

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Landmark Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call light systems were functioning at all times in 1 of 6 observed resident rooms (room [ROOM NUMBER]) reviewed for call lights. This deficient practice placed residents at risk for avoidable accidents and unmet care needs. Findings included. During an interview, on 01/13/2026 at 1:10 PM, a Resident Representative (RR) stated both call lights in room [ROOM NUMBER] were not working during their visit on 01/11/2025. The RR stated they attempted multiple times to activate the call lights in the room and verified the light above the resident room doorway in the hallway was not illuminated nor the red light at the call light plug in on the wall in the resident room. During a concurrent observation and interview, on 01/13/2026 at 1:45 PM, with Staff D, Nursing Assistant (NA), showed both call lights in room [ROOM NUMBER] were not consistently turned on when the buttons were pressed. Staff D stated the call light for the bed by the door would not turn on at all and needed to be replaced. Observation of Staff D testing the call light for the bed by the window showed the button was pressed more than three times before it turned on. Staff D stated the call light must be sticking and needed to be cleaned or replaced. During an interview, on 01/13/2026 at 2:10 PM, Staff C, Maintenance Director, stated their process for checking call light system operations was to manually test each call light in a particular section of the building once a month. Staff C stated they typically tested on e-half of the building during the first month, tested the second half of the building during the second month, and continued with the rotation with adjustments as needed. Review of the Call Light System Test Log, dated 12/25/2025, showed the call lights in resident rooms 301-315 were tested and passed. During an interview, on 01/13/2026 at 2:40 PM, Staff C stated the process for fixing call lights between test cycles was for care staff to verbally inform maintenance staff of the issue or for staff to input a work order through the TELS platform (an electronic software for managing maintenance tasks and compliance in healthcare facilities). Staff C stated based on the current testing rotation, room [ROOM NUMBER] was scheduled to be tested again in February 2026. During an interview, on 01/13/2026 at 3:15 PM, Staff A, Administrator, stated both call lights in room [ROOM NUMBER] required replacement and all resident call lights should be working at all times. Reference: WAC 388-97-2280 (1)(a)</p>

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
---	-------	-----------