

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50A261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2024
NAME OF PROVIDER OR SUPPLIER  Yakima Valley School		STREET ADDRESS, CITY, STATE, ZIP CODE  609 Speyers Road Selah, WA 98942	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure personal privacy was protected for 4 of 4 residents (Resident 1, 2, 3, 4), reviewed for the right to privacy. Resident 1, 2, 3 and 4's images were recorded on a staff member's (Staff C, Nursing Assistant (NA)) personal cell phone without the resident's and/or designated representative's consent and sent in text messages to an individual outside the facility. This failure placed the residents at risk for embarrassment, a violation of their privacy, and a decreased quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's policy titled, Cell Phone/Telephone/Intercom Usage, dated 09/26/2023, showed a staff must never use a personal electronic device to photograph or record residents and information involving or identifying residents must never be sent or shared via text message or social media.</p> <p>Record review of the facility's policy titled, Resident Privacy, dated 09/26/2023, showed personal privacy will be made available to all individuals, staff will be respectful of each individual's dignity and need for modesty.</p> <p>Record review of a Developmental Disabilities Administration 5-Day Investigation Report, dated 06/14/2024, showed the facility received notification by an anonymous reporter that Staff C, NA, sent photographs of Resident 1 and comments such as [Resident 1] has been going off for 2 hours Right now I'm just disgusted with [Resident 1] from the staff's personal electronic device. The facility's investigator obtained copies of 14 photographs sent to the anonymous source that included images of Resident 1 and the images of Resident 2, Resident 3 and Resident 4. The photographs were taken on night shift in the living and dining areas. The residents were clothed and either sitting or lying about the area.</p> <p>&lt;Resident 1&gt;</p> <p>Record review of Resident 1's medical record showed they were admitted to the facility on [DATE] with diagnoses to include intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior or angry verbal outbursts), autistic disorder (a condition related to brain development that impacts how a person perceives and socializes with others) and intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently).</p> <p>(continued on next page)</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
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a 03/29/2024 comprehensive assessment showed Resident 1 had severe cognitive impairment, had physical behaviors directed towards self and others and required extensive assistance from staff for their activities of daily living (ADL). Review of the 03/29/2024 plan of care showed Resident 1 had a goal to be free of harm to self and others.</p> <p>&lt;Resident 2&gt;</p> <p>Record review of Resident 2's medical record showed they were admitted to the facility on [DATE] with diagnoses to include intellectual disabilities, autistic disorder, and impulse control disorder (conditions where individuals have impulses that are difficult or impossible to resist).</p> <p>Review of a 06/12/2024 comprehensive assessment showed Resident 2 had severe cognitive impairment, had physical behaviors directed towards self and others and required supervision from staff for their ADLs. Review of the 03/24/2024 plan of care showed Resident 2 had a goal to be free of harm to self and others.</p> <p>&lt;Resident 3&gt;</p> <p>Record review of Resident 3's medical record showed they were admitted to the facility on [DATE] with diagnoses to include severe intellectual disabilities and autistic disorder.</p> <p>Review of a 05/30/2024 comprehensive assessment showed Resident 3 had moderate cognitive impairment, had physical behaviors directed towards self and others and required supervision from staff for their ADLs. Review of the 03/08/2024 plan of care showed Resident 3 had a goal to be free of harm to self and others.</p> <p>&lt;Resident 4&gt;</p> <p>Record review of Resident 4's medical record showed they were admitted to the facility on [DATE] with diagnoses to include intellectual disabilities and intermittent explosive disorder.</p> <p>Review of a 06/12/2024 comprehensive assessment showed Resident 4 had moderately impaired cognition and required supervision from staff for their ADLs. Review of the 04/04/2024 plan of care showed Resident 4 had a goal to be free of harm to self and others.</p> <p>During an interview on 06/14/2024 at 10:00 AM, Staff A, Administrator, stated Staff C was a NA who worked the night shift on Resident 1's living unit.</p> <p>During an interview on 07/01/2024 at 10:45 AM Staff B, Assistant Administrator, stated the facility's investigator obtained 14 photos that were taken between August and December of 2023.</p> <p>During a telephone interview on 07/01/2024 at 12:35 PM, the Anonymous Reporter (AR), stated Staff C would send them texts and photos while working at the facility at night a couple times a week. They stated that Staff C reportedly would say they knew they should not be sending these photos for confidentiality reasons. The AR stated they reported this in April 2024 because it seemed like the right thing to do.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Attempts on 07/01/2024 at 1:40 PM and 4:20 PM to contact Staff C by telephone failed. Review of the investigation showed, on 06/18/2024 at 10:00 PM, the facility investigator interviewed Staff C who denied taking any pictures of residents with their personal cellular phone or sending any pictures of residents to others via text or any social media.</p> <p>During an observation on 07/01/2024 at 3:30 PM of an enhanced staffed (three staff for four residents) Cottage 405 showed Resident 2 and Resident 3 pacing around the living unit. Staff D, NA, stated the two residents had line-of-sight, one-to-one staff assigned to them.</p> <p>During an observation on 07/01/2024 at 4:15 PM, Resident 1 was seated at the dining table in the enhanced staffed Cottage 406. Staff E, NA, was in the dining area with Resident 1. Staff E stated they were assigned one-to-one for Resident 1, required to stay in close proximity that allowed for personal space.</p> <p>The facility investigator concluded on 06/21/2024 that it appeared more likely than not that Staff C did take pictures of facility residents while at work and sent them by text to an individual that did not work at the facility and violated Resident's 1, 2, 3 and 4's right to privacy.</p> <p>On 07/01/2024 at 4:30 PM, Staff B stated they were aware this was a violation of resident rights.</p> <p>Reference: WAC 388-97-0360 (1)</p>		