

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 06/06/2025
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview and record review, the facility failed to provide care and services in a dignified manner when they served other residents their meals before everyone else seated in the dining area for 3 of 4 residents (Residents 2, 6, and 23) reviewed for dignity. This failure placed residents at risk for lack of inclusion and decreased dignity.</p> <p>Findings included .</p> <p>&lt;Resident 2&gt;</p> <p>Review of the resident's medical record showed they admitted with diagnoses to include Intellectual Disabilities (ID, limitations in cognitive functioning and skills, including conceptual, social, and practical skills) and mixed receptive-expressive language disorder (a communication disorder that affects both understanding and producing/expressing language). The 05/13/2025 comprehensive assessment showed Resident 2's cognition was severely impaired and was dependent on staff for eating their meals.</p> <p>&lt;Resident 6&gt;</p> <p>Review of the resident's medical records showed they admitted with diagnoses to include ID and epilepsy (a brain condition that causes recurring seizures, which are abnormal electrical brain activities). The 05/26/2025 comprehensive assessment showed Resident 6's cognition was severely impaired and was dependent upon staff for eating their meals.</p> <p>&lt;Resident 23&gt;</p> <p>Review of the resident's medical records showed they admitted to the facility with diagnoses to include ID and epilepsy. The 04/09/2025 comprehensive assessment showed Resident 23's cognition was severely impaired and was dependent upon staff for eating their meals.</p> <p>During an observation on 06/02/2025 at 11:56 AM, showed Resident 6 sitting in their wheelchair (w/c), looking downwards to their right side. Resident 6's meal had been served onto a plate and was waiting for staff to assist them with eating. Resident 23 was sitting in the recliner closest to the front door waiting for their meal. Observations showed all other residents had been served their meals or were being assisted with their meals while these two residents waited for staff to assist them. NAs began to assist Residents 6 and 23 at 11:59 AM. There were two other residents that required staff assistance with their meals that had already been assisted.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A concurrent observation and interview on 06/03/2025 at 5:09 PM, showed Residents 2, 6, and 23 had not been served their dinner. The living room area and the dining area are both in a combined space. At one table there was Staff H, Registered Nurse, assisting another resident with their meal and on a side table, there was a resident eating unassisted, and only required cueing. Resident 2 was sitting at a different table with their eyes closed, mouth opened, and their dinner plate was sitting in front of them, but staff clarified they had already eaten even though their food had not looked like it had been touched. Resident 6 was sitting in the dining room area, in between the tables, with a side table beside their w/c, waiting to be assisted to eat, and Resident 23 was walking back and forth from their room to the dining room. Staff H stated they were helping staff out because they were short-handed [not enough staff] today. Staff I, Nursing Assistant (NA), stated when they were short staffed, the residents were the ones who suffer, because look at [Resident 6], they haven't eaten yet. Staff I further confirmed that Resident 23 had not been assisted to eat either (exited the building at 5:23 PM and neither resident 6 nor 23 had been served or assisted with their meal. 14 minutes after the other residents had been observed being assisted).</p> <p>A concurrent observation and interview on 06/04/2025 at 11:38 AM, showed Staff R, NA, sitting at one table in the dining area assisting a resident with their meal. Resident 2 was sitting at the 2nd table with no food and directly across the table from Resident 2 was another resident who had been served their meal and was eating. Observations showed Resident 6 sitting in between the two tables in the dining room area, in their w/c, waiting for their meal and assistance, and Resident 23 stood by the two tables, walking back and forth from table to table. Additionally, Resident 2 blankly stared at the resident eating across from them, and at times would wrinkle their forehead and scowl (an angry or bad-tempered expression). Staff R stated they were the only NA at the time and the other NA had been on their lunch break.</p> <p>Observations at 11:55 AM, showed Staff K, NA, had returned from their lunch break and assisted Resident 6 with their meal. Resident 2 and Resident 23 were waiting for their meal and staff assistance. Resident 2 continued watching the resident across from them eating.</p> <p>An observation at 12:16 PM, showed Resident 2 received their lunch with staff assistance (38 minutes after the first resident was being observed being assisted). Observations at 12:36 PM (58 minutes after all other residents) showed Resident 23 received their lunch with staff assistance. Staff K stated they had four residents out of the seven they were assigned that required staff assistance with their meals and they just had to prioritize who to assist first.</p> <p>During an interview on 06/06/2025 at 1:38 PM, Staff B, Director of Nursing Services, stated they felt they had enough staff for the level of supervision the residents required, not the amount of assistance they needed. Staff B stated they would have expected the NAs to call for additional assistance if they did not have enough staff to assist with feeding all the assisted residents at the same time.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on interview, and record review, the facility failed to ensure that physical restraints (any manual method, physical or mechanical device, equipment or material, attached or adjacent to the residents body, that cannot be removed by the resident and restricts the resident's freedom of movement) were implemented in a safe manner, had the required resident specific medical symptoms (which warranted the use of physical restraints) identified, medical provider orders for the use of the specific type of physical restraint were obtained, nor that least restrictive measures were utilized to treat a resident's medical symptoms for 3 of 3 residents (Residents 20, 3 and 15), reviewed for physical restraints. This failure placed residents at an increased risk for injury, a loss of their freedom of movement and adverse mental health effects regarding their well-being, independence and self-direction.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Use of Restrictive Procedures, revised December 2024, showed that a medical professional would place an order for medically necessary mechanical restrictions/restraints to . protect a client's physical health and treat a medical condition . The policy showed that if medically necessary treatments were planned by an interdisciplinary team (IDT, a collaborative group of healthcare staff from various fields of work within a facility) for a resident to have restrictions/restraints the protocol and procedure would be on the Restraint Orders and Monitoring form. The policy showed that when physical restraints were used to complete a medical or dental procedure a medical professional would document medical necessity (refers to a determination that a treatment or procedure is essential to treat a diagnosed medical condition) and include the purpose of the restraint, and that lesser restrictive interventions (the choosing of interventions that limits a residents freedom, independence, or rights as little as possible) were tried but ineffective.</p> <p>Additionally, the policy showed the medical professional must document in the resident's medical record using the restraint orders and monitoring form, which included the type of physical restraint, the resident's response to the physical restraint and the emotional and behavioral state of the resident upon release of the restraint.</p> <p>Review of the facility's protocol form titled, Restraint Orders and Monitoring, revised March 2022, showed the restraint orders section needed to be fill out completely or to look at the physician's order and that the form would be used for all restraint checks and monitoring. The form has sections for the type of restraint order, type of restraint, description of restraints used, physicians order, restraint alternatives tried, and the reason for the resident's restraint.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Center for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (a tool used to facilitate accurate and effective resident assessment practices), Section P, Restraints and Alarms, dated 10/01/2024, showed, Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have: physician documentation of a medical symptom that supports the use of the restraint, a physician's order for the type of restraint and parameter of use, and a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate. Additionally, identification of medical symptoms could assist the facility in determining what less restrictive measure to utilize and that facility's should perform all due diligence (extensive evaluation before implementation) in documenting this process to ensure that they had exhausted alternative treatments and less restrictive measures before a physical restraint was employed to treat a resident's medical symptom.</p> <p>&lt;Resident 20&gt;</p> <p>Review of the resident's medical records showed they were admitted to the facility intellectual disabilities (ID, limitations in cognitive functioning and skills, including conceptual, social, and practical skills), hearing loss, anxiety and expressive language disorder (a communication challenge that affects a person's ability to express thoughts, ideas or feelings clearly and effectively). The 04/18/2025 comprehensive assessment showed the resident had severely impaired cognition and no physical restraints were documented being used. The 10/18/2024 comprehensive assessment showed that physical restraints were documented as used less than daily.</p> <p>Review of Resident 20's care plan, reviewed 06/06/2025 showed the resident would receive safe quality oral health care. The care plan showed, (Resident 20) is very resistant to oral health care. Restraint and/or oral sedation (the process of making a resident more relaxed through administration of medication) needed for safety during dental treatment.</p> <p>Review of Resident 20's dental progress notes showed:</p> <p>&bull;</p> <p>on 07/16/2024, Resident 20 was .adequately sedated and tolerated the procedure well. (Resident 20) was very cooperative. (Resident 20) was treated in the dental chair; hand restraints and leg wrap (applied 10:34 AM, removed 10:54 AM) . No documentation was noted on Resident 20's specific medical symptoms identified, which warranted the use of the physical restraints, the medical providers orders for implementation of the physical restraint, nor that least restrictive measures were utilized for Resident 20 prior to implementation of physical hand/leg restraints.</p> <p>&bull;</p> <p>on 10/17/2024 Resident 20 was .adequately sedated and tolerated the procedure well. (Resident 20) was very cooperative. (Resident 20) was treated in the dental chair; hand restraints and leg wrap (applied 09:44 AM, removed 10:13 AM) . Again, no documentation was noted on the specific medical symptoms identified for the use of physical hand/leg restraints, the provider orders for implementation of the physical hand/leg restraints, nor that lesser restrictive intervention were attempted before using the hand and leg restraints.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 20's provider orders for July 2024 and October 2024, showed no documentation of orders for specific medical symptoms that warranted the use of physical restraints had been completed.</p> <p>Review of the facility's restraint orders and monitoring form showed no documentation of the form being completed for Resident 20's dental appointments/physical restraint implementation.</p> <p>&lt;Resident 3&gt;</p> <p>Review of the resident's medical records showed they were admitted to the facility with diagnoses including ID, cerebral palsy (a neurological disorder that permanently affects body movement and muscle coordination) and expressive language disorder. The 05/10/2025 comprehensive assessment showed the resident had a severely impaired cognition and physical restraints were documented as used less than daily.</p> <p>Review of Resident 3's care plan, reviewed 06/04/2025 showed the resident would receive safe quality oral health care. The care plan showed that Resident 3 was very resistant to oral health care and that restraints/oral sedation may be needed for their safety during dental treatments.</p> <p>Review of Resident 3's dental progress notes showed that on 05/08/2025 at 10:27 AM, the resident was treated in their wheelchair .right hand restraint applied 9:47 AM/removed 10:04 AM . No documentation was noted with the specific medical symptoms identified for the use of the physical hand restraint, the provider orders for implementation of the physical hand restraint, nor that lesser restrictive intervention were attempted before implementing the hand restraint.</p> <p>Review of Resident 3's provider orders for May 2025, showed no documentation of orders for specific medical symptoms that warranted the use of physical restraints had been completed.</p> <p>Review of the facility's restraint orders and monitoring form showed no documentation of the form being completed for Resident 3's dental appointments/physical restraint implementation.&lt;Resident 15&gt;</p> <p>Review of the resident's medical record showed they were admitted to the facility with diagnoses including ID and epilepsy (a brain condition that causes recurring seizures, which are abnormal electrical brain activities). The 03/13/2025 comprehensive assessment showed Resident 15's cognition was severely impaired and received anxiety (excessive, persistent, and uncontrollable worry and fear about everyday situations) medications.</p> <p>Review of Resident 15's dental progress notes showed:</p> <p>&bull;</p> <p>on 01/29/2025, Resident 15 was seen for a dental appointment. Resident 15 was given anxiety medications for sedation prior to the appointment. Upon arriving to the dental department, Resident 15 was awake and alert. Resident 15 was transferred from their wheelchair to the dental chair and placed into protective stabilization a body wrap (a temporary restraining device that immobilizes a subject's body and restricts their ability to kick or do harm) restraint. The note showed Resident 15 was resistive at times but cooperative enough to treat.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&bull;</p> <p>on 02/06/2025, Resident 15 was seen for a dental appointment and provided the same medications and body wrap restraint as on 01/29/2025. Additionally, physical assistance was provided to stabilize the head. Resident 15 was very cooperative and tolerated the procedure well.</p> <p>&bull;</p> <p>on 02/19/2025, Resident 15 was seen for dental appointments and provided the same medications and wrap as on 01/29/2025. Resident 15 was awake and alert throughout the dental visit.</p> <p>&bull;</p> <p>on 03/19/2025, Resident 15 was seen for dental appointments and provided the same medications and wrap as on 01/29/2025. Resident was awake and alert through the dental visit.</p> <p>&bull;</p> <p>on 04/09/2025 Resident 15 was seen for dental appointments and provided the same medications and wrap as on 01/29/2025. Resident was awake and alert through the dental visit.</p> <p>&bull;</p> <p>on 05/15/2025 Resident 15 was seen for a dental appointment and provided the same medications and restraints as on 02/06/2025. Resident 15 was very cooperative and tolerated the procedure well.</p> <p>The notes showed no documentation that Resident 15 experienced any behaviors prior to being placed into the body wrap restraint or that they attempted to use a least restrictive option. The notes showed Resident 15 was taken from their cottage after being provided medication sedation and transferred from their wheelchair directly into the dental chair into a body wrap restraint.</p> <p>During an interview on 06/05/2025 at 3:55 PM, Staff B, Director of Nursing Services, stated the facility's process with physical restraints was to get a provider order for the restraint and how the restraint would be applied, obtain consents from the resident representative, complete assessments/care planning all before a restraint would be utilized for the resident. Staff B stated that they were not aware of physical restraints currently being needed for facility residents and that they would have received a notification from the nursing staff if they needed to apply a physical restraint. When asked about physical restraints during dental appointment, Staff B stated that dental staff were responsible for obtaining restraint consents, assessments and documentation of least restrictive measures being utilized.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/06/2025 at 9:47 AM, Staff B stated they were aware of facility residents having physical restraints applied during dental procedures. Staff B stated that it was not the facility's process to obtain provider orders for the implementation of physical restraints on residents during dental procedures. Staff B stated the restraint orders and monitoring form should be documented and would show a resident's orders, assessments, monitoring, and the lesser restrictive measures used before implementing physical restraints. Staff B stated they did not see that the facility's dental staff was completing the form when restraints were implemented during resident dental procedures.</p> <p>During an interview on 06/06/2025 at 10:30 AM, Staff B and Staff G, Dental Hygienist, stated they were familiar with the facility's resident population with intellectual disabilities, and dental procedures conducted. Staff G stated that during resident dental procedures, sedation/physical restraints were applied when a resident was starting to pull at the dentist's arm or when a resident would move their arms up to their mouth. Staff G stated that physical restraints were not utilized during every dental procedure. Staff G stated they did not put in a provider order when implementing physical restraints, but that a consent was obtained annually from resident representatives for implementation of physical restraints during dental procedures. Staff G stated that least restrictive measures were not conducted every time physical restraints were to be implemented for a resident and that they should have been. Staff G stated they document a dental progress note for residents, but that the note did not include all the required information that was on the restraint orders and monitoring form. Staff G stated they had not been completing the restraint orders and monitoring form for restraints implemented during the residents' dental procedures. Staff B stated the correct process was not being followed for the implementation of physical restraints with residents' dental procedures.</p> <p>During an interview on 06/06/2025 at 1:06 PM, Staff A, Administrator, stated that implementation of physical restraints during resident dental procedures was not being completed correctly. Staff A stated that least restrictive measures should be conducted with residents before moving to the application of physical restraints. Staff A stated that a provider order should be obtained, and dental staff should be completing the restraint orders and monitoring form when implementing physical restraints. Staff A stated that facility staff were not following the correct process for the implementation of physical restraints with residents during dental procedures.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) and provide a written notice to the resident and/or their representative of a hospital transfer for 1 of 2 residents (Residents 15) reviewed for hospitalization. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold and lack of discharge needs while in the hospital.</p> <p>Findings included .</p> <p>&lt;Resident 15&gt;</p> <p>Review of the resident ' s medical record showed they admitted to the facility with diagnoses to include Intellectual Disabilities (ID, limitations in cognitive functioning and skills, including conceptual, social, and practical skills) and epilepsy (a brain condition that causes recurring seizures, which are abnormal electrical brain activities). The 03/13/2025 comprehensive assessment showed Resident 15's cognition was severely impaired and had readmitted to the facility on after a hospital stay.</p> <p>Review of Resident 15's progress notes dated 02/12/2025 showed the resident experienced loose stools and an elevated temperature for three days. The provider was notified, and orders were given to send Resident 15 to the hospital. A follow-up progress notes on the same day showed the resident had sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) and was admitted to the hospital.</p> <p>Further review of the medical record showed Resident 15, nor their Resident Representative (RR) were offered a bed hold or were they given a notification of a hospital transfer.</p> <p>During an interview on 06/06/2025 at 3:04 PM, Staff N, Social Services Specialist, stated they normally received a notification by electronic mail (email) if a resident had been admitted to the hospital. Staff N stated they had not received that email or I missed it somehow and the bed hold, and transfer notification had not been done.</p> <p>During an interview on 06/06/2025 at 3:24 PM, Staff A, Administrator, stated they would have expected the bed hold and the notification of transfer to be completed per their policy. Staff A stated the process was to offer the bed hold and they were aware that got missed.</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** Based on interview and record review, the facility failed to validate the accuracy of a resident's 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) as required for 1 of 5 residents (Resident 35) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate to their needs.</p> <p>Findings included .</p> <p>&lt;Resident 35&gt;</p> <p>Review of Resident 35's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a bone infection of the lower spine, depression and anxiety. The comprehensive assessment, dated 05/05/2025, showed the resident was cognitively intact, could make their needs known and had active diagnoses of an anxiety disorder and depression.</p> <p>Review of Resident 35's PASARR, dated 11/01/2024, showed under section I, SMI/ID, had been marked for depression but was not marked for anxiety.</p> <p>During an interview on 06/06/2025 at 1:57 PM, Staff F, Social Service Director, stated they, along with the Resident Care Coordinators, reviewed resident PASARR's for accuracy before submitting a referral for positive Level 1 PASARR's. Staff F stated they were not aware that Resident 35 had a diagnosis of anxiety, and the resident PASARR was not accurate and needed to be corrected and resubmitted.</p> <p>During an interview on 06/06/2025 at 4:16 PM, Staff A, Administrator, stated the facility staff know the procedure for resident PASARR's and checking to make sure resident SMI diagnoses were accurate was a part of that. Staff A stated the correct process was not followed for Resident 35's PASARR.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a base line care plan (BCP), for 3 of 3 residents (Resident's 43, 44 and 35) reviewed for base line care planning. The facility failed to provide the residents or their representatives with a written summary of the required information upon completion of the comprehensive care plan. The missing information included the resident's initial goals, physician's orders and current diet orders. This failure placed the residents at risk for adverse events and unmet care needs.</p> <p>Findings included .</p> <p>&lt;Resident 43&gt;</p> <p>Review of the resident's record showed they were admitted to the facility on [DATE] with diagnoses which included autism (a mental health condition that affects an individual's ability to communicate and react to the environment), and intellectual disability (limitations in cognitive functioning). The comprehensive assessment dated [DATE] showed Resident 43 had severe cognitive impairment and required two staff to support their activities of daily living (ADL's, basic tasks needed for self-care).</p> <p>Review of Resident 43's CP dated 01/23/2025 showed the required components were not included such as initial goals, physician or dietary orders. Additionally there was no documentation that a written copy had been given to the resident's representative once it had been completed.</p> <p>During an interview on 06/06/2025 at 2:40 PM, Staff E, Resident Care Coordinator (RCC) stated they did not include initial goals, physician orders or current diet orders on the CP. Staff E stated they were unaware of the required components to be included on the CP.</p> <p>&lt;Resident 44&gt;</p> <p>Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses that included autism, intellectual disability and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures). Review of the comprehensive assessment dated [DATE] showed the resident had severely impaired cognition and required supervision and minimal assistance from staff for ADL's.</p> <p>Record review of Resident 44's CP dated 03/06/2025 showed no initial goals, physician orders or dietary orders listed.</p> <p>&lt;Resident 35&gt;</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 06/06/2025
NAME OF PROVIDER OR SUPPLIER Yakima Valley School		STREET ADDRESS, CITY, STATE, ZIP CODE 609 Speyers Road Selah, WA 98942	
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses including cerebral palsy (a congenital (prior to birth) disorder of movement and muscle tone), osteomyelitis (inflammation of bone caused by infection) in the sacrum (a bone located at the base of the spine) and diabetes (too much sugar in the blood). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial to total assistance from staff for ADL's and mobility.</p> <p>Record review of Resident 35's CP dated 10/23/2024 showed no initial goals, physician or dietary orders identified. Additional review showed there was no documentation that the CP had been given to the resident after it had been completed.</p> <p>During an interview on 06/06/2025 at 11:44 AM, Staff D, RCC stated they had been responsible to develop the CP's for Resident's 43 and 35. Staff D stated the CP's did not include the required components for initial goals, physician or dietary orders.</p> <p>During an interview on 06/06/2025 at 1:12 PM, Staff B, Director of Nursing Services, stated they had not been aware of the requirement to develop a CP which included the resident's initial goals, physician and dietary orders. Staff B stated, We are working on a new process to develop a CP with the identified components as we did not have one before.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review the facility failed to follow physician's orders to obtain specialized services for 1 of 2 residents (Resident 15) reviewed for pain. This failed practice placed residents at risk of not receiving needed specialized care and services and a decline in health and/or mobility.</p> <p>Findings included .</p> <p>&lt;Resident 15&gt;</p> <p>Review of the resident's medical records showed they admitted with diagnoses of Intellectual Disabilities (limitations in cognitive functioning and skills, including conceptual, social, and practical skills) and autism (when a person has trouble communicating and understanding what people think and feel). Review of the 03/13/2025 comprehensive assessment showed Resident 15's cognition was severely impaired and was independent for transfers and ambulation.</p> <p>During an observation and concurrent interview on 06/02/2025 at 3:00 PM, Resident 15 was sitting in a chair in the dining room, stood up, and walked towards the back patio door. When Resident 15 walked, they had a slight limp to their left leg. Resident 15 was wearing shorts, and the left knee showed some mild swelling compared to the visualization of the bones from the right knee to the left knee. Staff P, Nursing Assistant, stated Resident 15 had limped on their left leg for the past few months, off and on. Staff P stated they went to have imaging but for some reason that could not be completed. Staff P stated Resident 15 had been put on a pain medication for their left leg.</p> <p>Review of Resident 15's care plan dated 06/14/2024 through 09/13/2024, showed no care plan to reflect Resident 15's left leg limping or increased pain.</p> <p>Review of the Orthopedic (Ortho, a specialist who diagnoses and treats conditions affecting the bones, muscles, and joints) specialist's note, dated 03/06/2025, showed Resident 15 was being seen for left knee pain and the symptoms were gradually worsening. The plan was to obtain further imaging for concerns that Resident 15 experienced internal derangement (internal damage to the knee caused due to trauma) to their left knee. The note showed Resident 15 would require intravenous (IV, medication provided into the vein) sedation due to the resident's diagnoses. Further, Resident 15 was to have rest and activity modification to prevent increased stress to the knee, ice alternating with heat, and possible topical pain-relieving creams and ointments.</p> <p>Review of a follow-up note, dated 03/06/2025, sent to the facility from the Ortho showed; Ordering MRI (Magnetic Resonance Imaging, a medical imaging technique that uses a powerful magnet, radiation waves, and a computer to create detailed images of the inside of the body) with IV sedation of the left knee and to follow-up after the imaging was completed.</p> <p>Review of a follow-up note, dated 04/04/2025 sent to the local hospital, showed IV is not done at our facility and the provider was called and asked to prescribe oral sedation. The note had no other documentation or who signed or sent the note.</p> <p>Review of Resident 15 progress notes, showed:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&bull;</p> <p>03/17/2025 - the RR reached out to inquire about an imaging appointment and was told one had not been made yet and would reach out to the Ortho.</p> <p>&bull;</p> <p>04/04/2025 - Resident 15 went to the local hospital for scheduled imaging of their left knee. Staff that assisted Resident 15 was told they did not perform imaging under general anesthesia (a medical treatment that induces a sleep-like state by administering medications through an IV) so the imaging was not completed.</p> <p>&bull;</p> <p>04/04/2025 - the RR called the facility to see what the next steps were and informed the facility they wanted the provider, or the Medical Director consulted with for the next steps and requested the possibility of finding another facility for the imaging. The note showed they followed up with the provider and they were told to locate another facility that would perform the imaging.</p> <p>&bull;</p> <p>04/08/2025, 04/27/2025, 05/01/2025, 05/05/2025, and 5/15/2025 - Resident 15 continued with limping to their left leg.</p> <p>Review of Resident 15's 06/2025 physician orders showed an order initiated on 04/29/2025 for ibuprofen (a brand of medication used for pain and swelling) 600 milligrams (a unit of measure) twice daily for diagnosis of Osteoarthritis (breakdown of cartilage in the joints, leading to pain, stiffness, and limited movement) of knee (which knee is not specified).</p> <p>Review of a 03/06/2025 Physician's note, showed Resident 15 was followed up by the Ortho and had orders for imaging for further evaluation. Another note dated 05/05/2025, showed Resident 15 had on-going left knee pain with limping and had a referral to an Ortho for imaging. The note showed blood tests were ordered via verbal order due to the Resident Representative's (RR) concern for Rheumatoid Arthritis (RA, a chronic inflammatory disorder that can affect more than just your joints) and for Resident 15 to continue with the use of the ibuprofen.</p> <p>Review of Resident 15's blood test results showed no blood tests had been obtained to rule out RA as the RR had requested and the provider had verbally ordered on 05/05/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/06/2025 at 8:21 AM, Staff D, Resident Care Coordinator (RCC), stated the facility waited for the Ortho to make Resident 15 an appointment for the imaging (63 days later). Staff D stated their attempts to reach the Ortho had not been successful and had left requests for a return call. Staff D stated the RA blood tests were just ordered (32 days after verbal order) and were working on that. Staff D stated they had not reached out to Resident 15's primary provider because Resident 15 had been referred to a specialist and once, they were referred out, our hands don't do anything from that point, so we don't step on anyone's toes. Staff D stated they had reached out to the RR to request them to call the Ortho to see what the plan was. Staff D stated they thought they updated Resident 15's care plan but at times when they update it, stuff just disappears or doesn't go anywhere. Staff D stated they did not follow up with Ortho's plan for ice and heat and activity modifications because they must have overlooked those directions.</p> <p>A concurrent observation and interview on 06/06/2025 at 12:46 PM, Staff Q, Recreation Nursing Assistant, stated they attended the imaging appointment with Resident 15 for their left knee. Staff Q stated when they arrived, they were told by the local hospital that when the appointment was made, they informed the caller they did not do imaging under general anesthesia, so refused to see them. During this interview, Staff Q was walking with Resident 15 outside in the parking lot, Staff Q let go of Resident 15's hand to allow them to walk on their own. Resident 15 walked without a limp, but when taking a step with their left leg, they would swing the left leg slightly outwards, as if not to bend it all of the way. Staff Q stated they had noticed that as well. Resident 15's left knee showed mild swelling compared to the right knee.</p> <p>During an interview on 06/06/2025 at 1:38 PM, Staff B, Director of Nursing Services, stated they would have expected Staff D to have followed up with Resident 15's primary provider for additional imaging orders or at least a plan of action to ensure the imaging ordered had been completed. Staff B stated the RCC's should continue to do all they can, even when a resident was referred out to another provider, to ensure they get done what they need. Staff B stated they did not know why the blood work ordered had not been completed but it should have been. Staff B stated notes from providers should be read when a resident returned from an appointment and additional interventions put into place if that is what was ordered. Staff B stated that did not happen with Resident 15. Additionally, Staff B stated Staff D should not have reached out to Resident 15's RR for assistance in obtaining the imaging ordered.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were optimal nursing staff in order to provide appropriate supervision and individualized care needed based on the acuity (the level of severity of residents' illnesses, physical, mental, cognitive limitations, and conditions) level of care required for 6 of 10 residents (Residents 2, 6, 23, 10, 15, and 17) reviewed for staffing. This failed practice placed residents at risk for unmet care needs, not receiving care planned interventions, and negative outcomes.</p> <p>Findings included .</p> <p>Review of a policy dated 10/2024, titled Level of Supervision (LOS), showed that a LOS was to be assigned to each resident to provide an appropriate degree of supervision to protect their rights, keep them safe, and to staff to the maximum extent reasonable. The LOS showed:</p> <p>&bull;</p> <p>LOS 1- staff should have general knowledge of where residents are and what they are doing.</p> <p>&bull;</p> <p>LOS 2- staff were to have knowledge of where the residents were at, at all times, who they were with, and what they were doing.</p> <p>&bull;</p> <p>LOS 3- staff supervision must be positioned in a manner to protect from or deter danger.</p> <p>&bull;</p> <p>LOS 4- staff provided one-to-one supervision allowing as much social space as possible.</p> <p>&lt;Resident 2&gt;</p> <p>Review of the resident's medical record showed they admitted with a diagnosis of Intellectual Disabilities (ID, limitations in cognitive functioning and skills, including conceptual, social, and practical skills) and mixed receptive-expressive language disorder (a communication disorder that affects both understanding and producing/expressing language). The 05/13/2025 comprehensive assessment showed Resident 2's cognition was severely impaired and were dependent on staff for all of their care needs. Additionally, Resident 2 required a LOS 1, and staff needed to anticipate (foresee and prepared to meet the resident ' s needs in advance since they could not communicate that themselves) their needs due to their inability to communicate verbally.</p> <p>&lt;Resident 6&gt;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's medical records showed they admitted with a diagnosis of ID and mixed receptive-expressive language disorder. The 05/26/2025 comprehensive assessment showed Resident 6's cognition was severely impaired and required extensive assistance from staff for all of their care needs. Additionally, Resident 6 required a LOS 1, and their needs were to be anticipated by staff due to them not being able to communicate verbally.</p> <p>&lt;Resident 23&gt;</p> <p>Review of the resident's medical records showed they admitted with a diagnosis to include ID and mixed receptive-expressive language disorder (a communication disorder that affects both understanding and producing/expressing language). The 04/09/2025 comprehensive assessment showed Resident 23's cognition was severely impaired and was dependent on staff for eating. Additionally, the record showed Resident 23 required LOS 2 and staff were to anticipate their needs due to their limited ability (four words) to communicate verbally.</p> <p>An observation on 06/02/2025 at 11:56 AM, showed Resident 6 sitting in their wheelchair (w/c) with their plate of food sitting in front of them on the table. Resident 23 was sitting in a recliner waiting for their food to be served. Residents 6 and 23 both required the assistance of staff to eat but the staff were busy assisting the other two residents. At 11:59 AM, Residents 6 and 23 were assisted with their lunch, after the other two residents that required assistance had eaten.</p> <p>An observation on 06/03/2025 at 5:09 PM showed two staff members, Staff H, Registered Nurse, and Staff I, Nursing Assistant (NA), that were available to assist residents with their meals. Residents 2, 6, and 23 had not had their dinner served and all three residents required staff assistance with eating. Staff H was assisting a fourth resident who required assistance with eating. Staff H stated they were helping Staff I assist the residents to eat because they were short-handed (not enough staff). Staff I stated when they were short staffed the residents are the ones to suffer, because look at [Resident 6], they haven't eaten yet and the residents had to wait until one of the staff were finished with the residents they were currently assisting. Staff I stated Resident 23 had not eaten yet either.</p> <p>An observation on 06/04/2025 at 11:38 AM, showed Resident 2 sitting at the table without their meal. Resident 6 sat in their w/c in between the two dining room tables, and Resident 23 walked out into the dining area, from the back of the cottage (out of eyesight of staff), both residents were not served their meals. Staff R, NA, was sitting at one of the tables assisting another resident with their meal. There were no other staff observed. Staff R stated the other NA had gone on their lunch break. Staff R stated there were two NA staff assigned to the cottage, and another one would float from one cottage to the other to help. At 11:55 AM, Staff K, NA, returned from lunch and assisted Resident 6 with their meal. Then, at 12:16 PM, Staff R sat down at the table to assist Resident 2 with their meal (38 minutes after the first resident was observed assisted with their lunch) and at 12:36 PM, Resident 23 received assistance with their meal (58 minutes after the first resident was observed being assisted with their lunch). Staff R stated there were four residents that required assistance with eating and even if they were not short of staff, they still would not have enough staff for all the residents to eat their meals together.</p> <p>&lt;Resident 10&gt;</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's medical records showed they admitted with diagnoses to include ID. The 03/11/2025 comprehensive assessment showed Resident 10's cognition was moderately impaired and had inattentive (not paying attention to something) behaviors. Additionally, the record showed Resident 10 required a LOS 3 and the staff needed to anticipate their needs due to their limited verbal skills and use of body language. The record showed Resident 10 did not like the bathroom door closed all the way, so staff were to stand in the doorway while Resident 10 was toileted.</p> <p>&lt;Resident 15&gt;</p> <p>Review of the resident's medical records showed they admitted with diagnoses to include ID and mixed receptive-expressive language disorder. The 03/13/2025 showed Resident 15's cognition was severely impaired and required extensive assistance from staff for eating. The assessment showed Resident 15 had wandering behaviors. Additional review of the record showed Resident 15 required a LOS 4.</p> <p>&lt;Resident 17&gt;</p> <p>Review of the resident's medical records showed they admitted with diagnoses to include ID and PICA (an eating disorder where a person compulsively eats things that aren't food and don't have any nutritional value or purpose). The 03/15/2025 comprehensive assessment showed Resident 17's cognition was moderately impaired and required partial to moderate assistance of staff for toileting. Additionally, review of the record showed Resident 17 required a LOS 2 and their care needed to be anticipated due to their non-verbal and body language communication.</p> <p>An observation on 06/02/2025 at 10:48 AM showed Staff V, NA, was one on one with Resident 15 who was exit seeking. Staff T, NA, and Staff P, NA, were at the back of the cottage assisting with a mechanical lift transfer, and there was a volunteer reading to a resident in the dining room area. Resident 17 waited until staff walked out of their sight and jumped up from the table and walked quickly to the refrigerator, took out a black condiment container, scooped out a big bite with their finger and put it in their mouth. In the container was fry sauce (mayonnaise mixed with ketchup). The volunteer yelled out for the staff and Staff T ran to the refrigerator to intercept Resident 17 from eating the remainder of the container.</p> <p>During an interview on 06/03/2025 at 4:25 PM, Staff M, NA, stated they were short staffed because two of the NAs scheduled for this cottage were sent over to cottages 405 and 406 because they were also short staffed. Staff M stated when they were short staffed it could make providing care very challenging, especially during mealtimes. Staff M stated it was not an ideal situation because you had to prioritize and choose who was going to receive care first. Staff M stated when they were short staffed and needed to provide care to another resident, they would have to leave a LOS 2 resident without supervision until they were finished.</p> <p>During an interview on 06/03/2025 at 4:50 PM, Staff W, NA, stated the normal staffing pattern was to have six NAs, but most of the time they only had five NAs. Staff W stated that day (06/03/2025) the maximum staff was four and they would float back and forth from cottage to cottage to cover lunches, breaks, or help if they needed it. Staff W stated having four staff instead of six meant it would take longer to get to the needs of the residents because they would have to wait until someone was available from another cottage to help or if the other cottage called for help, they would have to wait until someone returned from their break.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/04/2025 at 10:19 AM, Staff L, Licensed Practical Nurse, stated they had one NA scheduled in cottage 402 with five residents who required being transferred with a mechanical lift (a device used to raise or lower people using mechanical systems like hydraulics, pulleys, or gears). The NA would have to go and prepare the residents to transfer to and from their bed and wheelchair and then the resident would have to sit there and wait for a NA to come from the other cottage to help transfer them (when using a mechanical lift, they require two staff for safety). Staff L stated they had quite a few NAs off work for injuries they had sustained while working in another cottage that housed residents with severe combative (ready or eager to fight)/physical behaviors (cottages 405 and 406) when that cottage is short staffed, the NAs were pulled from all the other ones to ensure they had the staff they needed, which made the rest of us have to work short staffed.</p> <p>Review of a list provided by the facility on 06/04/2025 titled OJI (on the job injury)/Out list, showed 15 NAs and one Registered Nurse were currently out or injured and not working. Review of the list showed 12 of the 15 NAs were from the day shift, one was from the swing shift, and two were from the night shift.</p> <p>An observation on 06/04/2025 at 11:08 AM showed Staff S, NA, and Staff P, NA, were the available assigned staff and Staff T, NA, was at lunch. Staff S was one on one with Resident 15, who had exit seeking behaviors and was actively seeking an exit. Staff S was walking in and out of resident rooms with Resident 15 and up and down the hallways in the back of the cottage. Staff P prepared residents for lunch at the front of the cottage and assisted Resident 17 in the restroom at the back of the cottage. Resident 10 assisted themselves to the restroom at the opposite end of the hall at the back of the cottage, pulled their pants down, and sat on the toilet. The door to the restroom was left open. While Resident 10 was sitting on the toilet, Resident 15 was walking out of the room right outside of the restroom and looked into the restroom at Resident 10. Resident 15 then continued up and down the hallway outside of the restroom where they could visibly see Resident 10 in the restroom. Resident 10 then stood up, pulled up their pants without wiping, and walked back to the dining area for lunch.</p> <p>Additional observation at 11:14 AM showed Staff T had returned from lunch and assisted Resident 10 to the restroom again in an attempt to clean them up from the previous trip to the restroom. Resident 10 had escalated behaviors of screaming and yelling and Staff T was attempting to redirect them. There were loud noises of someone yelling (possibly another resident alerting staff) at the front of the cottage when Resident 17, who had been sitting at the table in the dining area waited until Staff T walked out of their sight and quickly walked to the refrigerator and took out a white Styrofoam container, took the lid off, and scooped their finger into the dish and put it into their mouth. Staff T quickly walked away from Resident 10 who was sitting on the toilet, with the door open, to go and intercept Resident 17 from the refrigerator. Staff P and Staff S had assisted other residents during this time. Staff T stated Resident 17 needed to be a higher level of care because of their history of eating everything in sight and because they waited until the staff were not in their sight and would hurry and get into things.</p> <p>An observation on 06/05/2025 at 12:13 PM, showed Resident 17 walked to the restroom from the dining area, pulled their pants down, sat on the toilet, with the door open while Resident 10 (the opposite sex) walked up and down the hallways in visible sight of Resident 17 sitting on the toilet. While Resident 10 was walking towards the bathroom door, Resident 17 stood up, pulled up their shorts, and walked back to the dining room. The other NA assisted other residents with lunch and Resident 15 was outside one on one with a NA.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/06/2025 at 1:38 PM, Staff B, Director of Nursing Services, stated their process was to staff the cottages with the LOS required for the residents specific to that cottage and not the level of care each resident required. Staff B stated they had not been made aware that Resident 17 should have had their LOS assessed and changed. Staff B stated they had five NA vacancies and several on the job injured staff that were not working.</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 06/06/2025
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representative were offered/educated on the 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) immunization (the action of taking a vaccine for a particular infectious disease) for 1 of 5 sampled residents (Residents 38) reviewed for immunization status. This failure placed the resident at risk of making an uninformed decision and contracting the COVID-19 virus.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, COVID-19 Response, revised January 2025, showed the facility would offer residents or their representative the COVID-19 vaccine, educate on the risk/benefits of the immunization and obtain consent.</p> <p>&lt;Resident 38&gt;</p> <p>Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnosis including Autism (a developmental disorder characterized by differences in social interactions/communication and restricted or repetitive patterns of behavior/interests), anxiety and intellectual disabilities. The comprehensive assessment dated [DATE] showed the resident had a severely impaired cognition.</p> <p>Review of Resident 26's immunization records for years 2024 and 2025 showed no documentation of a COVID-19 immunization assessment, education or a signed consent/declination form completed for the resident.</p> <p>During an interview on 06/06/2025 at 4:00 PM, Staff C, Registered Nurse/Infection Preventionist, stated they did not have documentation of Resident 38's representative (RR) consent or education on the benefits/potential side effects of the COVID-19 immunization. Staff C stated the procedure was to send out letters to the facility RR about immunization information and had not received a response back from Resident 38's RR. Staff Q stated when a RR did not respond to the letter, that facility staff would contact the RR to offer and educate on the COVID-19 immunization. Staff Q stated that the correct process was not followed and Resident 38's RR was not contacted about the COVID-19 immunization.</p> <p>During an interview on 06/06/2025 at 4:16 PM, Staff A, Administrator, stated the correct process for offering/educating on the risk versus benefits and potential side effects of the COVID-19 was not followed for Resident 38.</p>		