

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 03/19/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on observation, interview and record review, the facility failed to protect 5 of 5 residents (Resident 1, 2, 3, 4, and 5) from misappropriation of controlled medications (narcotics) by 1 of 1 staff (Staff C, Registered Nurse [RN]), reviewed for drug diversion (transfer of medication from the resident it was prescribed for to another person for unlawful use). This failure placed the residents at risk for pain, unmet care needs, on-going misappropriation of medication, and a diminished quality of life.</p> <p>Findings included .</p> <p>Record review of the facility's policy titled Controlled Substance (Medication) Accountability, 7.08 dated 02/2025, showed that controlled substances would be strictly accounted for from acquisition through dispensing, and their disposal if necessary.</p> <p>An accurate inventory of all controlled substances would be conducted on the living unit by nursing staff. The pharmacist would review the controlled substance log monthly and sign the log.</p> <p>Each nursing unit would maintain a bound controlled substance logbook with consecutively numbered pages. The date, time, dosage, dosage remaining and the signature of the nurse would be documented each time a dose was removed from the controlled substance bingo card (a method of packaging medications in which a blister pack was enclosed in a folded-over card with foil backed blisters/bubbles, where medications were packaged in a seven day, 14 day, 30 dose or 60 dose card.)</p> <p>Controlled substances were double locked and counted each shift by two nurses.</p> <p>The Director of Nursing would investigate any significant loss of a controlled substance on the living unit.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility incident report dated 01/29/2025 showed that the Staff D, Clinical Pharmacist, had discovered oxycodone 5 milligram (mg) tablets (a controlled medication used for pain with a high potential for abuse and the potential to cause severe dependence if abused), had been replaced with loratadine 10 mg tablets (a medication used to treat allergy symptoms) for Resident 1 and Resident 3. The backs of the bingo card foil had a small cut, the tablets had been replaced, and the foil taped shut. Staff D reported to the facility administration and reviewed all schedule medications on the living unit. Three additional tampered bingo cards of oxycodone 5 mg were found, one bingo card each for Resident 2, Resident 4 and Resident 5. Staff E, RN / Acting Director of Nursing (DON), reviewed the impacted resident's records, found they were at baseline and placed the residents on ongoing monitoring.</p> <p><Resident 1></p> <p>Record review showed Resident 1 was a long-term resident with diagnoses that included profound intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), cerebral palsy (a group of conditions that affect movement and posture. Caused by damage that occurred to the developing brain, most often before birth), and dysmenorrhea (a condition that caused severe and frequent menstrual cramps and pain). Review of a 01/20/2025 comprehensive assessment showed that the resident had total dependence on staff for all their activities of daily living (ADL) and had severe cognitive impairment.</p> <p>Review of a 11/01/2024 care plan showed Resident 1 was treated for chronic pain caused by hip dislocation (when the ball-shaped head of the femur separates from its cup-shaped socket in the hip bone), and dysmenorrhea. Resident 1 would exhibit non-verbal signs of pain by crying, biting their hand and grimacing.</p> <p>Record review of Resident 1's January 2025 physician orders showed an order for oxycodone tab 5 mg prn (as needed) every eight hours for breakthrough pain after Tylenol and ibuprofen had been tried.</p> <p>On 02/11/2025 at 2:30 PM, an observation of the tampered bingo cards was made in the facility pharmacy with Staff F, Clinical Pharmacist. Review of Resident 1's bingo card of oxycodone tab 5 mg showed 30 tablets were filled by the facility pharmacy on 11/06/2024. Review of the front of the bingo card showed first dose of oxycodone 5 mg was given on 11/09/2024 (indicated by nurse initials and date). Review of the back of the bingo card showed doses 23 through 30 were not tampered with (had no cut foil). The cut foil was observed on the right side of the bingo card foil beginning with dose 22 through dose one. The last non-tampered dose was given on 12/02/2024 and the first tampered dose was given on 12/06/2024 (the tamper date window). Review of the corresponding controlled medication/narcotic record showed that Resident 1 received 14 doses of loratadine instead of the ordered oxycodone. The bingo card had eight taped foil bubbles of the loratadine tablets retained by the pharmacy on 01/29/2025.</p> <p><Resident 2></p> <p>Record review showed Resident 2 was a long-term resident with diagnoses that included profound intellectual disabilities, cerebral palsy and hip dislocation. Review of the 11/10/2024 comprehensive assessment showed that the resident had total dependence on staff for all their ADLs and had severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a 11/19/2024 care plan showed Resident 2 would exhibit discomfort and pain by yelling and slapping themselves on the face.</p> <p>Record review of Resident 2's January 2025 physician orders showed an order for oxycodone tab 5 mg every eight hours prn pain, must try and fail Tylenol prior to each use.</p> <p>On 02/11/2025 at 2:30 PM, observation of Resident 2's bingo card of oxycodone tab 5 mg showed 20 tablets were dispensed by the pharmacy on 10/02/2024. Review of the back of the bingo card showed the foil was cut on all 20 doses and two doses (of loratadine) were given to Resident 2 on 12/27/2024 and 01/19/2025.</p> <p><Resident 3></p> <p>Record review showed Resident 3 was a long-term resident with diagnoses that included profound intellectual disabilities. Review of the 02/07/2025 comprehensive assessment showed that the resident had total dependence on staff for all their ADLs and had severe cognitive impairment.</p> <p>Review of a 08/07/2024 care plan showed Resident 3 would exhibit discomfort and pain by pacing, dropping to the floor, pulling their hair and hitting self in the face.</p> <p>Record review of Resident 3's January 2025 physician orders showed an order for oxycodone tab 5 mg every six hours prn for pain.</p> <p>On 02/11/2025 at 2:30 PM, an observation was made in the pharmacy with Staff F of Resident 3's bingo card of oxycodone 5 mg showed 60 tablets were dispensed by the facility pharmacy on 01/11/2024 (more than one year ago). Review of the back of the bingo card showed the foil was cut and taped on all 60 doses with the first dose given on 03/30/2024. Resident 3 received 25 doses administered of loratadine (instead of oxycodone), and 35 loratadine tablets remained on the bingo card when retained by the pharmacy.</p> <p><Resident 4></p> <p>Record review showed Resident 4 was a long-term resident with diagnoses that included profound intellectual disabilities, cerebral palsy and kidney stones (hard deposits of minerals develop inside the kidney and cause symptoms of pain and difficulty passing urine). Review of a 01/19/2025 comprehensive assessment showed that the resident had total dependence on staff for all their ADLs and had severe cognitive impairment.</p> <p>Review of a 07/19/2024 care plan showed Resident 4 would exhibit discomfort and pain by their increased frequency of vocalizations.</p> <p>Record review of Resident 4's January 2025 physician orders showed an order for oxycodone 5 mg tab two times a day prn for pain.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/11/2025 at 2:30 PM, an observation was made in the pharmacy of Resident 4's bingo card of oxycodone 5 mg that showed 30 tablets were dispensed by the facility pharmacy on 11/06/2024. Review of the back of the bingo card showed the foil was cut on bubbles 25 through one. The first tampered foil/bubble was given to Resident 4 on 12/06/2024. There were eight doses of loratadine given instead of the ordered oxycodone and 17 doses of loratadine tabs remained on the bingo card.</p> <p><Resident 5></p> <p>Record review showed Resident 5 was admitted on [DATE] with diagnoses that included cerebral palsy, and osteoarthritis (a long-term degenerative joint condition in which the joints gradually deteriorate, causing pain and stiff joints).</p> <p>Review of a 10/23/2024 care plan showed Resident 5 would verbally express their discomfort and pain, received routine and prn pain medication.</p> <p>Record review of Resident 5's January 2025 physician orders showed an order for oxycodone tab 5 mg two times a day as needed for pain.</p> <p>On 02/11/2025 at 2:30 PM, observation made with Staff F, of Resident 5's bingo card of oxycodone 5 mg showed 60 tablets were dispensed by the facility pharmacy on 12/18/2024. Review of the back of the bingo card showed all 60 foil/bubbles were tampered with and the remaining 38 tablets were loratadine. Resident 5 received 22 doses of loratadine between 12/22/2024 and 01/29/2025.</p> <p>During an interview on 02/10/2025 at 11:10 AM, Staff E, RN / Acting DON, stated they started their investigation after being notified by the pharmacist on 01/29/2025. They stated they narrowed down the dates the bingo cards were tampered with and by reviewing the nursing schedules, they identified three licensed nurses that had keys to the narcotic drawers during the tamper dates. These nurses were removed from direct nursing care the morning of 01/30/2025. Staff E stated 187 doses of oxycodone tab 5 mg foil/bubbles were cut and taped on the five bingo cards. Staff E stated they reviewed the five resident's charts during the dates they did not receive the oxycodone for pain and found the residents had a documented decrease in pain symptoms or voiced pain relief.</p> <p>On 02/11/2025 at 2:30 PM the five tampered bingo cards were observed in the facility pharmacy with Staff E, Staff F, and law enforcement. The foil cuts and tape were not visible unless the card was held up to a light source. Staff F stated the loratadine tablets were part of the stock supply on each medication cart and look like the oxycodone tablets. Staff F stated they had never seen narcotic diversion accomplished this way.</p> <p>On 03/12/2025 law enforcement had interviews scheduled with each of the three licensed nurses (including Staff C) who had worked during the bingo card tamper date windows. A Residential Care Services investigator sat in on the interviews.</p> <p>On 03/12/2025 at 11:30 AM, Staff C, RN, stated during the law enforcement interview (Residential Care Services Investigator was present and observing) that they switched out the oxycodone with the loratadine tablets by cutting the foil back with a paperclip and taping the window shut.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/12/2025 at 3:15 PM, Staff B, Assistant Administrator, stated they were saddened this diversion occurred and was thankful that the other two licensed nurses could now return to work. Staff B stated, this was so wrong for the residents, who cannot verbalize how they feel and not get the pain medication that was ordered for them.</p> <p>Reference: WAC 388-97-0640(2)(a), (3)(c)(d)</p>		