STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505367	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Springs Care and Rehabilitation	4007 Tieton Drive Yakima, WA 98908

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect a resident's right to be free from verbal and physical abuse for 1 of 3 residents (Resident 1) reviewed for abuse investigations. This failure placed residents at risk for further abuse, injury, and diminished quality of life.Findings included .Record review of the facility's policy titled, Abuse Prevention Program, dated 10/01/2021, showed that the residents had the right to be free from abuse and the facility would protect residents from abuse by anyone including other residents. Resident 1 Record review showed Resident 1 was admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a potentially disabling disease of the brain and spinal cord) and depression. Record review of the 03/12/2026 comprehensive assessment showed that Resident 1 had moderate cognitive impairment and used a wheelchair for mobility. Record review of Resident 1's 03/09/2026 care plan showed they enjoyed socializing one-to-one with staff, small groups and visitors. Resident 1 was encouraged to engage in peer interactions during hallway or common area encounters when the resident was willing. Further review showed Resident 1 was at risk for impaired skin integrity related to impaired circulation and dry fragile skin. Resident 2 Record review showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), delusional disorders (a fixed false belief that is resistant to reason or confrontation), and dementia (a loss of mental ability severe enough to interfere with normal activities of daily living). Review of the 03/21/2026 comprehensive assessment showed the resident had moderate impaired cognition. Resident 2 was at risk for physical and verbal behaviors directed towards others that put others at risk for physical injury. Record review of Resident 2's care plan, dated 05/01/2026, showed the resident would have verbal abusive outbursts toward staff and residents. The interventions included removing Resident 2 from the situation and taking them to an alternative location. Record review of an incident report dated 05/11/2026 showed while residents were waiting for the dining room to open for breakfast, Resident 1 and Resident 2 had a verbal altercation that became physical and Resident 1 received some scratches on their arm. During a concurrent observation and interview on 05/26/2026 at 11:00 AM, Resident 1 was observed in their wheelchair in their room. The resident stated that [Resident 2] was giving another resident the bird and I went near [Resident 2] to find out what was going on and got grabbed on the arm by [them]. Resident 1 pulled up their left sleeve and showed a three centimeter (cm) by five cm steri-strip (a thin, sticky bandage made of special tape that you can put across a small cut or wound to help the two sides of the skin stay together as it heals) dressing on the left forearm that was clean and intact. Resident 1 stated they were waiting for it to heal. During an interview on 05/26/2026 at 11:18 AM, Staff B, Licensed Practical Nurse, stated that they heard Resident 1 and Resident 2 shouting at each other, came around the corner and saw Resident 2 holding onto Resident 1's left forearm. Staff B assisted Staff C, Director of Rehab, to separate the two residents. Resident 1 had three skin tears (a traumatic wound caused by friction, shearing or blunt force that separated the top layers of the skin, the epidermis and dermis) on their left arm that were bleeding. Staff B stated they (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaned and steri-stripped the wound. During concurrent observation and interview on 05/26/2026 at 1:00 PM, Resident 2 was observed in their room on the bed. They stated they did not recall grabbing anyone and added I would never do that. During an interview on 05/26/2026 at 2:00 PM, Staff C, stated they heard the yelling from their office and came out to find Resident 2 had grabbed Resident 1 on the arm while they continued to yell at one another. They were both very angry and separated by myself and Staff B without further incidents. Staff C stated they had heard Resident 2 yell at staff, but this was the first they were aware of physical contact with another resident. Record review of a 05/11/2026 at 8:29 AM progress note by Staff B showed that Resident 1 received three skin tears on the left forearm that were each two cm, four cm and two cm. The wounds were cleansed, dried, approximated (the two sides of a wound were brought together so they were touching and fit neatly), and steri-strips were applied. During an interview on 05/26/2026 at 3:15 PM, Staff A, Administrator, stated no further incidents had occurred and it was the first time they were aware Resident 2 had been physical with another resident. Reference: WAC 388-97-0640(1)