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	05/06/2026

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. Based on interview and record review the facility failed to investigate a staff altercation witnessed by 2 of 2 residents (Resident 1 and 2) reviewed for allegation of abuse. This failure placed residents at risk for unidentified emotional/psychological abuse and undermined their right to a safe environment free from the effects of staff misconduct. Finding included.Review of a facility policy titled, Abuse, revised 10/20/2022, showed residents had the right to be free from abuse, neglect, misappropriation or property, and exploitation. Abuse of residents, regardless of mental or physical condition, could cause mental anguish and designated staff would immediately review and investigate all allegations of abuse. Resident 1Review of the medical record showed Resident 1 was admitted with diagnoses including dementia (decline in thinking, memory and the ability to perform daily activities) and muscle weakness. Review of the 03/29/2026 comprehensive assessment showed Resident 1 required one staff member for mobility and had an impaired cognition. Resident 2Review of the medical record showed Resident 2 was admitted with diagnoses including Parkinson's disease (a progressive movement disorder that causes tremors, stiffness and impaired balance) and heart disease. Review of the 03/21/2026 comprehensive assessment showed Resident 2 required one to two staff members for mobility and had impaired cognition. During an interview on 05/06/2026 11:16 AM, Staff C, Licensed Nurse, stated during the night shift on 04/28/2026, the staff scheduled showed Staff D, Nursing Assistant (NA) and Staff E, NA were scheduled to work the night shift. Staff C stated Staff D did not report to work and called another NA to cover the shift. Staff C stated Staff D arrived at work a few hours later and began to yell and curse at them at the nurse's station after they were provided with their staff assignment. Staff C stated there were Resident 1 and Resident 2 were at the nurse's station during the altercation. Staff C stated Resident 1's facial expression became fearful when their eyes widened, and they pointed at Staff D. Staff C stated they told Staff D to stop and directed them to care for residents. Staff C stated the Charge nurse was made aware of the situation by Staff E and was then asked to leave the facility. Staff C stated they informed Staff B, Director of Nursing Services (DNS), of the altercation when their shift ended in the morning. Staff C stated they should have put the residents on alert charting for psychosocial harm monitoring for witnessing the altercation. Staff C stated they did not do this as they had gotten busy. During a follow-up interview on 05/07/2026 at 8:00 AM, Staff C stated they were not provided any follow-up for the reported altercation from administration. During an interview on 05/06/2026 at 12:35 PM, Staff D stated they were not scheduled to work the night shift on 04/28/2026 and there was an error on the schedule. Staff C stated they had received a text message from Staff C telling them they were considered a no call/no show for not coming to work. Staff D stated they then reported to work. Staff D stated when they arrived there were two NA's working. Staff D proceeded to begin cares for residents when they were informed that one NA was sent home and they needed to care for additional residents. Staff D stated Staff C began to yell at them when they questioned their assignment. Staff D stated they did yell at Staff C and Staff E during this altercation. Staff D stated there were residents at the nurse's station during the altercation. Staff D stated they were told by the Charge nurse that they had spoken to Staff B and were instructed to send them home. Staff D stated they had not been provided with any follow-up from administration about the altercation. During an interview on 05/07/2026 at 7:36 AM, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E stated they were working the night shift on 04/28/2026 when Staff D had not arrived at work. Staff E stated Staff C had requested another NA to come in and work. Staff E stated when Staff D arrived and was informed, they needed to care for additional residents as the other NA went home. Staff E stated Staff D blew up and began to curse and yell at them. Staff E stated Staff C had told Staff D to stop and they did not. Staff E stated Staff D began to yell and curse into may face and asked them to take it outside. Staff E stated they would not discuss anything further with Staff D without a witness. Staff E stated Resident 1 was sitting at the nurse's station during the altercation and appeared nervous. Staff E stated Resident 1 was pointing at Staff D when they yelled and slammed doors and displayed a worried look on their face. Staff E stated they reassured Resident 1 they were safe and okay. Staff E stated when the Charge nurse told Staff D to leave, Resident 1 appeared relaxed. Staff E stated they believe this altercation was mental abuse towards the residents as they were witnessed to the altercation. Staff E stated they provided a handwritten document of the altercation and provided it to administration and had not heard any follow-up. During an interview on 05/06/2026 at 1:03 PM, Staff B, stated they were aware of the verbal altercation between Staff D and Staff E. Staff B stated they were notified during that night by the Charge nurse of what was occurring and instructed the Charge nurse to send Staff D home for their behavior. Staff B stated they did not perform an investigation into the staff altercation, as it was a staff issue. Staff B stated they did not document any of their conversations with the staff. Staff B stated they were not aware residents had been nearby and heard the altercation. Staff B stated they should have performed an incident report, investigation and placed the residents on alert monitoring. Staff B stated the residents were at risk of psychological harm and could have experienced verbal and mental abuse. During an interview on 05/06/2026 at 3:04 PM, Staff A, Administrator, stated the facility should have handled this incident promptly. Staff A stated the process should have been to complete an investigation and follow up with residents to ensure no lasting fears or concerns about their safety. Staff A stated the process to complete an investigation was not followed and residents should not have been exposed to a staff alteration. Reference WAC: 388-97-0640(1)(3)(a)(6)(a)