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	04/14/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical and verbal abuse by Resident 2 for 1 of 3 residents (Resident 1) reviewed for abuse. This failure placed the residents at risk for continued abuse, injury, and emotional distress. Findings included. Review of a policy titled, Abuse and Neglect, dated 12/18/2024, showed physical abuse was the willful action of inflicting bodily injury or physical mistreatment that included striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding. Mental abuse was a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, or punishes a vulnerable adult (a person [AGE] years of age or older who has the functional, mental, or physical inability to care for themselves) that may include ridiculing, yelling, or swearing. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including age-related cognitive decline (a natural slowing of processing speed, reduced working memory, and occasional word-finding difficulties, but generally does not impair daily functioning), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety disorder. The 02/07/2026 comprehensive assessment showed Resident 1 required maximum assistance/dependence of one to two staff members for activities of daily living [(ADLs) activities related to personal care)]. The assessment also showed Resident 1 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 2Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), Alzheimer's disease, and an irregular heart rhythm. The 03/21/2026 comprehensive assessment showed Resident 2 required moderate/maximum assistance of one staff member for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Record review of Resident 2's care plan dated 04/08/2026, showed Resident 2 had episodes of verbally and physically abusive behavior. An intervention for the behavior showed to avoid sitting Resident 2 near specific residents at meals whenever possible; Resident 2 preferred to sit with Resident 1. If Resident 1 was sitting at another table, that may persuade Resident 2 to sit away from the other residents. Record review of a facility investigation dated 02/05/2026, showed on 02/02/2026 at 5:15 PM, Resident 2 was irritable and having difficulty getting along with other residents. Resident 1 had received their plate of food for dinner and Resident 2 accused Resident 1 of taking their dinner plate. Resident 2 became angry and hit Resident 1 on their left arm. Record review a facility investigation dated 04/04/2026, showed on 04/03/2026 at 6:00 PM, Resident 2 became agitated with Staff B, Registered Nurse, during their medication administration and accused Staff B of stealing their inhaler (a handheld device that delivers medication directly to the lungs). Resident 2 became verbally aggressive with Staff B and was redirected to their room to calm down. Resident 2 did not remain in their room and wheeled themselves in their wheelchair to sit next to Resident 1. Resident 2 stated to Resident 1 you are not helping me and hit Resident 1 twice on the left arm. During an interview on (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/14/2026 at 2:22 PM, Staff C, Nursing Assistant, stated Resident 2 had random outbursts that was normal behavior for them. They stated Resident 2 was mean to Resident 1. Staff C stated there was an incident when Resident 2 yelled at Resident 1 over dinner then hit Resident 1. Staff C stated Resident 2 was frequently upset with the staff when they tried to take Resident 1 to their room for personal cares. Staff C stated Resident 1 did not realize what was happening and could not advocate for themselves. During an interview on 04/14/2026 at 2:53 PM, Staff B stated they recalled the second incident between Resident 1 and Resident 2. They stated Resident 2 became angry with them during their medication administration. Staff B stated Resident 2 continued to escalate and punched and kicked at them. They stated they took Resident 2 back to their room because there were other residents in the dining area. Staff B stated Resident 2 came back out of their room. They recognized that they were causing Resident 2's behaviors to escalate and stepped back to allow a different staff member to attend to Resident 2 and continued to monitor them from a distance. Resident 2 became angry with that staff member, went to Resident 1 and punched them in the arm twice. Staff B stated they had seen Resident 2 hit other residents in the past. They stated Resident 2 had altercations with whoever gets in their way but goes towards (Resident 1). During an interview on 04/14/2026 at 3:27 PM, Staff A, Director of Nursing Services, stated they did not look at abuse as a resident-to-resident issue, but as a staff to resident issue. They stated they now understood the definition of abuse and agreed that Resident 1 was abused by Resident 2. Reference: WAC 388-97-0640(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse prevention policy in the areas of prevention and protection for 1 of 3 residents (Resident 1) reviewed for abuse. This failure placed the residents at risk for continued unidentified abuse, fear, and dissatisfaction with their living situation.Findings included. Review of a policy titled, Resident Abuse Prevention, dated 12/18/2024, showed prevention of abuse included identifying, correcting, and intervening in situation in which abuse, neglect, and/or misappropriation of resident property was likely to occur. The facility would provide sufficient staff to meet the needs of the residents and ensure the staff assigned had knowledge of the individual resident's care need. Assessments, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors. Review of a policy titled, Abuse and Neglect, dated 12/18/2024, showed upon receiving notice of allegations of resident abuse, the Administrator, or designee, shall undertake reasonable and prudent actions to ensure the safety and protection of the rights of the alleged victim and other residents of the facility. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including age-related cognitive decline (a natural slowing of processing speed, reduced working memory, and occasional word-finding difficulties, but generally does not impair daily functioning), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety disorder. The 02/07/2026 comprehensive assessment showed Resident 1 required maximum assistance/dependence of one to two staff members for activities of daily living [(ADLs) activities related to personal care)]. The assessment also showed Resident 1 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 2Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), Alzheimer's disease, and an irregular heart rhythm. The 03/21/2026 comprehensive assessment showed Resident 2 required moderate/maximum assistance of one staff member for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Review of a nursing progress note (PN) dated 02/02/2026 at 6:51 PM, showed Resident 2's irritability was increasing throughout the afternoon with behaviors including yelling at others and calling staff b*****s. Resident 2 believed Resident 1 was eating from their dinner plate and they hit Resident 1. Review of a PN dated 04/03/2026, showed Resident 2 had an altercation with Staff B, Registered Nurse (RN), related to their medication administration. Resident 2 was placed in their room due to their escalating behaviors of hitting, kicking, and cursing at Staff B. Resident 2 came back out of their room in their wheelchair, wheeled over to Resident 1, stated to them you are not helping me, and punched them twice on their left arm. During an interview on 04/14/2026 at 3:07 PM, Staff D, RN, stated Resident 2 had increased behaviors over the last month. They stated when the resident had increased behaviors, staff tried to redirect them. Staff D stated Resident 2 had connected with Resident 1 after Resident 2's spouse passed away and thought it was good that Resident 1 had a companion, someone to sit with, and someone to talk to, despite Resident 2 being an aggressor, getting angry with, and cursing at Resident 1. During an interview on 04/14/2026 at 3:27 PM, Staff A, Director of Nursing Services, stated once abuse was identified, the residents would be separated to protect the alleged victim. Staff A stated they did not know why the residents were encouraged to sit together and not separated after the first incident. They stated the facility policy was not followed. Cross reference F600 for further information.Reference: WAC 388-97-0640(1)(2)(a)(b)(5)(a)(a)(b)(c)

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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. Based on interview and record review, the facility failed to provide adequate supervision and update care plan interventions to prevent resident-to-resident altercations with Resident 2 for 1 of 3 residents (Resident 1) reviewed for accidents. This failure placed the residents at risk for potential verbal and physical abuse, serious pain and injury, and emotional distress.Findings included. Review of a policy titled, Safety and Supervision of Residents, revised 07/2017, showed the interdisciplinary care team (a group of healthcare professionals from different disciplines to help people receive the care they need) would analyze information obtained from assessments and observations to identify specific accident hazards or risks for individual residents. The care team would target interventions to reduce individual risks, including adequate supervision. Resident supervision was a core component of the system approach to safety. The type and frequency of resident supervision may vary over time for the same resident. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including age-related cognitive decline (a natural slowing of processing speed, reduced working memory, and occasional word-finding difficulties, but generally does not impair daily functioning), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety disorder. The 02/07/2026 comprehensive assessment showed Resident 1 required maximum assistance/dependence on one to two staff members for activities of daily living [(ADLs) activities related to personal care)]. The assessment also showed Resident 1 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 2Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), Alzheimer's disease, and an irregular heart rhythm. The 03/21/2026 comprehensive assessment showed Resident 2 required moderate/maximum assistance of one staff member for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Review of Resident 2's care plan dated 04/08/2026, showed identified interventions for episodes of verbally and physically abusive behavior that included avoid seating Resident 2 near (identified residents) for meals.whenever possible. Encourage Resident 2 to sit at another table for activities.Resident 2 generally prefers to sit with Resident 1 and if Resident 1 is sitting at another table that may persuade Resident 2 to sit in a different location than (identified residents). Additional interventions included Resident 2 having a quiet moment in their room, on the patio, and going for a walk. Position Resident 2 and staff in ways to enable quick intervention when necessary. Intervene as necessary to protect the rights and safety of others. Remove from the situation and take to alternate location as needed. Record review of a facility investigation dated 02/05/2026, showed on 02/02/2026 at 5:15 PM, Resident 2 was irritable and having difficulty getting along with other residents. Resident 1 had received their plate of food for dinner and Resident 2 accused Resident 1 of taking their dinner plate. Resident 2 became angry and hit Resident 1 on their left arm. Record review a facility investigation dated 04/04/2026, showed on 04/03/2026 at 6:00 PM, Resident 2 became agitated with Staff B, Registered Nurse (RN), during their medication administration. Resident 2 became verbally aggressive with Staff B and was redirected to their room to calm down. Resident 2 did not remain in their room and wheeled themselves in their wheelchair to sit next to Resident 1. Resident 2 stated to Resident 1 you are not helping me and hit Resident 1 twice in the left arm. During an interview on 04/14/2026 at 3:07 PM, Staff D, RN, stated when Resident 2 had behaviors the staff tried to intervene and redirect them. They stated Resident 2 connected with Resident 1 and considered them a surrogate (substitute) spouse. Staff D stated Resident 1 used to call staff over to sit and talk with them; now Resident 2 sat and talked with them so staff did not have to. Over the last month, Resident 1 had become more agitated and more difficult (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to redirect. Staff D stated Resident 2 was more agitated with Resident 1, angry with them, and cursed at them. They stated Resident 1 was not offended when Resident 2 swats at them. Staff D stated the care plan interventions were appropriate in the past but with the new abuse allegations, they should have been updated. Staff D stated they were responsible for updating the care plan interventions but had not done so for Resident 2, despite the resident-to-resident altercations. During an interview on 04/14/2026 at 3:27 PM, Staff A reviewed the facility policy related to safety and supervision of residents and stated the facility did not follow the policy. Cross reference to F600 for further information. Reference: WAC 388-97-1060(3)(g)