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	08/20/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure supervision for 1 of 4 residents (Resident 1) reviewed for dental sedation. The failure to follow post sedation safety protocol resulted in Resident 1 to have an unwitnessed fall that caused a 10-centimeter (cm) laceration mid forehead that required 11 staples at the hospital. 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 would 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 danger. Enhanced staffing [was] required.Record review of facility's policy titled, Nursing Standard Operating Procedure IV.A.17 Sedation, dated 02/2024, showed that after receiving sedation, the Attendant Counselor (AC, a nursing assistant) would maintain close observation of the resident (LOS 3), maintain safety precautions as directed by the nurse and the resident would not be allowed to lay down in bed until released by the nurse.Resident 1Resident 1 was admitted to the facility on [DATE] for a short-term respite stay and discharged back home on [DATE].Review of the resident's 07/31/2025 comprehensive assessment showed Resident 1 had 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) and was blind. The resident was dependent on staff for their activities of daily living (dressing, toileting and bathing); however, they were independent with walking around in the cottage.Review of the 07/24/2025 care plan showed the resident would receive sedation prior to going to dental and upon return to the cottage the resident would be monitored by staff for drowsiness, eating problems and discomfort. Review of the 07/31/2025 facility investigation showed Resident 1 received Lorazepam (a medication that has sedative and antianxiety effects) three milligrams (mg) on 07/29/2025 at 8:30 AM for a dental appointment. Later that day, Resident 1 had an unwitnessed fall in the cottage at 1:15 PM that caused a laceration to their forehead and required medical care at the hospital.Record review of the 07/29/2025 Sedation Protocol Checklist showed Resident 1 was to remain in the wheelchair with a positioning belt and stay in the line of sight of staff until released by the nurse. The resident's vital signs were attempted prior to the sedation and every 30 minutes after until the resident returned to their baseline. Resident 1 would not allow their pulse or blood pressure to be measured; however, their level of consciousness and respiratory rate was monitored by the unit nurse and were within stable parameters. Resident 1 was drowsy and had not been released by the nurse prior to their injury.Review of statements included in the 07/31/2025 facility investigation showed that Staff D, AC, was working with Resident 1 just prior to the incident on 07/29/2025. Staff D transferred Resident 1 to their bed due to falling asleep in their wheelchair around 1:00 PM. Staff D watched Resident 1 from the bedroom door for about 10 minutes until Resident 1 appeared asleep. Staff D then went to the front of the cottage to wash their hands and chart. When done washing their hands, they heard a noise in the back of the cottage and found Resident 1 bleeding from their forehead, while standing in the hallway.Review of statements included in the 07/31/2025 facility investigation showed that Staff C, Licensed Practical Nurse, was the nurse on duty when Resident 1 was found with a laceration on their forehead. They reported they had not released Resident 1 from sedation observation and were not notified prior to the resident's transfer to bed.Review of the 07/31/2025 facility investigation conclusion showed Staff D failed to follow the sedation protocols to maintain line of sight of the resident.Review of a 07/29/2025 at 2:49 PM progress note showed Staff C was called to attend Resident 1 at 1:14 PM after staff heard a loud thud in the back hall. Resident 1 was standing near their bedroom door with a bleeding laceration to their forehead. The laceration was measured 10 cm long by 2 cm wide and 0.5 cm deep. Pressure was applied and the resident was transported by ambulance to the hospital.During a telephone interview on 08/18/2025 at 12:45 PM, Resident 1's Representative (RR) stated the facility reached them by phone by the time Resident 1 was in transport to the hospital. The staff stated they thought Resident 1 fell in the back hall and hit their head on a hard surface. The RR stated, the wound was horrific and was very upset this happened. The RR stated after returning home, they took Resident 1 to the hospital on [DATE] to have the staples removed. The RR stated the hospital staff instructed them to clean the wound two to three times a day and it would take a while to heal. The RR stated Resident 1 was very resistant to having the wound cleaned and it had become a fight.During an interview on 08/18/2025 at 1:20 PM, Staff D stated they knew Resident 1 was