STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505409	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summitview Rehab and Health Center	3801 Summitview 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for falls with injury, was provided adequate supervision to prevent accident hazards. Resident 1 experienced harm when they were left alone on the toilet and found on the bathroom floor after an unknown amount of time. The fall resulted in a forehead hematoma (a pooling of blood in the surrounding tissues after an injury to the blood vessels) with bleeding, and transfer to the hospital where they were diagnosed with a brain bleed. Failure to identify residents that need supervision while on the toilet put residents at risk for injuries and diminished quality of health. Findings included .Review of Resident 1's medical record showed that they were admitted on [DATE] after a stroke (a medical emergency occurring when blood flow to part of the brain is blocked or a blood vessel bursts). Review of the 01/20/2026 comprehensive assessment showed that they had severe cognitive impairment and required assistance from staff for bed mobility, transfers and toileting. Review of Resident 1's 01/16/2026 care plan showed they were at risk for falls due to intermittent confusion and from taking medications for anxiety and high blood pressure that can affect balance and cause dizziness. Fall prevention interventions included sensor alarms and hourly rounding (There were no directives/interventions to stay with the resident while toileting). Record review of a 02/10/2026 bedside care plan for Resident 1 showed they required the assistance of one staff for toileting and had sensor alarms in place and hourly rounding for injury protection (There were no directives to stand by while using the toilet). During a telephone interview on 03/12/2026 at 11:08 AM, Resident 1's Representative (RR1) stated staff notified them on 02/28/2026 that Resident 1 was found on the bathroom floor at 6:20 PM after being toileted. RR1 stated that Resident 1 had many falls at the facility, and the staff should have known not to leave Resident 1 while toileting. RR1 stated the hospital emergency room reported [Resident 1] had two subdural (outermost membrane that protects the brain) brain bleeds and a huge bump at least an inch and a half. [Resident 1] was in a lot of pain while in the hospital. Record review of Resident 1's progress notes showed they had five falls prior to 02/28/2026:- 01/24/2026 resident found on the floor outside bathroom door at 9:57 PM. There were no injuries.-01/27/2026 resident found next to the bed, on the floor at 3:00 AM. There were no injuries.-02/05/2026 bed alarm sounding at 5:05 AM, resident sitting on floor mat next to the bed and stated they needed to use the bathroom. There were no injuries.-02/07/2026 at 12:05 AM, resident found on the floor mat, stated they needed to use the bathroom. There were no injuries.-02/10/2026 resident found on the floor at 10:10 AM, they stated they needed to go to the bathroom. There were no injuries. Record review of a 03/04/2026 Staff D, Nursing Assistant (NA), statement showed on 02/28/2026 Staff D responded to Resident 1 yelling they needed to use the bathroom and saw the resident standing next to their bed beginning to lower their pants. Staff D helped Resident 1 to sit on the toilet where Resident 1 said it was going to take a minute. Staff D stepped out due to another alarm going off down the hall. They helped another resident to and from the toilet and then returned to Resident 1's bathroom about five minutes later and found them on the bathroom floor. During an interview on 03/12/2026 at 4:54 PM, Staff C, Registered Nurse (RN), stated they were the Charge (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

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse on 02/28/2026 when Resident 1 was found on the bathroom floor. Staff C stated that Staff D took the resident to the bathroom that evening and stepped out of the to take care of a couple of things. Staff C stated that after their initial assessment, Staff E, Nurse Tech, and Staff D started the neuro checks and vital signs while they prepared for their change of shift. Record review of the 02/28/2026 incident report written by Staff C showed Resident 1 was found lying on their left side. There was a hematoma on the right side of the forehead with a three-millimeter open area where it was losing blood, 90 cubic centimeter (cc, a metric unit of volume) was observed on the floor under and around Resident 1's head. Pressure was applied to slow bleeding. The predisposing factors to the fall included an impaired memory and was toileting. Notifications to the provider and family were not documented on the incident report form. During an interview on 03/12/2026 at 5:20 PM, Staff F, NA, stated that Resident 1 did not use the call light very well and needed their walker with one staff to go to the bathroom. Staff F stated, One time [Resident 1] said they needed a minute, so I waited by the bathroom door until they were done. On 03/23/2026 at 1:33 PM, Staff H, RN and Case Manager (CM) stated they were currently Resident 1's CM and their office was right next to the resident's room. Staff H stated that Resident 1 was very impulsive, they were not safe to stand alone and needed one staff to assist them in the bathroom. Resident 1 had many falls, and various interventions were tried like a mat beside the bed and position alarms. Staying with the resident during toileting was not an intervention but I would have stayed outside the door and in hindsight, the staff should have stayed with [Resident 1]. During a telephone interview on 03/24/2026 at 9:50 AM, Staff I, NA, stated that they helped Resident 1 to the bathroom several times the morning of 02/28/2026. Staff I stated they would stay by the bathroom with the door cracked for the resident's safety. They stated Resident 1 seemed more confused that morning and was very impulsive. During a telephone interview on 03/24/2026 at 10:18 AM, RR 1 stated they visited Resident 1 every day between 9:00 AM and 6:00 PM and would assist them to the bathroom while they were visiting. RR1 stated that Resident 1 was confused, impulsive and needed someone to stay by the bathroom, the staff knew this. RR1 stated that [Resident 1]'s bedside care plan required one staff assist and to stand by while toileting. RR1 stated [Resident 1] should not have been left alone, this could have been avoided. Record review of 02/28/2026 emergency department documents showed Resident 1 arrived at 9:24 PM and had two CT scans (a special kind of X-ray that can show more details than regular X-rays) that showed subdural hematomas on both the right and left side of their brain. A decision was made with family for Resident 1 to be admitted to the hospital, monitor and medicate for their pain. During an interview on 03/24/2026 at 12:15 PM, Staff A, Administrator, stated they could not find fall interventions to stay near the bathroom when toileting Resident 1. During an interview on 03/24/2026 at 12:18 PM, Staff B, Director of Nursing, acknowledged Resident 1's care plan did not include a directive for staff to stand by during toileting. Staff B stated that they believed Resident 1 wanted privacy. The surveyor pointed out that staff interviewed stated they would stay by and monitor through the crack in the door because the resident was impulsive. Staff B stated there should have been a stand by in the care plan and that might have prevented the fall. Reference: WAC 388-97-1060(3)(g)