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	05/28/2025

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 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. 30528 Based on observation, interview, and record review, the facility failed to ensure care, the assessed level of supervision and assistance were consistently provided to prevent an avoidable accident for 1 of 3 residents (Resident 1) reviewed for falls with injury. Resident 1 experienced harm when they were left unsupervised, had an unwitnessed fall or contact with a firm surface and developed a hematoma (a localized collection of clotted blood that pools outside of the blood vessels, similar to a bruise) to the right eye. Findings included . Record review of facility's policy titled, Level of Supervision (LOS) 1.08, dated 10/2024, showed that a LOS would be assigned to provide an appropriate degree of supervision for each resident. Direct care staff will check the LOS assigned in the resident's record daily. Definition for LOS 3 was supervision must be positioned in a manner to protect the resident from or deter (prevent) danger. Enhanced staffing [was] required. <Resident 1> Record review showed Resident 1 was a long-term resident of the facility with a diagnosis that included severe intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations), Obsessive-compulsive disorder (a disorder that causes unwanted thoughts and fears [obsessions] and repetitive behaviors [compulsions] that interfere with daily life) and cataracts (a clouding of the lens of the eye that affects vision) in both eyes. Record review of a 03/11/2025 comprehensive assessment showed that Resident 1 walked independently and required some staff assistance for activities daily living, such as dressing and hygiene. The resident had a history of falls. Record review of the resident's 03/12/2025 care plan showed Resident 1 required LOS 3 to deter them from danger related to their lack of safety awareness, lack of coordination and impaired vision. (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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(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	Review of a 05/06/2025 at 6:30 AM progress note showed that staff heard a loud thud in the back hallway earlier that morning and Resident 1 was later found walking in the back hallway with a bump and swelling to their right eye and right cheek bone. Record review of the incident investigation, dated 05/13/2025, showed that Staff C, Attendant Counselor (AC, same as a nursing assistant) was assigned to Resident 1 the morning of 05/06/2025 and left the resident unsupervised in the back hallway to take out the garbage at 5:30 AM. Resident 1 was found at 5:40 AM walking out of the back hallway with swelling and bruising above and below their right eye. The possible cause was determined to be an unwitnessed fall and/or bumping into a firm surface while unsupervised. Record review of a 05/06/2025 at 12:39 PM nursing progress note showed a hematoma developed to the right eye that measured six centimeters (cm) by four cm. Observation on 05/27/2025 at 3:30 PM showed Resident 1 was leaving the bathroom after changing their pants and walked from the back hallway to the dining room with their assigned staff nearby. Resident 1 had resolving bruises above and below their right eye. Resident 1 smiled, clapped their hands and sat in a dining chair. During an interview on 05/27/2025 at 3:35 PM, Staff D, AC shift charge, stated that residents on LOS 3 have an assigned staff that needed to be able to always see the resident. Staff D stated that Resident 1 was at risk for falling and that was one reason the resident was LOS 3. During a telephone interview on 05/27/2025 at 11:00 PM, Staff E, AC, stated they worked the morning of 05/06/2025 and heard a loud thump come from the back hallway around 5:30 AM. They stated they were not aware Resident 1 was in the back hallway unsupervised when they heard the sound until they observed Staff C enter the front door after taking out the garbage. They stated they then went back to check on Resident 1 and observed them walking into their bedroom, however, they did not see Resident 1's face. During an interview on 05/28/2025 at 2:30 PM, Staff C stated they were assigned to Resident 1 the morning of 05/06/2025. Staff C stated they had just finished assisting their assigned residents to toilet and dress when they took the garbage from the back of the unit out the front door. Staff C stated before leaving the back hallway, they found Resident 1 standing in the clean linen room (the door was propped open). Staff C stated they guided Resident 1 out of the clean linen room, shut the door and proceeded to take the garbage to the front of the unit and went out of the front door. Staff C stated they saw the two other staff in the dining and living areas; however, they did not notify these staff that they were taking out the garbage and Resident 1 was alone in the back hallway. Staff C stated that when they returned to the unit, they went to the kitchen area to document on the resident sleep charts. Then at approximately 5:40 AM when heading to the back hallway, they observed Resident 1 walking down the hall with the injuries around their right eye. During an interview on 05/28/2025 at 3:55 PM, Staff B, Director of Nursing, stated that residents on LOS 3 should always be in a staff's line of sight. Staff C did not follow the resident's care plan and should not have left Resident 1 alone in the back hall. Reference: WAC 388-97-1060(3)(g)