STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on interview and record review, the facility failed to document in the medical record any discussions regarding Advanced Directives (AD), including incorporation into the care planning process, for 2 of 3 residents (Residents 1 and 2) reviewed for AD. This failure placed the residents at risk of losing their right to have their preferences/decisions followed regarding end-of-life care. Findings included . Review of the facility policy titled Advance Directives, dated 10/29/2023, showed the facility would help residents, who did not have an AD in place, to establish one, and nursing staff would document the resident's decision to accept or decline assistance in the medical record. <Resident 1> Review of the medical record showed Resident 1 admitted to the facility on [DATE] with diagnoses of surgical after care for abscess and injury to urinary bladder, muscle weakness, and mild cognitive impairment. Review of the comprehensive assessment, dated 06/25/2024, showed Resident 1 required the assistance of one person for all personal cares and had severe cognitive impairment. During an interview, on 08/08/2024 at 11:15 AM, Resident 1 stated they were unsure of who made decisions for them when they were unable to. Review of the medical record, on 08/08/2024 at 12:45 PM, showed Resident 1 did not have any AD documents on file. During an interview, on 08/08/2024 at 1:40 PM, Staff D, Social Services Director, stated Resident 1 verbally designated a Resident Representative (RR) to be their decision maker and all residents receive a copy of the Five Wishes (a booklet that summarizes important aspects of a resident's right to make their own decisions for medical treatments) upon admission. Staff D stated they did not document this in the medical record. <Resident 2> (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. Building B. Wing	08/08/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed Resident 2 admitted to the facility on [DATE] with diagnoses including right hip replacement, dementia (condition that affect the brain and impairs a person's ability to think, remember, and reason), and muscle weakness. Review of the comprehensive assessment, dated 08/05/2024, showed Resident 2 required the assistance of one person for all personal cares and had severe cognitive impairment. During an interview, on 08/08/2024 at 11:25 AM, Resident 2 was unable to name who their decision maker was. Review of the medical record, on 08/08/2024 at 12:45 PM, showed Resident 2 did not have any AD documents on file. During an interview, on 08/08/2024 at 1:10 PM, Staff C, Resident Care Manager (RCM), stated they refer to the person listed as Responsible Party on the resident's face sheet for decision making when an AD was not available. Staff C stated it was not a part of their process to discuss or help in developing ADs, or document decisions regarding AD development in the medical record. During an interview, on 08/08/2024 at 1:40 PM, Staff D stated they requested copies of AD during the 72-hour care conference (a meeting held three days after admission to discuss goals, needs and care plan), and referred residents who did not have an AD to the Five Wishes booklet from the admission packet. Staff D stated they did not routinely document the discussions or decisions made regarding ADs in the medical record. During an interview, on 08/08/2024 at 2:35 PM, Staff B, Director of Nursing, stated the expectation was ADs were reviewed upon admission, quarterly, and documented in the care plan. Staff B stated the facility had not been following their process. Reference: WAC 388-97-0280 (3)(c)(i-ii)