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	04/07/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure consistent one to one supervision for 2 of 4 residents (Resident 2, Resident 1) reviewed for accidents, when Resident 2 experienced a superficial scalp laceration of unknown origin and Resident 1 was left on the toilet for an unknown about of time without staff supervision at the door. This failure placed the residents at risk for accidents, injuries and diminished quality of life.Findings included Record review of the facility's policy titled, Level of Supervision, LOS, dated 10/07/2024, showed that a LOS was assigned to provide an appropriate degree of supervision for each resident to promote the free exercise of a resident's rights while also ensuring the safety of residents and staff. LOS level 4 was 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.Resident 2Record review showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include autistic disorder (a condition related to brain development that impacts how a person perceives and socializes with others), conduct disorder (a serious behavioral and emotional disorder in children and adolescents characterized by aggressive and destructive behavior), aphasia (condition characterized by either partial or total loss of the ability to communicate verbally or using written words) and seizure disorder (the brain's electrical activity is periodically disturbed, resulting in some degree of temporary brain dysfunction).Review of a comprehensive assessment dated [DATE] showed Resident 2 had severe cognitive impairment and had behavior towards self and others that put them at significant risk for physical injury.Review of a 03/07/2025 care plan showed Resident 2 required LOS level 4 staffing.During a telephone interview on 04/01/2026 at 8:00 AM, Resident 2's Representative (RR2) stated that the evening of 03/24/2026, Resident 2 was found to have a two-centimeter (cm) laceration (a torn or jagged wound to the skin and soft tissue underneath) on the top of their head. The facility staff could not identify how or where the injury happened. Resident 2 had one-to-one staff assigned to them 24 hours a day, seven days a week. RR2 stated How could [Resident 2] have an unknown injury with one-to-one staff always present? I want to know how this happened.Review of a 03/25/2026 at 1:37 AM progress note by Staff C, Licensed Practical Nurse, showed that at 10:13 PM the previous evening, Resident 2 had a two cm by 0.25 cm laceration to the top of their head, the area was cleaned and left open to the air. Resident 2 smiled and laughed during the assessment and did not show signs of discomfort when cleaned.Review of a 04/02/2026 Statewide Investigation Unit ([NAME], performs impartial abuse and neglect investigations in state residential facilities) report showed that four direct care staff that were present on evening shift 03/24/2026 were reassigned to non-resident work duties during the investigation. The investigation showed that none of the staff assigned to Resident 2 and or in the immediate vicinity saw or heard anything that could have caused the resident's injury. Staff interviews showed that Resident 2 had no falls, no destructive or aggressive behaviors. Review of a statement by Staff D, Registered Nurse, showed they searched the soiled laundry on 03/25/2026 at 3:15 AM and found a bag with a fitted sheet, comforter, pullup brief, shorts and a shirt with Resident 2's name on the tag. The comforter had a red 12 cm by 12 cm circle that was dried blood. The (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous evening shift staff reported changing urine-soaked sheets around 9:30 PM on 03/24/2026 and did not report seeing blood. The investigation concluded that Resident 2's scalp laceration remained an injury of unknown origin. During an interview on 04/07/2026 at 2:20 PM, Staff C stated they assessed Resident 2's injury when it was first found. Staff C stated the wound was fresh, no active bleeding, swelling or bruising noted in the area. The laceration was neither deep nor wide enough that would suggest need for stitches. Resident 2's movement and behavior were at baseline; they did not appear in pain. There was no blood on the residents' clothing.During an interview on 04/07/2026 at 3:30 PM, Staff B, Director of Nursing, stated that no staff that day reported seeing the blood on the comforter or any blood in the environment. The staff maintained that they did not know how Resident 2 could have received the laceration. Staff B stated staff did find one sharp area on [Resident 2's] closet; however, there was no evidence of an impact on the closet frame.During an interview on 04/07/2026 at 4:00 PM, Staff A, Administrator, stated that Resident 2's laceration had remained an injury of unknown origin and should not occur for residents that have one to one staff assigned to them. Resident 1Record review showed Resident 1 was admitted to the facility in 1969 with diagnoses to include profound intellectual disability (significant limitations in both intellectual functioning and adaptive behavior with the inability to live independently, being in need of close supervision, limited communication, and physical restrictions), and anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations).Review of a comprehensive assessment dated [DATE] showed Resident 1 required extensive staff assistance to walk, sit, stand and use the toilet.Review of the 08/07/2025 care plan showed Resident 1 could sit on the toilet, should be toileted every two hours, do not leave unattended, and ensured the door was closed for privacy. Resident 1 had a history of eating toilet paper and leaving the bathroom unclothed from the waist down.During an observation and interview on 04/07/2026 at 12:00 PM, Resident 1 was observed on the toilet with the door closed and no staff standing by for five minutes. The surveyor entered cottage 204 at 12:00 PM and observed Staff E, Nursing Assistant (NA) and Staff F, NA, out front in the kitchen/living area. The recliner that Resident 1 sat in was empty. Looking through the back of the cottage, Resident 1 was not in their bedroom and there was a toilet door shut with the light on. At 12:05 PM, Staff E came out of the staff bathroom and began gathering supplies to enter the bathroom. When asked, Staff E stated that they assisted Resident 1 on the toilet at 11:50 AM.During an interview on 04/07/2026 at 12:15 PM, Staff F stated that Resident 1 was assisted to the toilet every two hours and staff were to stand outside the door because the resident could try and get up on their own. Resident 1 could fall or come out of the bathroom undressed.Record review of a 10/08/2026 staff training showed staff were to ensure the door was closed for privacy when residents were utilizing the toilet, and staff stayed with or stood outside the door to assist the resident when they were done.During an interview on 04/07/2026 at 1:25 PM, Staff E stated they were aware they should stay with Resident 1 while they used the toilet, however they did not implement that during the resident's toileting that day.During a telephone interview on 04/07/2026 at 2:35 PM, Collateral Contact (CC), stated that they were in cottage 204 about two or three weeks ago around lunchtime and believed Resident 1 was left on the toilet with no staff near for a minimum of 30 minutes. During an interview on 04/07/2026 at 4:00 PM, Staff A stated there had not been any reports regarding Resident 1's toileting supervision care plan not being followed. Reference: WAC 388-97-1060(3)(g)