

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 11/26/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on interview and record review, the facility failed to ensure allegations of potential abuse were reported to the administration and the state survey agency (SA) abuse hotline as required for 1 of 1 resident (Resident 1) reviewed for reporting allegations of abuse. Failure to report an incident of potential abuse placed residents at risk for additional abuse.</p> <p>Findings included .</p> <p>Review of the Washington State Reporting Guidelines for Nursing Homes (Purple Book) dated October 2015, showed that for the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, a nursing home employee (or other mandated reporter) was required to make a report if they had reasonable cause to believe the incident occurred. Examples of reasonable cause may include: The individual observes the incident or hears the victim state it happened.</p> <p>Record review of the facility's policy titled, Resident Incident Management 2.02, dated 09/30/2024, 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, State Agency [SA] abuse hotline). After fulfilling the duty as a Mandated Reporter, they must also report the incident to the Director of Nursing Services (DNS) and Superintendent (Nursing Home Administrator, NHA) or Officer of the Day (designee).</p> <p><Resident 1></p> <p>Record review showed the resident was admitted to the facility with diagnoses to include autistic disorder (a condition related to brain development that impacts how a person perceives and socializes with others), moderate intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) and disruptive mood disorder (when an adolescent experiences ongoing irritability, anger and frequent, intense temper outbursts). Review of the 09/11/2024 comprehensive assessment showed the resident had moderate impaired cognition and had daily physical and verbal behaviors directed towards others. These behaviors put the resident and others at risk for physical injury.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a 10/31/2024, 9:00 AM facility incident report showed on 10/30/2024, Resident 1 appeared to have a bruise to their right eye while at school and stated they were hit in the eye by a facility staff. The information came through e-mail from Resident 1's public school teacher and was received the morning of 10/31/2024. The facility administration removed the identified staff from direct care and initiated an investigation.</p> <p>Record review of a 10/31/2024 at 3:12 PM nursing progress note showed Resident 1 returned from school at 1:55 PM and was assessed for injuries in response to the report from the resident's school teacher. Staff C, Registered Nurse, documented there were no injuries to Resident 1's face or eyes. The resident's skin color appeared at baseline.</p> <p>During an interview on 11/26/2024 at 1:20 PM, Staff G, Licensed Practical Nurse, stated they also saw Resident 1 on 10/31/2024 after they returned from school. Staff G stated that they were in the resident's room with Staff C and Staff B, DNS, while Resident 1 was assessed for injuries. Staff G stated there were no bruises anywhere to the resident's face or around the eyes.</p> <p>During an interview on 11/26/2024 at 1:40 PM, Staff E, stated they were in the dining area on 10/30/2024 around 2:00 PM and heard Resident 1 state someone hit them, pointing to their right eye and was laughing. Staff E stated they did not see anything on the resident's face. Staff E stated they did not report what the resident said to SA per an online report or phone call to CRU or the superintendent.</p> <p>Record review of Resident 1's behavior log entry dated (late entry) 10/31/2024 showed Staff D, Nursing Assistant (NA), documented that on 10/30/2024 at 2:00 PM, Resident 1 was sitting at the table and said they had a black eye, and someone hit them. There were no signs of black on either eye.</p> <p>During a telephone interview on 11/27/2024 at 12:15 PM, Staff D stated on 10/30/2024 at 2:00 PM, they heard Resident 1 say they thought they had a black eye, pointing to their right eye, stated someone hit them. Staff D stated they did not report what Resident 1 said to the SA or notify the superintendent and should have.</p> <p>Review of an 11/08/2024 Developmental Disabilities Administration (DDA) Statewide Investigation Unit ([NAME]- performs impartial abuse and neglect investigations in state residential facilities) report showed that they could not substantiate the allegation of a staff hitting Resident 1. Further review of the investigation showed Staff D, NA, and Staff E, NA, were aware of the abuse allegation made by Resident 1 on the afternoon of 10/30/2024 and did not report to the SA or the superintendent as required.</p> <p>During an interview on 11/26/2024 at 3:15 PM, Staff F, Assistant Superintendent, stated that the facility staff that heard Resident 1 say someone hit them should have reported as they had been trained.</p> <p>Reference: WAC 388-97-0640(2)(b)(5)</p> <p>This is a repeat citation from the Statement of Deficiencies dated 09/03/2024.</p>		