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	08/23/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to ensure a resident's right to privacy, security, and confidentiality when a staff member relayed confidential information to a visiting family member for 1 of 1 resident (Resident 2) reviewed for personal privacy/confidentiality of records. This failed practice placed residents at risk for the loss of confidentiality and privacy and the right to have their preferences honored. Findings included . <Resident 2> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include an infection in their digestive system. The 06/21/2024 comprehensive assessment showed the resident's cognition was intact. During an interview on 08/23/2024 at 12:25 PM, the Resident's Representative (RR) stated Resident 2 discharged from the facility to the hospital on 06/23/2024. The RR stated Resident 2 had a urine infection that had gone into their blood stream and required hospitalization . The RR stated the infection had made Resident 2 incontinent of their bladder and caused some confusion at times and was embarrassed to be seen that way. The RR reported Resident 2's brother and sister-in-law arrived at the facility to visit Resident 2 and were told by an unidentified staff member that Resident 2 had been sent to the hospital. The staff member informed the family that Resident 2 had a urine infection and disclosed to them what hospital the resident had been admitted to. The RR stated the staff member was identified as a male, taller than the average male, and had facial hair and stated the family members were not listed as a contact for the resident, so should have never been given that information. The RR was unable to give a name of the staff member, only a description. The RR further stated they were angry when the family showed up at the hospital to see Resident 2 and called the facility and reported the incident to Staff A, Administrator. (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	08/23/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a document titled, Grievance/Complaint Report dated 06/24/2024, showed Staff A had received a complaint by Resident 2's RR that showed Resident 2's son had been given Resident 2's hospital location and diagnosis without identifying and securing Health Insurance Portability and Accountability Act, (HIPPA, a Privacy Rule that protects the Personal Health Information and medical records of individuals, with limits and conditions on the various uses and disclosures that can and cannot be made without patient authorization) guidelines to protect Resident 2's privacy. The document showed the complaint had been assigned to Staff D, Director of Rehab. Staff D documented their follow-up with the RR showed the staff member was described as a tall male with a beard and they did not have staff that fit the description given so could not identify the staff member. Staff D documented the RR informed them Resident 2 would be going to another facility once discharged from the hospital. Staff D further documented they would review the HIPPA Policy with the team on 07/01/2024. During an interview on 08/23/2024 at 1:55 PM, Staff D stated they received a complaint from Staff A that Staff C, Occupational Therapist (OT, a specialist that performs a treatment that helps people improve their ability to perform daily tasks) was accused of giving a resident's information to a family member that was not supposed to have it. Staff D stated at that time they felt the leadership decided the staff member was Staff C, but Staff C did not fit the description that the RR described. Staff D stated they provided HIPPA education to the therapy staff despite not believing it was a therapy staff member. Staff D could not provide any documentation to show the HIPPA education had been completed. During an interview on 08/23/2024 at 5:03 PM, Staff A stated when the RR called and reported the HIPPA issue they wanted Staff A to write up the staff member, but I can't write up someone that doesn't fit that description. When asked if education had been provided to staff, Staff A stated they could not be sure it was a staff member that told the family that information. Staff A stated Staff D provided education to their staff but was not aware that Staff D could not provide documentation that education had been done. Reference: WAC 388-97-0360

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	08/23/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44922 Based on interview and record review, the facility failed to ensure residents received care and services according to standards of practice when they failed to timely implement their grievance process for 3 of 3 residents (Residents 3, 4, and 5) reviewed for grievances. This failed practice placed residents at risk for unmet care needs. Findings included . Review of a policy titled Grievances/Concerns dated 09/26/2022, showed the Grievance Officer (GO) was responsible for ensuring the grievance process was followed through with from beginning to completion. Once the grievance was resolved by the department manager assigned to the grievance and the resident was provided a follow-up, the department manager was to provide a written report of the findings to the Administrator and the GO within five working days. <Resident 3> Review of the resident's medical record showed the resident admitted with diagnoses to include a fracture of their left knee and muscle weakness. The 07/05/2024 comprehensive assessment showed the resident's cognition was intact. Review of a written grievance document dated 07/06/2024, showed a concern had been reported regarding inadequate pain management. Resident 3 reported they had a pain level of ten (on a pain scale of zero to ten, with ten being the worst pain possible and zero being no pain) at 12:37 AM and had to wait until 3:40 AM before they received pain medication. The document showed the grievance was not assigned to the nursing manager until 07/17/2024 (11 days after grievance was received). The resident discharged from the facility on 07/11/2024 without their grievance being resolved. <Resident 4> Review of the resident's medical record showed the resident admitted with diagnoses to include Multiple Sclerosis ((MS), a potentially disabling disease of the brain and spinal cord (central nervous system) and muscle weakness. The 06/08/2024 comprehensive assessment showed Resident 4's cognition was intact. Review of a written grievance document dated 08/13/2024, showed a concern had been reported by Resident 4 and they had not received a shower since 07/26/2024. The concern was written by Staff E, Social Services. The document showed no investigation, no follow-up and no resolution as of 08/23/2024 (ten days after grievance was received). <Resident 5> (continued on next page)

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	08/23/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record showed the resident admitted with diagnoses to include dementia (group of diseases and conditions that affect your thinking, memory, reasoning, personality, mood and behavior). The 08/09/2024 comprehensive assessment showed Resident 5's cognition was moderately impaired. Review of a written grievance document dated 08/13/2024, showed a concern had been reported by Resident 5 that when they used their call light to request assistance it took awhile to get assistance. The concern was written by Staff E and the document showed no investigation, no follow-up, and no resolution as of 08/23/2024 (10 days after grievance was received). During an interview on 08/23/2024 at 3:35 PM, Staff B, Assistant Director of Nursing Services, stated their responsibility in the grievance process was to investigate the concern (interview residents, staff, determine shifts if a certain one) then figure out how to fix the issue (audits, care plan updates), and then complete the bottom portion of the grievance document and notify the resident of the outcome or resolution. Staff B stated they did not know why Resident 3's grievance took so long to be assigned but they had one Social Services staff that was training and one that was currently off. Staff B stated Resident 4 and 5's grievances had not been given to them until 08/22/2024 and they had not had a chance to start the investigation and would be addressing those on Monday, 08/26/2024 (13 days after the grievance was received). During an interview on 08/23/2024 at 3:42 PM, Staff E stated they were one of the GOs and they were in training and the other GO was currently off. Staff E stated they received the grievances, then forwarded them to the Administrator to review and then assigned to the department manager. The department manager was then to come up with a plan to ensure the issue did not continue, completed the bottom portion of the grievance form, informed the resident of the resolution, and returned the form to the GO. The GO then followed up with the resident to ensure the issue had not continued. Staff E further stated during morning meetings with the administrative staff they reviewed all grievances until they were completed. Staff E stated Residents 4 and 5's grievances were originally given to Staff B and were misplaced in their office and were recently given to Staff B again on 08/22/2024. During an interview on 08/23/2024 at 5:03 PM, Staff A, Administrator, stated they had issues with the timeliness of the grievance process. Staff A stated the grievances were to come to Staff A, then to the manager of that department. The managers were to initiate the investigation, talk to the residents and families, decide a plan for a resolution, and then follow-up with the resident to ensure there were not any other issues. Staff A stated they instructed Staff B to complete the two grievances for Residents 4 and 5 before they had left for the weekend and that had not been done. Reference: WAC 388-97-0460 (2)

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	08/23/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44922 Based on observation, interview, and record review, the facility failed to report suspected allegations of abuse and/or neglect to the State Agency for 1 of 1 resident (Resident 1) reviewed for abuse/neglect. This failed practice placed the residents at risk for unidentified and ongoing abuse and/or neglect. Findings included . <Resident 1> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include dementia (a group of diseases and conditions that affect your thinking, memory, reasoning, personality, mood and behavior), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of worry, nervousness, or unease). The 05/21/2024 comprehensive assessment showed Resident 1's cognition was severely impaired. During an interview on 08/23/2024 at 12:25 PM, a collateral contact (CC) discussed an allegation of abuse involving a resident, later identified to be Resident 1 and the alleged perpetrator (AP) Staff C, Occupational Therapist (OT, a specialist that performs a treatment that helps people improve their ability to perform daily tasks). The CC stated Resident 1 carried a baby doll with them when they were out of their room and treated the baby doll as if it were their own child. The CC stated Staff C had been talking with other staff at the front desk of the nurse's station, when they asked Resident 1 if they could see their baby. Staff C then took the baby doll, held it up and deliberately threw the baby doll to the floor and smiled about it. The CC stated the look on Resident 1's face, was horrible, as if someone had just killed [Resident 1's] child. The CC stated they called the facility on 06/24/2024) and spoke to Staff D, Director of Rehab, and informed them of the incident that took place between Resident 1 and Staff C. Review of the June 2024 State Reporting Log showed no incident had been logged or reported to the State Agency involving the allegation reported on 06/24/2024. During an interview on 08/23/2024 at 1:55 PM, Staff D stated they recalled receiving a report of an allegation regarding Staff C and an unnamed resident but after speaking with Staff C and other unidentified staff that were involved, they thought the [CCs] interpretation of the situation was wrong. Staff D stated they did not report the allegation to the administration staff because they believed it was not in Staff C's character to do what they were being accused of and after talking to Staff C, they believed them. During an interview on 08/23/2024 at 2:16 PM, Staff A, Administrator, stated the CC's allegation should have been reported and they would have expected Staff D to report the allegation to Staff A and the State Agency. Reference: WAC 388-97-0640 (6)(c)

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	08/23/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to conduct a thorough investigation into an allegation of abuse and did not protect the resident from further potential abuse when the Alleged Perpetrator (AP) was not removed for 1 of 1 resident (Resident1) reviewed for abuse. This failed practice placed residents at risk for unidentified abuse, unmet emotional needs, and the continued exposure to abuse and/or neglect. Findings included . <Resident 1> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include dementia (a group of diseases and conditions that affect your thinking, memory, reasoning, personality, mood and behavior). The 05/21/2024 comprehensive assessment showed the resident's cognition was severely impaired. During an interview on 08/23/2024 at 12:25 PM, the Collateral Contact (CC) reported an allegation to the facility involving Staff C, Occupational Therapist (OT, a specialist that performs a treatment that helps people improve their ability to perform daily tasks) and Resident 1, on 06/24/2024. The CC stated Resident 1 carried a baby doll with them around the facility and the staff would tell the resident how precious the baby doll was, and Resident 1 would [NAME] (excessive love or admiration) over the baby doll. The CC reported that Staff C asked Resident 1 if they could see the baby doll and when Staff C was handed the baby doll, Staff C smiled and deliberately threw the baby doll to the floor. The CC stated Resident 1 looked horrible as if someone had just killed their child. During an interview on 08/23/2024 at 1:55 PM, Staff D, Director of Rehab, stated they had received an allegation regarding Staff C and an unidentified resident, later identified as Resident 1. Staff D stated they talked to Staff C and other staff that were involved and felt the CC was upset and projecting over other issues they had reported that same day (Staff D could not recall who the other staff were that they talked to and did not obtain written statements). Staff D stated when they questioned Staff C, they stated Resident 1 had dropped the baby doll and Staff C had picked the baby doll up and handed it to Resident 1. Staff D stated they believed what Staff C reported because it was not in their character to do what they were being accused of. Staff D further stated they did not conduct an investigation because the CC reported an array of things and that wasn't one of the things I focused on. Staff D additionally stated they did not think the allegation was harmful, and it was such a vague thing. Staff D stated looking back on it now, there should have been an investigation started. Staff D stated their process for abuse/neglect allegations was to protect the resident and report and they did not follow that process. During an interview on 08/23/2024 at 2:16 PM, Staff A, Administrator, stated when the CC reported the allegation to Staff D an investigation should have been started. Staff A stated Staff D did not follow the correct process. Reference: WAC 388-97-0640 (6)(a)(b)(c)