive decline that include aggression, wandering, and hallucinations), and anxiety. The 09/23/2025 comprehensive assessment showed Resident 1 was dependent on two staff members for activities of daily living. The assessment also showed Resident 1 had a severely impaired cognition. During an interview on 12/04/2025 at 12:41 PM, the Resident Representative (RR) stated they were not notified of two injuries. The first injury involved Resident 1's toes. They stated Resident 1's socks were soaked with blood. The RR stated when they asked how the injury occurred; they were told it happened on night shift. The second injury involved a skin tear to Resident 1's left wrist. They stated it was more than a skin tear, it was a laceration that had steri-strips (thin, sticky bandages that help cuts or wounds stay closed as they heal) as a dressing. The RR stated they were not notified by the facility of either wound. Record review of a facility investigation dated 10/11/2025 at 5:00 AM, showed Resident 1 was found in their room with blood on the end of their sock to the right great toe. The injury was cleansed, and interventions were initiated to prevent further injury. The investigation report showed the provider, residents power of attorney, and Director of Nursing were notified of the injury on 10/14/2025, three days after the injury occurred. During an interview on 12/04/2025 at 12:34 PM, Staff C, Registered Nurse (RN), stated when a resident had a fall or injury, they assessed the injury, measured the wound, provided treatment, notified other shifts, the provider, and the Director of Nursing. They stated they would also notify the family. Staff C stated if they notified the family, they would have documented that information in the medical record, including if they left a voicemail. Staff C stated they did not remember calling the family to notify them of Resident 1's toe injury. Record review of a progress note dated 10/13/2025 at 11:30 AM, showed Staff D was called to Resident 1's room by a nursing assistant, who noticed a skin tear to the resident's left wrist while they were getting them up for lunch. Staff D assessed the skin tear that measured four centimeters (a unit of measurement), cleansed the site and applied steri-strips. A dressing was applied over the steri-strips to protect the area and prevent further injury. The progress note showed the Director of Nursing, provider, and resident care manager were notified. There was no documentation that the family had received notification of the injury. During an interview on 12/04/2025 at 12:29 PM, Staff D, RN, stated they did not remember notifying Resident 1's family of the skin tear. They stated the process following an injury included completing a risk management form, assessing the wound, and per protocol, entering a progress note into the medical record. They stated notification of the injury included notifying the provider, the resident care manager, the Director of Nursing, and the family. Staff D stated if the injury occurred on night shift, they would pass it on to the day shift nurse to notify the family. Staff D stated they were unsure if the family was notified of Resident 1's injury. Record review of a facility investigation dated 10/13/2025 at 11:30 AM, showed the date of the incident was 10/11/2025 at 5:00 AM. The investigation showed the provider, Director of Nursing, and Resident 1's power of attorney was notified on 10/14/2025, three days after the injury. During an interview on 12/04/2025 at 1:02 PM, Staff B, Director of Nursing, stated the process included providing notification to the family when a resident was injured. They stated the facility was unable to locate any documentation to verify that the RR was notified. Staff B stated the nursing staff did not follow the process. During an interview on 12/04/2025 at 1:12 PM, Staff A, Administrator, stated the process included notifying the family of the injuries, but they were unable to locate documentation of the notification. They stated they believed one injury had been reported to the family and would continue to search for that documentation. During a follow-up voicemail received on 12/09/2025 at 8:38 AM, Staff A stated one of the injuries (toe injury) had been brought to the facility's attention by the RR. They stated the RR had talked to the facility staff about the injury and that was the reason why nursing staff did not notify the RR of the injury. Reference: WAC