

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 04/26/2024
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48406</p> <p>Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident's dignity for 1 of 2 sampled residents (Resident 12) reviewed for gastrostomy tube ([GT], a surgically placed tube in the stomach to allow liquid food and water to be given). This failure placed the resident at risk for psychosocial harm and lack of privacy.</p> <p>Findings included .</p> <p><Resident 12></p> <p>Resident admitted to the facility on [DATE] with diagnosis to include GT and developmentally delayed. The comprehensive assessment dated [DATE], showed Resident 12 had severely impaired cognition and was dependent of two staff members with activities of daily living.</p> <p>During an observation on 04/25/2024 at 2:54 PM, Resident 12 was observed sitting in their wheelchair in the common area with other residents and staff. Staff P, Licensed Practical Nurse (LPN), was observed lifting Resident 12's shirt exposing the resident's stomach and disconnected the tube feeding port from the gastrostomy port.</p> <p>During an interview on 04/26/2024 at 1:01 PM, Staff M, LPN, stated if they needed to access or disconnect a resident's GT or indwelling medical device, they would take the resident back to their room or a private area, put on personal protective equipment (PPE) and complete the task. Staff M stated accessing a resident's GT in the common area in front of other residents was a dignity issue.</p> <p>Reference: WAC 388-97-0860(1)(2)</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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on interview and record review, the facility failed to ensure quarterly personal fund statements were provided to residents and/or resident representative (RR) for 2 of 9 sampled residents (Resident 43 and 47) reviewed for personal fund accounts. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust by the facility.</p> <p>Findings included .</p> <p>Review of a policy titled, Local Funds, dated 02/2023, showed statements were to be mailed quarterly to the residents or RR.</p> <p><Resident 43></p> <p>The resident was admitted to the facility on [DATE] with diagnosis including intellectual disabilities, and epilepsy. The comprehensive assessment dated [DATE] showed the resident had severely impaired cognition and required assistance of one staff member for activities of daily living (ADLs).</p> <p>During an interview on 04/22/2024 at 3:48 PM, the RR stated they had only received a statement regarding Resident 43's personal funds three times since they had admitted to the facility.</p> <p>Review of the quarterly statement logbook showed the last quarterly statement mailed to Resident 43's RR was signed and dated on 10/12/2023.</p> <p><Resident 47></p> <p>The resident was admitted to the facility on [DATE] with diagnosis including learning disabilities). The comprehensive assessment dated [DATE] showed that resident had severely impaired cognition and required extensive assistance of one staff member for ADL's.</p> <p>During an interview on 04/23/2024 at 9:22 AM, the RR stated they had not received any statements regarding Resident 47's personal funds.</p> <p>Review of the quarterly statement logbook showed there had been no quarterly statement mailed to Resident 47's RR as of 04/26/2024.</p> <p>During an interview on 04/26/2024 at 2:27 PM, Staff A, Administrator, stated they were behind on mailing the quarterly statements and their expectations was for statements to be mailed out quarterly.</p> <p>Reference WAC 388-97-0340(3)(a)(b)(c)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368</p> <p>Based on interview and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were correct on admission and corrected/updated as needed for 2 of 5 residents (Resident 47 and 50) reviewed for unnecessary medications. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.</p> <p>Findings included .</p> <p><Resident 47></p> <p>Resident was admitted to the facility on [DATE] with diagnosis including anxiety disorder and attention deficit hyperactivity disorder ([ADHD] marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.) The comprehensive assessment dated [DATE] showed that resident had severely impaired cognition and required extensive assist of one staff member for activities of daily living (ADL's).</p> <p>Review of Resident 47's 10/20/2023 PASARR, showed under section I, SMI/ID all diagnosis were marked as no including anxiety disorder.</p> <p><Resident 50></p> <p>Review of Resident 50's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), and post-traumatic stress disorder ([PTSD], a mental health condition that's triggered by a terrifying event-either experiencing it or witnessing it). Review of the quarterly comprehensive assessment dated 02/12/2024, showed the resident's cognition was severely impaired and was dependent for bed mobility, transfers, and walking.</p> <p>Review of Resident 50's 01/29/2024 PASARR, showed under section I, SMI/ID all diagnosis were marked as no including other psychotic disorder. The resident had a diagnosis of PTSD that was not included.</p> <p>During an interview on 04/24/2024 at 4:01 PM, Staff CC, Resident Care Coordinator (RCC), stated the only thing they do with the PASARR is note the date it was completed in the resident's care plan and social services reviews them for accuracy.</p> <p>During an interview on 04/24/2024 at 4:19 PM, Staff BB, Institutional Counselor 3, stated they were responsible for receiving the PASARRs but did not review them for accuracy upon admission or update them when a resident had a change in diagnoses. They were not aware that needed to be done and stated, we have had no training on that.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/25/2024 at 3:21 PM, Staff A, Administrator, stated that their expectation was for the RCC to review the PASARR for accuracy and to contact the PASARR coordinator or work with social services to get them corrected.</p> <p>Reference: WAC 388-97-1915 (1)(2)(a-c)</p> <p>44922</p> <p>45642</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) for 1 of 5 residents (Resident 39) reviewed for unnecessary medications. The facility failed to ensure individualized targeted behaviors were being monitored while they received psychotropic medications. These failures placed residents at an increased risk for experiencing medication-related adverse side effects, and unnecessary medications.</p> <p><Resident 39></p> <p>Review of Resident 39's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), Seizures [a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness)], Developmental disorders of speech and language (a communication disorder that interferes with learning, understanding and using language), violent behavior (any behavior by an individual that threatens or actually harms or injures the individual or others or destroys property). Review of the quarterly comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and was independent for bed mobility, transfers, and walking.</p> <p>During record review on [DATE] at 3:42 PM, Review of resident 39's behavior binder showed, no interventions for staff to follow if the resident had expressed behaviors.</p> <p>During an interview on [DATE] at 10:57 AM, Staff T, Psychology Associate, stated that when Resident 39 was not feeling well they will have some behaviors and refuse cares. Their behaviors will be expressed only if they are not feeling well. Staff T then stated we have determined that resident 39 should have had a behavior plan in place.</p> <p>During an interview on [DATE] at 1:57 PM, Staff U, Resident Care Coordinator (RCC) stated that resident 39's violent behavior is not a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis. The Psychologist will find the appropriate diagnosis for their medications. Their behavior has been minimal, both their mother and brother died close together. Their care plan was formulated for a short-term resident and has turned into a long-term care resident. We are working on the care plan as we go, there is a lot of residents that don't have interventions on their care plan. Redirection is what staff are using. The care plan looks like the nurse just put in their behaviors and no interventions.</p> <p>During an interview on [DATE] at 9:18 AM, Staff B, Director of Nursing Services, stated that they would expect that the non-pharmacological interventions would be in the resident's care plan for staff to follow.</p> <p>Reference WAC: [DATE] (3)(k)(i)</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45642</p> <p>Based on interview and record review, The facility failed to ensure individualized targeted behaviors were being monitored and or interventions in place while they were receiving psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) for 1 of 5 residents (Resident 39) reviewed for unnecessary medications. This failure placed the resident at an increased risk for experiencing medication-related adverse side effects, and unnecessary medications.</p> <p>Finding included .</p> <p><Resident 39></p> <p>Review of Resident 39's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), seizures [a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness)], developmental disorders of speech and language (a communication disorder that interferes with learning, understanding and using language), and violent behavior (any behavior by an individual that threatens or actually harms or injures the individual or others or destroys property). Review of the quarterly comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and was independent for bed mobility, transfers, and walking.</p> <p>Record review of Resident 39's February through [DATE], behavior monitor sheets showed, no behaviors or interventions for staff to follow if the resident were to exhibit violent behaviors.</p> <p>During an interview on [DATE] at 10:57 AM, Staff T, Psychology Associate, stated that Resident 39 did exhibit behaviors and refusals of cares. Staff T stated Resident 39 should have had a behavior plan in place that included interventions.</p> <p>During an interview on [DATE] at 1:57 PM, Staff U, Resident Care Coordinator stated Resident 39's care plan was formulated for short-term, and Resident 39 has turned into a long-term care resident. Staff U further stated they were working on the care plan as able and, there are a lot of residents that do not have interventions on their care plan.</p> <p>During an interview on [DATE] at 9:18 AM, Staff B, Director of Nursing Services, stated that they would expect that individualized targeted behaviors and non-pharmacological interventions would be in the resident's care plan for staff to follow.</p> <p>Reference WAC: [DATE] (3)(k)(i)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled, found in a single locked drawer during one medication pass for 5 of 11 residents (Residents 4, 7, 26, 31, and 35) reviewed for medication administration. This failure placed residents at risk of receiving incorrect medication, adverse side effects and increased the facility's risk for medication errors.</p> <p>Findings included .</p> <p><Resident 4></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include epilepsy (a neurological disorder that causes seizures or unusual sensations and behaviors) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p><Resident 7></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include intellectual disability ([ID] a condition that limits intelligence and disrupts abilities necessary for living independently), epilepsy, and cerebral palsy (a group of conditions that affect movement and posture caused by brain damage before birth).</p> <p><Resident 26></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include ID and epilepsy.</p> <p><Resident 31></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include ID, cerebral palsy, and epilepsy.</p> <p><Resident 35></p> <p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include ID and epilepsy.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation of medication administration and interview on 04/26/2024 at 11:35 AM, showed cottage 401 medication cart's top drawer contained five pre-poured medications in cups. Three of the cups were in clear, 30 milliliter (a type of measurement) medication cups, two of them unlabeled, with crushed, white medications and the third one contained a thick, clear liquid. The other two cups were dixie cups (a paper cup coated with plastic to make them waterproof) with multiple-colored crushed medications mixed with chocolate pudding. Staff AA, Licensed Practical Nurse (LPN), was being trained by Staff M, LPN, stated the medications belonged to five residents. Staff AA further stated their normal practice was not to pre-pour medications.</p> <p>During an interview on 04/26/2024 at 2:47 PM, Staff M stated it was not the normal process to pre pour any medications.</p> <p>During an interview on 04/26/2024 at 3:44 PM, Staff B, Director of Nursing Services, stated Staff AA did not follow the correct process and they would have expected them to prepare and distribute medications for residents one resident at a time.</p> <p>Reference: WAC 388-97-1300(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922</p> <p>45642</p> <p>48406</p> <p>Based on observation, interview, and record review, the facility failed to ensure Cottage refrigerators and cupboards were free of expired foods and refrigerator temperatures were logged appropriately for 3 of 8 Cottages (Cottages 401, 402, and 403) reviewed for food storage. This failure placed the residents at risk of receiving food or drink that decreased their quality of life and had the potential to cause harm.</p> <p>Findings included .</p> <p><Cottage 403></p> <p>An initial tour observation on [DATE] at 9:37 AM, the refrigerator/freezer showed expired food as follows:</p> <p>two frozen waffle molds (food that is blended up and then shaped back into the shape it originated as), expired [DATE].</p> <p>two frozen pear molds, expired [DATE].</p> <p>two frozen roast beef molds, expired [DATE].</p> <p>two frozen corn molds, expired [DATE].</p> <p>in the refrigerator, a white bowl, half full of peaches, uncovered and undated.</p> <p>round, pink/brownish colored cup half full of white, thick liquid, undated.</p> <p>Additionally, in the cupboard above the sink, there were five (7.25 ounce) cans of chicken noodle soup that expired [DATE].</p> <p><Cottage 401></p> <p>During an observation on [DATE] at 10:10 AM, the unit freezer contained:</p> <p>A pint (a unit of measure) -sized white foam container with a white lid, labeled fruit paste with no date.</p> <p><Cottage 402></p> <p>During an observation on [DATE] at 10:10 AM, the unit freezer/refrigerator contained:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A pint-sized white foam container with a white lid, labeled fruit paste with no date.</p> <p>The unit refrigerator contained an identical container labeled fruit paste with an expired date of ,d+[DATE] written on the lid in black ink.</p> <p>During an observation on [DATE] at 3:27 PM, a printed paper taped to the front of the refrigerator showed the month of [DATE] with instructions to record the daily temperatures of the unit refrigerator / freezer and to perform a deep cleaning on Sundays. The temperatures were required to be within the range of ,d+[DATE] degrees Fahrenheit (F). The temperatures were not documented daily for the dates below:</p> <p>[DATE], [DATE], [DATE], [DATE], and [DATE].</p> <p>The documentation showed no deep cleaning had been performed.</p> <p>During an interview on [DATE] at 9:41 AM, Staff Y, Registered Nurse, stated the Nursing Assistants (NA) were responsible for ensuring all foods were checked for dates daily and thrown out if they were expired.</p> <p>During an interview on [DATE] at 9:45 AM, Staff V and Staff W, NAs, stated they were responsible for ensuring the expired foods were disposed of and were to check during each shift. Staff V and Staff W stated they had overlooked the expired foods.</p> <p>During an interview on [DATE] at 10:18 AM, Staff Z, Dietary Manager, stated it was the responsibility of the NAs to check, clean and dispose of expired foods from the refrigerator/freezer.</p> <p>Reference: WAC [DATE](3)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642</p> <p>Based on observation, interview and record review, the facility failed to maintain infection control practices for 1 of 1 resident (Resident 39), by not wearing the proper Personal Protection Equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) during COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) isolation, perform hand hygiene and glove changes between dirty and clean tasks (after touching the resident and/or the resident's environment). These failures placed residents at risk for development of communicable diseases and the spread of infections.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Infection Control Program revised on 11/2023, showed that the purpose was to prevent the development and/or transmission and disease to residents while providing a safe, sanitary, and comfortable environment in which clients reside.</p> <p>Review of the facility's policy titled, Covid Response revised on 03/2024, showed that higher level (N95) masks will be utilized with Aerosol Contact Precautions in units with active transmission, and with suspected or confirmed cases of COVID-19.</p> <p><Resident 39></p> <p>Review of Resident 39's medical records showed the resident admitted to the facility on [DATE] with diagnoses to include Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), seizures [a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness)], and developmental disorders of speech and language (a communication disorder that interferes with learning, understanding and using language). Review of the quarterly comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and was independent for bed mobility, transfers, and walking.</p> <p>During an interview and concurrent observation on 04/22/2024 at 9:03 AM, In Cottage 203 all staff were wearing surgical masks. Staff D, Nursing Assistant (NA), stated that Staff C, Infection Preventionist (IP) directed staff to wear surgical mask until the COVID test results for Resident 39 came back. Observation of Resident 39's room showed the door was wide open with an isolation cart next to the doorway and an aerosol sign that gave direction to wear a N95 respirator (a respiratory protective device designed to achieve a very close facial fit and efficient filtration of air borne particles), gown, goggles, and gloves prior to entering room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/22/2024 at 1:16 PM, Staff C, IP, stated Resident 39 was tested on [DATE] with a rapid COVID-19 test that was inconclusive (leading to no conclusion or definite result) so they sent out a another COVID-19 test to be tested at the lab. Staff C stated if the rapid test would have been positive, they would have moved Resident 39 to the COVID unit. It was on Friday 04/19/2024 that the facility sent the test to the lab. Staff were monitoring all residents for symptoms, and staff remained in surgical masks.</p> <p>During an interview on 04/23/2024 at 10:25 AM, Staff D, NA, stated they had transitioned to wearing surgical masks sometime last week, either 04/17/2024 or 04/18/2024.</p> <p>Observation on 04/23/2024 at 10:28 AM, showed Resident 39 had an isolation cart next to the doorway with an aerosol sign above the cart, and the room door was wide open. All staff working in the cottage were wearing surgical masks. Resident 39 was clean, well groomed, walked into the common area without a mask and sat down in a recliner. Further observation showed no staff redirecting the resident back to his room to maintain their isolation precautions.</p> <p>During an interview on 04/22/2024 at 2:47 PM, The Local Health Jurisdiction (LHJ), stated if a rapid test was inconclusive and if residents were eating and wandering throughout the cottage, staff were to remain in source control to include, N95 respirator, goggles, gowns, and gloves until the COVID-19 lab test results were negative.</p> <p><Dining Room Hand Hygiene></p> <p>Review of the facility's policy titled, Hand Hygiene dated 07/27/2023, showed Hand hygiene should be performed:</p> <p>Before and after caring for a resident or when moving from a contaminated task to a clean task.</p> <p>Before and after performing invasive procedures.</p> <p>Before and after handling food.</p> <p>During an observation on 04/24/2024 at 11:28 AM, Staff R, Speech Language Pathologist, removed a meal from the cart, stirred, and scooped the food on to a plate. Staff R delivered the plate to a resident sitting at the dining room table. Staff R obtained a cup of milk and grasped the cup by the rim while they set the cup on the table next to the resident. During this observation Staff R did not perform hand hygiene or apply gloves.</p> <p>During an observation on 04/24/2024 at 11:57 AM, Staff S, NA, obtained a clean plate and transfers food from a bowl to the plate without gloves or performing hand hygiene.</p> <p><PPE use for residents on EBP></p> <p>During an observation on 04/25/2024 at 2:43 PM, Staff P, Licensed Practical Nurse (LPN), exited room [ROOM NUMBER]A, Cottage 402, an aerosol precautions room related to the COVID-19 virus, wearing only gloves. Staff P entered the next resident room, 4A, without removing their gloves or performing hand hygiene.</p> <p>(continued on next page)</p>		

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 04/26/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/25/2024 at 2:45 PM, Staff P was asked what PPE was required for the Aerosol Precaution room. Staff P stated gown, gloves and an N-95 mask. Staff denied being in room [ROOM NUMBER]A.</p> <p><Resident 12></p> <p>The resident admitted to the facility with diagnosis to include gastrostomy tube ([GT], a surgically placed tube in the stomach to allow liquid food and water to be given), developmentally delayed. The comprehensive assessment dated [DATE], showed Resident 12 had severely impaired cognition and was dependent of two staff members with activities of daily living.</p> <p>During an observation on 04/25/2024 at 2:57 PM, Staff P, LPN, was observed in the dining room in Cottage 401 accessing Resident 12's GT port. Staff P removed the feeding tube from Resident 12's GT port while wearing only gloves. They did not put on the additional required gown and face protection.</p> <p>During an interview on 04/26/2024 at 1:01 PM Staff M, LPN, stated if they had a resident that received tube feeding, they would take the resident back to their room, perform hand hygiene, put on a gown, gloves and eye or face protection, and unhook the resident. They further stated when they were finished with resident care, they would take off the PPE in the room, perform hand hygiene, and take the resident back to the common area. Staff M explained they would take the resident back to their room because accessing an indwelling medical device such as a GT required infection control. They stated the new enhanced barrier precautions (EBP) required them to wear a gown, gloves, and eye protection when accessing a GT.</p> <p>During an interview on 04/25/2024 at 3:01 PM, Staff S, NA, and Staff O, NA, stated if a resident was on EBP they only need to gown and glove when moving or providing care in the resident's room, not when they were in the common areas.</p> <p>Reference WAC: 388-97-1320 (1)(c),(2)(b),(1),(2),(3)</p> <p>48406</p>		