

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/31/2026
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)		
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of nursing staff to provide care and services for 13 of 13 residents (Residents 54, 35, 4, 3, 79, 89, 7, 53, 62, 90, 92, 6, and 23) reviewed for sufficient staffing as evidenced by failures related to Resident Rights, Quality of Care and Pressure Injuries. Additionally, resident interviews, staff interviews and reports from the resident council meeting provided evidence of insufficient staffing without resolution. This failed practice placed residents at risk of not having their needs met and potential negative outcomes to their physical and mental health. Findings included .Resident Rights: The facility failed to provide care and services in a manner that maintained and promoted dignity for three residents observed during meal service. Resident 54 During an observation on 07/27/2026 at 12:15 PM, Resident 54 was observed attempting to eat their meal in the assisted dining room and were sitting approximately three feet away from the table, attempting to eat their meal with a spoon causing them to spill food on their person and the floor. At 12:40 PM, 25 minutes later, a nursing assistant (NA) came into the dining room and assisted them with their meal. Resident 35 During an observation on 07/28/2026 at 9:15 AM, Resident 35 had been served their breakfast tray on their bedside table. The tray table was 6 feet away from where Resident 35 was seated and they were unable to reach the tray. At 9:30 AM, 15 minutes later, a NA came into the resident's room and moved them to their bedside table so they could access their meal. Resident 4 During an observation on 07/28/2026 at 9:16 AM, Resident 4's left arm was observed to be paralyzed, and they were attempting to eat with their right hand while the food tray was positioned on the left side of the resident. The position of the tray on the resident's neglected side caused them to drop food on their clothing and the floor. An interview on 07/27/2026 at 12:20 PM with Staff S, NA, stated they were the only one working today in the assisted dining room and were also helping pass meal trays on the south hallway. Quality of Care: The facility failed to ensure care, services and documentation that addressed skin integrity issues were provided in accordance with professional standards of practice. Resident 3 Assessment reviews and interviews showed the nursing staff were not adequately assessing, monitoring or providing wound care as required of a surgical wound on Resident 3's right hip. Prevent/Heal Pressure Injuries: The facility failed to ensure pressure injuries did not develop or worsen in the facility. Resident 79 During an observation on 07/27/2026 at 9:00 AM, a pressure injury was found on Resident 79's right hip. Further review of assessments and interview with staff showed Resident 79's pressure injury developed in the facility. Resident and Resident Representative interviews: Resident 89 During an interview with Resident 89 on 07/27/2026 at 3:26 PM, they stated the call light response time could take up to an hour for anyone to answer. Resident 89 further stated even when the staff do come, they seem rushed and like we are an inconvenience to them. Resident 7 During an interview with a Resident Representative (RR) of Resident 7 on 07/28/2026 at 11:21 AM, (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received wound care treatment and management in accordance with professional standards of practice regarding a surgical wound which was not consistently/adequately assessed, monitored, or had the ordered wound care dressing changes completed for 1 of 3 residents (Resident 3) reviewed for non-pressure related skin issues. These failures placed residents at an increased risk for unmet care needs, untreated skin impairments, and a diminished quality of life. Findings included .Review of the facility's undated policy titled, Documentation of Wound Treatments, showed the facility would complete accurate documentation of wound assessments and treatment. The policy showed that wound assessment would be completed on admission and weekly. The documentation would include measurements (like length, width and depth of the wound), descriptions of the wound characteristics (wound bed color, skin tissue color surrounding wound, presence/amount of wound drainage, odor and pain) and each treatment or dressing changes performed. Additionally, the policy showed that documentation would include the wound progress towards healing, effectiveness of current interventions, modification of treatment, and notification to the physician regarding wound treatment or changes. The facility's policy utilized references from Lippincott Nursing Procedures 8th edition.Review of professional nursing guidelines, Lippincott Nursing Manual of Nursing Practice 11th edition, and Lippincott Nursing Procedures 8th edition, both dated 2019, showed postoperative surgical wounds dressing changes should be completed per the surgeon's instructions along with being assessed at least every shift, which included the type of surgical wound, how it was held together (like staples, sutures or surgical glue), the wounds appearance (like redness, swelling, irritation, drainage, and if the sides of surgical wound closely aligned or touching) and the type of dressing used. The postoperative surgical wound guidelines for bathing/showing showed that a surgical wound could get wet three days after operation if the initial dressing had already been changed. Additionally, the guidelines showed, .Because many practitioners prefer to change the first postoperative dressing themselves to check the incision, don't change he first dressing unless you have specific instructions to do so . and if the wound had drainage and required a dressing change an order and communication with the practitioner would be necessary.Review of Resident 3's medical records showed that they were admitted on [DATE] with diagnoses including a fracture of the neck of right femur (long hip and thigh bone) with hemiarthroplasty (a surgery that replaces half of the hip joint), bladder infection, multiple heart complications and anxiety. The 06/25/2026 comprehensive assessment showed was cognitively intact, able to make their needs known and had a surgical wound that required dressing changes.Review of Resident 3's hospital transfer orders, dated 06/19/2026 showed the resident was to follow-up with the orthopedics (a specialized medical branch focused on correcting and treating bones, joints and muscles) department in two weeks to monitor the surgical wound healing. The orders showed restrictions of keeping the wound covered while bathing and that for wound care, Follow current wound care recommendations .Review of Resident 3's progress notes showed;06/19/2026 at 2:50 PM, admission note stated the resident was alert, cognitively intact and had a right femur neck fracture that required surgical intervention.06/19/2026 at 10:11 PM, daily skilled assessment note stated, .Skin Observation: Resident noted to have a surgical wound. Surgical incision .No clarification of wound care orders or communication with practitioner nor an assessment of Resident 3's surgical wound/dressing had been noted.Review of Resident 3's wound care orders showed;Starting on 06/19/2026 at 7:00 PM nursing staff were to document assessments of the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's right femoral neck fracture hemiarthroplasty incision two times a day. Starting on 06/20/2026 the right surgical hip incision was to be cleansed with wound cleanser (a special solution used to clean out the wound bed), rinsed with a normal saline solution, pat dry, apply skin prep to peri wound (skin area surrounding the wound) and cover with bordered dressing (a gauze pad surrounded by adhesive tape border). Additionally, the order showed the dressing was to be changed every day or if soiled (made dirty or unclean) or displaced. Review of Resident 3's June 2026 and July 2026 shower schedule documents showed they had received showers on 06/20/2026, 06/23/2026, 06/26/2026, 06/30/2026, 07/03/2026 and 07/07/2026. All shower documented noted Residents right hip surgical incision wound. Review of Resident 3's progress notes for their June 2026 and July 2026 shower days showed that on 06/20/2026, 06/23/2026, 06/26/2026, 06/30/2026 and 07/07/2026 no additional dressing changes were performed after Resident 3 showers had been completed. Review of Resident 3's June 2026 medication administration record/treatment administration record (MAR/TAR) showed that nursing documentation on the resident's surgical wound was not completed on 06/28/2026 and did not include descriptions of the wound characteristics or the surgical wounds measurements and appearance. The TAR showed that Resident 3's right hip surgical incision dressing change had not been performed on 06/26/2026, 06/29/2026 and 06/30/2026. Additionally, no documentation of the surgical site having required a dressing change from being soiled or displaced. Review of Residents 3's July 2026 MAR/TAR showed that nursing documentation on the resident's surgical wound did not include descriptions of the wound characteristics or the surgical wounds measurements and appearance. The TAR showed that Resident 3's right hip surgical incision dressing change had not been performed on 07/06/2026. Additionally, no documentation of the surgical site having required a dressing change from being soiled or displaced. During an interview on 07/29/2026 at 2:45 PM, Staff Y, Nursing Assistant (NA), stated that when showering if the resident had a wound with a dressing, they would try to cover the wound so that it would not get wet. Staff Y stated they were not able to cover surgical hip incision dressings during showers like with Resident 3 and would let the nursing staff know that a dressing change was needed after the shower, since it would get wet during the shower. Staff Y stated that with each shower they had a long-bordered dressing on their hip which would get wet during showers and the dressing sometimes have a brown stained color to it. Staff Y stated that Resident 3's dressing would come off and/or get soaked from the shower water, so they would notify the nursing staff that after the shower was completed. During an interview on 07/29/2026 at 4:13 PM, Staff E, Resident Care Manager, stated the process for residents with surgical wounds and showering would be to not have the resident complete a shower. Staff E stated they still had some resident with surgical wounds complete showers but they when performing the shower, the NA was to not get the dressing or wound area wet. Staff E stated that when the shower NA staff get resident wound dressing wet, they would notify the nurse, and an assessment/dressing change would need to be completed/documented in the progress notes or assessments tab of the resident medical record. During an interview on 07/30/2026 at 7:25 AM, Staff D, Director of Nursing Services/Infection Preventionist, stated the facility process for residents with surgical wounds was usually for the dressing to remain in place due to the orthopedic provider usually wanting to perform the first dressing change. Staff D stated that surgical dressing was supposed to be in place for 14 days and the dressing would not be changed by the facility staff before that time. After reviewing Resident 3's hospital transfer orders Staff D stated that clarification of the surgical wound care orders should have been completed, and they did not see that it was. Staff D stated they were unable to find an assessment of the Resident 3 surgical site wound other than the wound characteristics form the resident's hospital stay. Staff D stated that nursing staff should have been documenting on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's admission assessment, the surgical wounds characteristics, the wounds appearance/measurements and the type of dressing the resident had in place when admitted to the facility but was unable to find it. Staff D stated they were unable to determine if Resident 3 had received dressing changes after their shower was performed and that a progress note should have been completed with a dressing change since the surgical hip dressing was not waterproof and would have been wet after each of the showers. Staff D stated the correct process for Resident 3's surgical wound care treatment and management was not followed. During an interview on 07/30/2026 at 9:38 AM, after reviewing Resident 3's medical record Staff E stated the residents right hip surgical wound care, dressing changes and shower recommendation should have been clarified with the orthopedic provider when the resident was admitted to the facility. Staff E stated they did not see that clarification or communication with the orthopedic provider was completed. Staff E stated they did not see an assessment of the resident surgical wound characteristics, appearance or measurements upon admission or during the resident's stay. During an interview on 07/30/2026 at 12:01 PM, Staff C, Regional Administrator/Registered Nurse, stated they would have expected to see more documentation of Resident 3 surgical wound assessment upon admission and during the weekly assessment. Staff C stated that nursing staff should have been performing dressing changes on a surgical wound after showers. Staff C stated the resident surgical wound care orders should have been clarified regarding the dressing changes due to the dressing being different from the normal post-surgical dressing and communication with the orthopedic provider on specific shower/other restriction for the resident. Staff C stated the correct process for Resident 3's surgical wound care treatment and management was not followed. Reference: WAC 388-97-1060(1)(3)(b)		