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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A261	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yakima Valley School	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)
F 0600 Level of Harm - 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** 30528 Based on interview and record review the facility failed to protect a resident's right to be free from physical abuse for 2 of 2 cognitively impaired residents (Resident 1 and Resident 3) reviewed for allegations of abuse. This failure resulted in physical harm when Resident 1 who had severe cognitive impairment, dependence on staff, and was unable to express discomfort, was kicked in the face. Resident 1 experienced psychosocial harm, applying the reasonable person concept when Resident 1 had a change in sleep behaviors and eating patterns and seemed more withdrawn. This failure placed the residents at risk for further abuse, injury, and diminished quality of life. Findings included . Review of the State Operations Manual (SOM), Psychosocial Outcome Severity Guide dated 10/24/2022, showed when a resident's reaction to a deficient practice (such as physical abuse) were markedly incongruent (or different) with the level of reaction a reasonable person in the resident's position would have to the physical abuse (such as the facility being their home with the expectation of safety and trust in the facility staff to protect them from harm). Record review of the facility's policy titled, Resident Rights 1.02, dated 06/30/2023, showed that residents have the right to legal protections from mental, physical, and sexual abuse. Record review of Developmental Disabilities Administration (DDA) policy titled, Protection from Abuse: Mandatory Reporting 5.13, dated 07/2024, showed abuse and neglect of vulnerable adults is prohibited by law and will not be tolerated. <Resident 1> A record review showed Resident 1 was admitted on [DATE] with multiple diagnoses including profound intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), autism (a condition related to brain development that impacts how a person perceives and socializes with others), insomnia (a sleep disorder characterized by difficulty falling asleep or staying asleep) and anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations). (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the 06/01/2024 comprehensive assessment showed Resident 1 had no speech, highly impaired vision and moderate cognitive impairment. The resident had self-injurious behaviors (SIB) that put them at risk for injury to themselves. Review of Resident 1's care plan dated 06/14/2024 showed that they exhibited severe self-injurious behaviors, such as slapping self, punching their head or pulling their hair. Staff had interventions to redirect the behavior by identifying what the resident needed and if not redirectable, the staff had a protective helmet and mitts they could apply with a physician order to protect the resident from injury. Further review of Resident 1's care plan showed that when awake, they were on a Level of Supervision (LOS) 4: One-to-one supervision, allowing as much social space as possible. Supervision must be positioned in a manner to prevent danger or harm to self or others. If the resident were in their room, staff were to be positioned outside the door, with the curtain pulled, staff were to be positioned outside their door and perform visual checks (eyes on Resident 1) every five minutes. When sleeping, the resident was on a LOS 3: supervision must be positioned in a manner to protect from or deter danger. Staff were to provide 15-minute checks when they were asleep, and the curtain was pulled. <Allegation 1> Record review of a 07/25/2024 witness statement written by Staff M, Attendant Counselor Nursing Assistant (NA) showed that on a day they worked evening shift in cottage 405/406 (shift log showed the date was 06/29/2024) while they were one-to-one supervision with Resident 1, they observed Staff N, NA, hit Resident 1 in the head around 5:30 PM. They stated that they took Resident 1 to the toilet and noticed they had a soiled incontinent brief. They asked Staff N to keep an eye on the resident while they got a new brief and disposed the soiled one. Staff M stated that when they returned to the bathroom, Staff N was telling Resident 1 that they needed to sit down (on the toilet) and push. Resident 1 began hitting themselves in the head and Staff N proceeded to also hit the resident in the head stating that was how to get Resident 1 to stop their SIB. Resident 1's SIB did not stop, and the nurse was notified and helped take Resident 1 to their room to apply their safety gear. Review of a 07/16/2024 DDA Statewide Investigation Unit ([NAME]- performs impartial abuse and neglect investigations in state residential facilities) report showed the facility was informed of an allegation that Staff N had hit Resident 1 in the head to stop their behaviors, no date, time or name of witness of the alleged abuse was provided. The facility removed Staff N from resident care. Based on the information available at the time, there was insufficient evidence to conclude the allegation occurred. The investigation had been turned over to law enforcement on 07/10/2024. Review of nursing progress notes from 06/29/2024 showed that Resident 1 had three episodes of SIB between 6:00 PM and 9:20 PM. The resident required application of their helmet and mitts due to Resident 1 pulling their hair, hitting their face/head with fists and biting their wrists. The nurse documented at 9:30 PM that there was no open skin on the resident's wrists nor other skin injuries observed from Resident 1's attempts at SIB. Review of Resident 1's sleep and meal consumption logs from 06/29/2024, 06/30/2024 and 07/01/2024 showed no changes to their usual sleeping and eating habits. <Allegation 2> (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a 07/10/2024 DDA [NAME] report showed that through several witness reports and the change in Resident 1's sleep behavior, it was more likely than not that on 07/06/2024 Staff C, NA, kicked Resident 1 (in the face). Staff C was removed from direct resident care after the incident. Review of a witness statement written by Staff D, NA, on 07/08/2024, showed that on 07/06/2024 at 10:00 PM, Resident 1 was lying down in bed and could be heard tapping on their head. [I] redirected to not hit [them]self and told [them] it's bedtime. Staff C goes in and kicks [Resident 1] in the face. [I] told [Staff C] to leave, [Resident 1] had no response and went to bed. Review of a nursing progress note dated 07/07/2024 showed that on 07/06/2024 at 10:50 PM Resident 1 was examined from head to toe. The nurse observed the resident's right cheek was light red, no other injuries were found, and the resident went right back to sleep. Review of Staff E's, NA, statement from 07/11/2024 at 6:45 PM phone interview, documented in the 07/10/2024 DDA [NAME] report showed, Staff E was in the cottage 405 hall near Resident 1's bedroom, on 07/06/2024 at 10:00 PM. They could hear Resident 1 in the beginning stages of a behavior and asked Staff D if they needed help with Resident 1's safety gear (helmet/mitts). Staff E stated that Staff C started walking to Resident 1's room and stated 'oh, I want some of this' with Staff F, NA, behind them. Staff E stated within seconds, they (Staff C and Staff F) were walking out of the room giggling and there were no sounds coming from Resident 1's room. Staff E asked them 'what did you do to get [Resident 1] to stop the behavior' and they just ignored Staff E. Review of Staff G's, NA, statement from 07/15/2024 at 1:22 PM interview, documented in the 07/10/2024 DDA [NAME] report, showed that they were hanging around the hallway of cottage 405 by the bedrooms around 10:00 PM on 07/06/2024. Staff G stated they saw Staff C and Staff F enter Resident 1's bedroom. Staff G walked towards the room and stood by a short distance outside of the doorway. Staff G stated they saw Staff C pick up their right leg, like they were going to kick Resident 1, at the same time Staff F was closing the curtain. Staff G stated that they 'found it strange' that they were handling a behavior with the lights off and closing the curtain. Staff G stated they didn't hear Resident 1 after they closed the curtain only heard Staff C state you need to stop and go to sleep. Review of Staff F's statement from 07/15/2024 at 1:57 PM, documented in the 07/10/2024 DDA [NAME] report showed that they walked in directly behind Staff C and saw them lift their leg towards Resident 1. Staff F stated they then saw Staff C raise their arms over their head and bringing them down on Resident 1. Staff F stated they didn't directly see where Staff C hit or kicked Resident 1 but heard (the sounds of) making impact. During an interview on 08/07/2024 at 2:54 PM, Staff D refused to talk about what they witnessed on 07/06/2024 and stated, I don't want to talk, you can read my statement and ended the interview. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/07/2024 at 3:15 PM, Staff E, stated they were assigned one-to-one for a resident in the bedroom next to Resident 1 on 07/06/2024. Staff E stated they could hear Resident 1 start hitting themselves, I stated, is [Resident 1] going to SIB? Staff D, who was the assigned one-to-one, stood up, but Staff C headed for Resident 1's room and stated 'oh, I want some of this'. Staff F was behind Staff C, and they went into Resident 1's room with Staff D following. I heard the privacy curtain close. Staff D came out quick. I said, wow you got [Resident 1] to calm down fast. Staff D had a look of shock on their face and said, a yeah. Staff C and Staff F both came out of the room. I did not know what happened until the next day. I started my shift at 2:00 PM with Resident 1, they were sleeping and according to their sleep log had slept the whole day. Resident 1 woke up for dinner and then returned to bed and this was not normal for them. During an interview on 08/08/2024 at 4:35 PM, Staff L, NA, stated they worked evening shift in cottage 405 on 07/06/2024. Staff L stated they were in the back hallway around the time of the incident talking with Staff E and had their back to Resident 1's room. Staff L stated they heard a bit of a commotion from the room, then Resident 1 got quiet, the room got quiet. After Staff C and Staff F went to the front of the cottage, Staff D looked worried, anxious and was pacing. Staff L stated they followed Staff D into Resident 1's room and saw Staff D use their cell phone flashlight to check the right side of Resident 1's face. Staff D did not say what they were looking for. Staff L stated that the next day Resident 1 was really out of it, they slept a lot, skipped dinner and a snack, that was real unusual behavior. During an interview on 08/09/2024 at 3:05 PM, Staff K, NA, stated that they worked evening shift in cottage 405 on 07/07/2024. Staff K stated that Resident 1 was not their normal self, they seemed withdrawn and was sleeping more than usual. Staff K stated they looked at Resident 1's sleep log and they had slept all on day shift and on evening shift until 8:00 PM. <Resident 3> A record review showed Resident 3 was admitted on [DATE] with multiple diagnoses including cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth), unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), and adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior). Review of the 07/14/2024 comprehensive assessment showed Resident 3 had no speech, highly impaired vision and moderate cognitive impairment. Review of Resident 3's care plan dated 04/14/2024 showed they could be unsteady with ambulation, did not understand personal space, would get too close to others trying to touch or pinch and was obsessive about taking their clothes off. Further review of the care plan showed Resident 3 was a LOS 3 (supervision must be positioned in a manner to protect from or deter danger. Enhanced staffing was required) when the resident was awake. They were a LOS 2 (knowledge of where resident was at all times, whom they were with and what they were doing) when asleep. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of an 08/03/2024 DDA [NAME] report showed that based on two staff witness statements, it was more likely than not that on 08/02/2024 Staff I, NA, drug Resident 3 across the floor from the living area to the resident's bedroom by dragging Resident 3's lower body as they held the top of the torso with their arm hooked under Resident 3's shoulder. Review of an 08/03/2024 at 11:01 AM nursing progress note showed that Resident 3 had a full body check with no injuries found. Review of an 08/03/2024 witness statement written by Staff H, NA, showed that on 08/02/2024 at 2:15 PM, they observed Resident 3 begin taking off their shoes while sitting in a recliner in the cottage 203 living area. They stated Staff I walked up to Resident 3, grabbed their shirt pulling them aggressively to the floor. Resident 3 then grabbed another resident's shirt who was also sitting on the floor. Staff H stated they got between the two residents, and Staff I then drug Resident 3 back to their bedroom. After Resident 3 got to their room, they started taking off their clothes and the privacy curtain was closed let Resident 3 cool down. Record review of an 08/03/2024 witness statement written by Staff J, NA, showed that on 08/02/2024 at 2:25 PM they observed Resident 3 throwing their shoes on the floor. Staff I told Resident 3 to take their shoes to their room three times. The third time, Staff I suddenly grabbed Resident 3's shirt and pulled them out of the recliner and when on the floor, Resident 3 grabbed another resident's shirt. During an interview on 08/14/2024 at 2:03 pm, Staff I stated they worked in cottage 203 on 08/02/2024. They stated that Resident 3 was sitting in a recliner in the living area and started to remove and toss their shoes. Staff I asked Resident 3 to grab their shoes and let's go to your room, the resident had no response. Staff I stated they gave the verbal que again, but the resident scooted forward in the chair, sat on the floor and grabbed another resident's shirt. Staff I stated that after a couple minutes, Resident 3 stood up on their own and were directed to their room by walking next to the resident. Staff I denied pulling the resident out of the recliner and denied dragging the resident across the floor back to their bedroom. During an interview on 08/14/2024 at 2:40 PM, Staff H stated they witnessed the incident in cottage 203 on 08/02/2024. Staff H stated Resident 3 was upset because they wanted to go on a walk and could not at that time. Resident 3 was sitting in a recliner and started to take off their shoe and tossed it. Staff I told Resident 3 to pick up your shoe and let's go to your room. Staff H stated, Resident 3 shook their head no and took off the other shoe. Then Staff I walked over to Resident 3 and grabbed the front of the resident's shirt and pulled them off the chair. Resident 3 was then laying on the floor and reached out to grab another resident's shirt. I got in the middle and pried Resident 3's fingers off the shirt. Staff H stated, [Staff I] was now grabbing Resident 3 by the wrists to get them up, but they would not stand, and while the resident was on their back, Staff I drug Resident 3 to the back hall with Staff J walking behind Staff I. Staff H stated they heard Resident 3 screaming after they were all out of sight around the corner. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/15/2024 at 1:45 PM, Staff J stated that on 08/02/2024 at shift overlap Resident 3 was seated in a recliner in the cottage 203 living area and had just returned from a recreation outing. They observed Resident 3 take off their shoe and toss it on the floor. Staff I told Resident 3 to put your shoe back in your room. Resident 3 then removed their other shoe and tossed it to the floor. Staff I said again put your shoes back in your room. The third time Staff I told Resident 3 to pick up their shoes, Staff I approached Resident 3 and hooked their arm under the resident's left arm making an upward motion. Resident 3 slid onto the floor and grabbed another resident's shirt. Resident 3, now laying on the floor, was grabbed by Staff I on to the left upper arm and front of the resident's shirt, and was drug across the floor by Staff I, who was walking backwards. Staff J stated they helped Staff I by lifting both of Resident 3's legs by holding their feet. Staff J stated Resident 3 was screaming and yelling when they got back to their bedroom. Resident 3 got up on their bed and removed all their clothing. Staff J stated they felt it was wrong and was in shock that Staff I did that. During an interview on 08/15/2024 at 2:45 PM, Staff B, Assistant Superintendent, stated that they were shocked at the abuse that had occurred and did not understand why this was happening. These residents do not deserve to be treated this way. Reference: WAC- 388-97-0640 (1), (3)(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528 Based on interview and record review, the facility failed to have written policies and procedures to include the time frames for the immediate reporting of abuse according to CFR S483.12(c)(1) and a written policy to define how staff will communicate and coordinate situations of abuse with the quality assurance performance improvement (QAPI) program according to CFR S483.12(b)(4), and failed to ensure implementation of the facility procedure to immediately notify the Nursing Home Administrator (NHA), and State Survey Agency of abuse violations was followed by staff. This failure caused a delay of protection for 2 of 2 residents (Resident 1, 3) reviewed for allegations of abuse, and placed the residents at risk for unrecognized abuse and unmet care needs. Findings included Record review of the facility's policy titled, Resident Incident Management 2.02, dated 08/22/2023, showed that abuse and neglect of vulnerable adults was prohibited by law and would not be tolerated. All facility employees, contractors, volunteers, and students must report every incident observed, reported, or suspected abuse of residents to Complaint Resolution Unit (CRU) (State Agency- SA abuse hotline). After fulfilling the duty as a Mandatory Reporter, they must also report the incident to the Director of Nursing Services (DNS) and Superintendent (NHA) or Officer of the Day (NHA designee). The facility reporting policy, Resident Incident Management 2.02, did not include the requirements of CFR S483.12(c)(1) F609, Reporting Alleged Violations, to report immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and do not result in serious bodily injury, to the NHA of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of the Developmental Disabilities Administration (DDA) policy titled, Protection from Abuse: Mandatory Reporting 5.13, dated 07/2024, showed that the policy applied to all DDA employees, contractors, volunteers, interns and work-study students; abuse and neglect of vulnerable adults was prohibited by law and would not be tolerated; when there was reasonable cause to believe that any client had been abused, neglected, or exploited, they must immediately make a report to the investigative agency, Residential Care Services (RCS, state hotline), immediately after making the report to the investigative agency, a mandated reporter must also report the incident to their immediate superior or the next highest supervisor in the facility. Review of the facility abuse policies showed no policy or procedure for communicating and coordinating allegations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. <Resident 1> (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review showed Resident 1 was admitted on [DATE] with multiple diagnoses including profound intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and autism (a condition related to brain development that impacts how a person perceives and socializes with others). Review of the 06/01/2024 comprehensive assessment showed Resident 1 had no speech, highly impaired vision and moderate cognitive impairment. The resident had self-injurious behaviors (SIB) that put them at risk for injury to themselves. Review of Resident 1's care plan, dated 06/14/2024, showed that they exhibited severe self-injurious behaviors, such as slapping self, punching their head or pulling their hair. The care plan included interventions for staff to redirect the behavior by identifying what the resident needed and if not redirectable, the staff had a protective helmet and mitts they could apply with a physician order to protect the resident from injury. Review of a 07/29/2024 DDA Statewide Investigation Unit ([NAME]- performs impartial abuse and neglect investigations in state residential facilities) report showed that Staff M, Nursing Assistant (NA), stated they observed Staff N, NA, hit Resident 1 in the head on 06/29/2024. Staff M stated they did not report the incident to anyone at the facility before leaving at the end of their shift. Staff M did not report to the facility NHA and state hotline according to facility policy. Review of Staff D, NA's, statement from 07/12/2024 at 11:00 AM interview, documented in a 07/10/2024 DDA [NAME] report, showed that they witnessed Staff C, NA, kick Resident 1 in the face on 07/06/2024. They stated they were confused and in shock and did not know what to do. Staff D stated they reported to their shift charge (Staff Q, NA) after they had left work on 07/06/2024. Staff D did not report to the facility NHA and state abuse hotline according to facility policy. <Resident 3> A record review showed Resident 3 was admitted on [DATE] with multiple diagnoses including cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth) and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). Review of the 07/14/2024 comprehensive assessment showed Resident 3 had no speech, highly impaired vision and moderate cognitive impairment. Review of an 08/03/2024 facility incident report showed on 08/02/2024 at 2:25 PM, Staff J, NA, and Staff H, NA, observed Staff I, NA, drag Resident 3 across the floor to their bedroom. Staff J and Staff H did not report to the facility NHA and state abuse hotline according to policy. During an interview on 08/08/2024 at 8:30 AM, Staff U, Social Service Training Specialist, stated they did the annual and new staff Abuse, Neglect, Mistreatment and Mandatory Reporting training. They based their training on the policy, Protection from Abuse: Mandatory Reporting 5.13. When instructing staff where to report witnessed or suspected abuse, they were told to report to the unit nurse and the State Hotline. Staff U stated they were not aware of any time frames for reporting. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/15/2024 at 9:40 AM, Staff AA, QAPI program manager, stated that although information about facility incidents were reported at QAPI, there was no specific policy related to QAPI and abuse allegations and they had just been made aware of the requirement. During an interview on 08/15/2024 at 2:50 PM, Staff B, Assistant Superintendent, stated their abuse policies directed staff to immediately notify the state hot line and the unit nurse. The unit nurse usually would notify the administrative staff like the DNS or Superintendent/designee. Staff B stated they did not have QAPI included in their abuse policies. Reference: WAC 388-97-0640(2)(b)(5)(a)(7)(a)(i)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528 Based on interview and record review, the facility failed to ensure 7 of 11 staff (Staff M, O, Q, D, F, J, and H) immediately (not later than two hours after the allegation was made) reported allegations of abuse to the facility administration and State Agency (SA) and to implement timely interentions to protect 2 of 2 residents (Resident 1 and Resident 3) reviewed for abuse reporting. This failure placed the residents at risk for continued abuse, potential for harm, and diminished quality of life and constituted an immediate jeopardy (IJ). On 08/29/2024 the facility was notified of the noncompliance identified at the level of an IJ in F-Tag 609, 42 CFR S483.12(c)(1) Reporting of Alleged Violations, for failure to ensure staff reported alleged abuse immediately to both the facility Nursing Home Administrator (NHA) and Stage Agency (SA) abuse hotline that resulted in a delay of up to 17 days to remove the alleged perpetrators from direct resident care. The facility removed the immediacy on 08/30/2024 with an onsite verification from investigators. The facility provided all staff mandatory training on Abuse, Neglect, and Mandatory Reporting with a live instructor in a classroom setting prior to working with vulnerable adults. The staff training plan included on-call staff and new hires. Staff were provided with a small how to report card during the live training that included numbers for the SA abuse hotline and a designated Officer of the Day (NHA/Superintendent and Director of Nursing Services [DNS]), who were on-call and available 24 hours, seven days a week. Findings included . Record review of the facility's policy titled, Resident Incident Management 2.02, dated 08/22/2023, showed that abuse and neglect of vulnerable adults was prohibited by law and would not be tolerated. All facility employees, contractors, volunteers, and students must report every incident observed, reported, or suspected abuse of residents to the Complaint Resolution Unit (CRU) (SA abuse hotline.) After fulfilling the duty as a Mandatory Reporter, they must also report the incident to the DNS and Superintendent (NHA) or Officer of the Day (designee). <Resident 1> Record review showed Resident 1 was admitted on [DATE] with multiple diagnoses including profound intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and autism (a condition related to brain development that impacts how a person perceives and socializes with others). Review of the 06/01/2024 comprehensive assessment showed Resident 1 had no speech, highly impaired vision and moderate cognitive impairment. The resident had self-injurious behaviors (SIB) that put them at risk for injury to themselves. Review of Resident 1's care plan, dated 06/14/2024, showed that they exhibited severe SIB, such as slapping self, punching their head or pulling their hair. Staff had interventions to redirect the behavior by identifying what the resident needed and if not redirectable, the staff had a protective helmet and mitts they could apply with a physician order to protect the resident from injury. (continued on next page)

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 09/03/2024
NAME OF PROVIDER OR SUPPLIER: Yakima Valley School		STREET ADDRESS, CITY, STATE, ZIP CODE: 609 Speyers Road Selah, WA 98942	

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<Allegation 1> Record review of a 07/25/2024 witness statement written by Staff M, Nursing Assistant (NA), showed that on a day they worked evening shift in cottage 405/406 (shift log showed it was on 06/29/2024) they observed Staff N, NA, physically abuse Resident 1. They stated that they reported the incident the following day (06/30/2024) to their supervisor, Staff O, NA Supervisor. Staff M did not report to the facility NHA and the SA abuse hotline within the required time frame. Review of a 07/16/2024 Developmental Disabilities Administration (DDA) Statewide Investigation Unit ([NAME]- performs impartial abuse and neglect investigations in state residential facilities) report showed the facility administration was informed of an allegation that Staff N had hit Resident 1 on the head to stop their behaviors, no date or time of the alleged abuse was provided. The facility removed Staff N from resident care when the Administrator was made aware of the incident (17 days after alleged abuse). Review of a 07/29/2024 DDA [NAME] report showed that Staff O stated that Staff M reported to them on 06/30/2024 that the day prior, they observed Staff N hit Resident 1 in the head. Staff O reported they told Staff M that they needed to report the allegation to the SA abuse hotline and to Staff P, NA Manager. Staff O stated that they reported the 06/29/2024 allegation, to Staff Q, NA Charge, by telephone on 07/01/2024. Staff O stated that they reported the allegation during a meeting with Staff P on 07/23/2024. Staff O and Staff Q did not report the alleged abuse to the NHA or SA abuse hotline. Review of a 07/16/2024 DDA [NAME] report showed that based on the information available, there was insufficient evidence to conclude the allegation occurred. The investigation had been turned over to law enforcement on 07/10/2024. <Allegation 2> Review of a witness statement written by Staff D, NA, on 07/08/2024, showed that on 07/06/2024 at 10:00 PM, Resident 1 was lying down in bed and could be heard tapping on their head. [I] redirected to not hit [them]self and told [them] it's bedtime. [Staff C, NA] goes in and kicks [Resident 1] in the face. [I] told [Staff C] to leave, [Resident 1] had no response and went to bed. Review of Staff D's, statement from a 07/12/2024 at 11:00 AM interview, documented in a 07/10/2024 DDA [NAME] report, showed that they were confused and in shock and did not know what to do and they reported to their shift charge (Staff Q) after they had left work on 07/06/2024. Staff D did not report to the NHA and SA abuse hotline. Review of Staff F's, NA, statement from 07/15/2024 at 1:57 PM, documented in the 07/10/2024 DDA [NAME] report showed that they walked in directly behind Staff C and saw them lift their leg towards Resident 1. Staff F stated they then saw Staff C raise their arms over their head and bringing them down on Resident 1. Staff F stated they did not directly see where Staff C hit or kicked Resident 1 but heard the sound of making impact. Staff F did not report what they witnessed to the facility NHA and SA abuse hotline. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the 07/06/2024 facility initial incident report showed that Staff Y, Licensed Practical Nurse, was notified of the allegation of abuse at 10:47 PM, the DNS designee and the NHA designee were both notified at 11:00 PM. Review of a statement written by Staff R, Registered Nurse, dated 07/07/2024 at 9:23 PM, showed they were made aware of the allegation of abuse on 07/06/2024 at 11:00 PM. Staff R reported they went to cottage 405 and found [Staff C] was still working in the cottage and stocking the clean linen room. I asked [Staff C] to remove [them]self from the cottage to protect the residents. Record review of the State complaint tracking system showed the State Agency abuse hotline received an online/portal report of the abuse allegation on 07/07/2024 at 12:49 AM. <Resident 3> Record review showed Resident 3 was admitted on [DATE] with multiple diagnoses including cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth), unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), and adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior). Review of the 07/14/2024 comprehensive assessment showed Resident 3 had no speech, highly impaired vision, and moderate cognitive impairment. Review of Resident 3's care plan, dated 04/14/2024, showed they could be unsteady with walking, did not understand personal space, would get too close to others trying to touch or pinch, and was obsessive about taking their clothes off. Review of an 08/03/2024 facility incident report showed on 08/02/2024 at 2:25 PM, Staff J, NA, and Staff H, NA, observed Staff I drag Resident 3 across the floor to their bedroom. The NHA designee was notified on 08/03/2024 at 12:50 AM (10.5 hours after alleged abuse was witnessed). The SA abuse hotline was notified on 08/03/2024 at 1:21 AM (11 hours after alleged abuse). Review of an 08/03/2024 DDA [NAME] report showed on 08/09/2024 at 12:51 PM Staff J stated that they were shocked by what they witnessed Staff I do with Resident 3 and that they did not know what to do and reported the incident to Staff P, NA supervisor, on 08/02/2024 at 10:00 PM. During an interview on 08/14/2024 at 2:03 PM Staff I, NA, stated that they worked in cottage 203 on 08/02/2024 and denied they handled Resident 3 in a rough manner before the end of their shift. Staff I stated they started work at 6:00 AM on 08/03/2024 in cottage 203. They stated at 7:30 AM they were told by Staff V, Registered Nurse, to go up to the duty desk (a central staffing office) for the rest of the day and 08/04/2024. (17 hours after alleged abuse.) During an interview on 08/14/2024 at 2:40 PM, Staff H stated they witnessed Staff I drag Resident 3 to their bedroom on 08/02/2024. Staff H stated they knew Staff J reported what they witnessed to their supervisor, Staff P, NA. Staff H stated they had been trained to report abuse by calling the SA abuse hotline, notify the nurse and the NA Manager/supervisor, however they did not report because they knew Staff J had reported. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/15/2024 at 1:45 PM, Staff J stated that after the incident occurred, they did not say anything to any one until I reported to [Staff P], my supervisor, at 10:00 PM when they came to work. [Staff P] told me to call the state abuse hotline and found the phone number for me. During an interview on 08/30/2024 at 3:38 PM, Staff B, Assistant Superintendent (Assistant NHA), stated we should not have missed these reports of abuse, it was expected that all staff know how to report abuse allegations. Reference: WAC 388-97-0640(2)(b)(5)(a)(6)(b)(7)(a)