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	01/29/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that documented resident specific goals, physician orders, treatment plans and social services needs for 5 of 5 residents (Residents 1, 2, 3, 4 and 5) reviewed for baseline care plan. This failure place residents at risk of not receiving necessary care and services and continuity of care. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including paralytic syndrome (loss of muscle function/feeling), bleeding around the brain and chronic pain. The 01/15/2025 comprehensive assessment showed Resident 1 required maximal assistance of one to two staff for activities of daily living (ADLs) and was able to make their needs known. Review of Resident 1's admission nursing assessment dated [DATE], showed they had identified a sacral (relating to the sacrum [a triangular shaped bone at the base of the spine, forming the posterior wall of the pelvis]) pressure wound described as a suspected deep tissue injury. Review of Resident 1's baseline care plan dated 01/09/2025, showed no focus areas, initial goals or interventions for Resident 1's specific care needs related to physician orders, treatments, and social services. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including nontraumatic ischemic infarction of right lower leg muscle (decreased blood flow that causes death to a muscle) and nutritional anemia (low oxygenated red bloods caused by lack of nutrients). The 12/30/2024 comprehensive assessment showed Resident 2 was independent/partial assistance with ADLs and had an intact cognition. Review of Resident 2's baseline care plan dated 12/23/2024, showed no focus areas, initial goals or interventions for Resident 2's specific care needs related to physician orders, treatments, and social services. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including heart failure, obstructive sleep apnea (sleep disorder that causes a pause of breathing during sleep), and depression. Resident 3 required assistance of one to two staff for ADLs and mobility and was able to make their needs known. Review of Resident 3's baseline care plan dated 01/22/2025, showed no documentation of initial goals, focus area or interventions for admission orders, therapy and social services. Additionally, there was no pre-admission screening and resident review [(PASARR) - a federally required form that is used to help ensure individuals were not inappropriately placed in nursing homes for long term care] recommendations, behavioral health goals, or interventions. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including stroke, diabetes (a group of diseases that result in too much sugar in the blood), dysphagia (difficulty swallowing) and depression. The medical record also showed Resident 4 had a feeding tube (a tube inserted into the stomach to provide nutrition). The 01/09/2025 comprehensive assessment showed Resident 4 required supervision/substantial assistance of one to two staff for ADLs and a moderately impaired cognition. Review of Resident 4's baseline care plan dated 01/02/2025, showed no documentation of initial goals, focus areas or interventions for admission orders, therapy and social services. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), metabolic encephalopathy (a chemical imbalance in the blood that affects the brain function), and anxiety. The medical record showed Resident 5 required limited assistance of one staff member for ADLs and was able to make their needs known. Review of Resident 5's baseline care plan dated 01/20/2025, showed no documentation of initial goals, focus areas or interventions for admission orders, physician orders or social services. During an interview on 01/29/2025 at 2:53 PM, Staff A, Resident Care Manager, stated they performed nursing admission assessments on new resident admissions. Staff A stated they reviewed the resident's history and prior functional needs with the resident and/or resident representative. Staff A stated they developed a baseline care plan on the resident's admission and the baseline care plan included ADLs, pain and fall risks. During an interview on 01/29/2025 at 3:55 PM, Staff B, Director of Nursing, stated the process of developing a 48-hour baseline care plan should have five areas necessary for resident care needs that included ADL's, pain, fall risks, skin integrity and bowel and bladder continence. Repeat deficiency from Statement of Deficiencies dated 05/22/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC: 388-97-1020(3)