STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A261	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yakima Valley School	609 Speyers Road Selah, WA 98942

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0566 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Protect residents from being forced to work at the nursing home, or 2) let residents work if they want to. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who had expressed the need/desire to work, had previously worked and agreed to the work arrangements, was given the choice to perform voluntary services at the facility for 1 of 2 residents (Resident 44) reviewed for resident rights. This failure placed the resident at risk of confusion/frustration with facility staff and an increased risk of behaviors regarding their choice/arrangement to work.Finding included .Review of the facility's policy titled, Resident Rights, revised January 2025, showed the facility resident had the right to participate in the development of their plan of care and they would be .permitted successive degrees of freedom of movement and opportunities/responsibility for self-management and independent decision making. Review of Resident 44's medical record showed they were admitted to the facility on [DATE] with diagnoses including Autistic Disorder (a condition related to the brains development which can affect and individuals' communication, social interaction and can cause behaviors), Attention-Deficit Hyperactivity Disorder (ADHD, a developmental disorder characterized by inattention, hyperactivity, and impulsivity [to act on a whim without reflecting on consequences] that interferes with daily functioning) and Intermittent Explosive Disorder (a mental health condition characterized by recurrent, sudden, uncontrollable outburst of aggression that are inappropriate and lack justification) and problems related to education and literacy (the ability to read, write and use information). The 03/04/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Additionally, the medical records showed the resident became an adult and their own responsible person/decision maker in January 2026.During a concurrent observation and interview on 04/27/2026 at 10:45 AM showed Resident 44 in their room, lying on their bed, playing video games. Resident 44 had a one-on-one (one facility staff member designated to supervise just Resident 44, in order to prevent danger/harm to the resident from themselves and/or other residents) staff watching over them. When asking about activities, the resident stated they liked mowing lawns (using a lawn [NAME] to cut grass), and had been mowing the facility's lawns/working with the ground's keeper staff last year in 2025. Resident 44 stated they wanted to keep working and [NAME] lawns, but the facility was no longer allowing them to. The resident stated, they cannot pay me or something, and was still unsure of why they could not continue mowing the lawns like last year.Review of Resident 44's care plan, dated 03/05/2026 showed the resident had a one-to-one staff supervision throughout the day inside and outside the cottage (a small house that a limited number of residents reside in). The care plan showed that due to Resident 44's autistic disorder and ADHD, diversional activities (engaging recreational tasks designed to distract from stress, pain, or boredom while also stimulating the mind, body and emotions) were to be implemented. The goal was to provide the resident .with preferred leisure/recreational activities on the living unit at least twice daily. The care plan showed the resident liked activities that included video games, watching TV, building/fixing things, yard work (gardening, mowing lawns), and lawnmowers. The plan was to have the resident actively participate in gardening and yard activities.Review of Resident 44's quarterly recreation activities from 08/27/2025 to 12/02/2025 showed: On 09/08/2025 the resident (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 0566 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participated in lawn mowing with staff and enjoyed activity. On 09/15/2025 the resident participated in mowing the lawn with staff and was alert and sociable (a person who is friendly and interacting with others). On 09/30/2025 the resident participated in lawn mowing independently and was alert during the activity.During an interview on 04/28/2026 at 12:54 PM, Staff T, Attendant Counselor (AC, a Nursing Assistant-Certified) and Staff U, AC, were both familiar with Resident 44. Staff U stated that Resident 44 used to have a program where they would [NAME] the lawns around the facility, but was now on hold, and Staff U was unable to state the reason why. Staff T stated that last year (2025) the facility had bought the resident a lawnmower to utilize and Resident 44 was mowing the front grass/lawn area outside of cottages 405/406. Staff T was unsure of why Resident 44 had not been able to [NAME] the lawn yet this year. Both Staff T and Staff U stated that a committee had been formed around Resident 44 wanting to work/[NAME] lawns and Staff V, Psychology Associate/Licensed Provider would know more about what was happening.During an interview on 04/28/2026 at 2:25 PM, Staff B, Director of Nursing Services and Staff K, Registered Nurse/Resident Care Coordinator, stated that Resident 44 was cognitively intact, able to make their own decisions and was their own responsibility party since they had become an adult. Staff K stated the resident had stable behaviors with some outburst when overly frustrated and enjoyed activities that were hands on like taking care of the greenhouse garden and mowing lawns the past 2025 year. During a concurrent observation and interview on 04/29/2026 at 11:36 AM, in cottage 405, Resident 44 showed the surveyor a realistic, metal black rose they had created during a shop class at school. Resident 44 stated they had not been allowed to [NAME] yet this year (2026) and inquired about if the surveyor had heard if the facility was going to let the resident [NAME] again or not. The resident stated they saw that mowing the lawn and yard work was voluntary as an activity, I really want to [NAME] the yard on the other side of the fences . as the resident pointed to the back of the 405/406 cottages. During an interview on 04/30/2026 at 7:40 AM, Staff V, Psychology Associate/Licensed Provider, stated they had been working with Resident 44 since that had admitted to the facility and the resident was a highly capable individual, who was cognitively intact and had typical teenage behaviors. Staff V stated that Resident 44 took pleasure in doing activities with their own hands, to gain skills for the future, like mowing the lawn and so a plan had been made for the resident to work with the Maintenance and Operations Division (MOD) staff to get the resident involved in activities that the resident enjoyed. Staff V stated that the resident was mowing lawns with one-on-one staff supervision and MOD staff towards the end of the 2025 summer season, before the MOD staff would normally cease for the fall/winter seasons. Staff V stated the resident preferred activities that were hands on and found mowing the lawn to be relaxing, but some staff brought up safety concerns, before the 2026 spring season of mowing, around the resident behaviors, training on [NAME] equipment and safety with landscaping work. Staff V stated that was when a committee was formed and a work safety agreement was developed for Resident 44. Staff V stated the work agreement addressed resident specific safety rules, responsibilities and education that were to be completed in order for Resident 44 to volunteer for work that involved mowing lawns and other landscaping tasks. Staff V stated that Resident 44 and Staff V had worked together to meet/complete the requirements of the work safety agreement, but then MOD changed their minds and put a stop to the agreement.Record review of Resident 44 work safety agreement showed that on 03/27/2026 an agreement was made between the volunteering Resident 44, Staff V and Staff W, MOD Facility Manager. The record showed, .the purpose of this agreement is to ensure that all work is performed safely and responsibly. The Volunteer understands that the work involves available outdoor lawn car, landscaping, and related tasks. The agreement stipulated the safety rules/responsibilities that included following instructions, use of equipment properly, the wearing of safety gear, how to work safely and outdoor safety practices, respecting others/property, and the safety/training videos to be completed. The work agreement was signed by Resident 44, Staff V and Staff W, on 03/27/2026.During an interview on 04/30/2026 at 9:25 AM, Staff W and Staff Y, MOD Regional (continued on next page)

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F 0566 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager, were aware that Resident 44 had expressed interest in mowing lawns at the facility. Staff W stated they had signed the volunteer work safety agreement when Resident 44 and Staff V had come to the main building on 03/27/2026, the kid is very smart. Staff W stated that after making the agreement they reached out to Staff Y and that was when they had put a hold on it. Both staff stated they had concerns about ensuring the resident's safety, with using a gas-powered [NAME], and who would be liable if Resident 44 was injured. Staff W stated that in 2025, Resident 44 had worked with MOD staff on mowing, raking leaves, washing cars and other landscaping tasks along with the resident's one-on-one AC staff supervision. When asked what had changed from the resident working with MOD staff in 2025 to now, regarding the safety/accident liability, Staff W stated the concerns raised after the 03/27/2026 work safety agreement had come from the resident taking on landscaping tasks more frequently in 2025, along with who was liable for injuries and Resident 44 education on using a lawn [NAME]. Staff W stated the nursing home staff ensured Resident 44's safety, supervision, accident liability and education when Resident 44 had previously performed mowing/landscaping tasks in 2025. Record review of a late entry progress note (PN) for 03/31/2026 entered 04/02/2026 at 9:54 AM showed that Resident 44 had volunteered to work with MOD which would allow the resident to complete tasks and keep busy while helping around the facility's campus. The PN stated the resident had watched all of the safety/training videos and had .signed contracts agreeing to the specific terms for the volunteer program . The PN stated the resident have been previously cleared/performed mowing of the lawns which was .one task (Resident 44) especially enjoys . but had not been approved yet. The PN showed that Resident 44 had mention to staff the resident was expecting the program to start and was .upset that others had mowed the lawn that (the resident) was to [NAME] . During an interview on 04/30/2026 at 10:50 AM, Staff B stated that Resident 44 enjoyed mowing the lawn. Staff B stated the resident, and MOD had signed an agreement, but MOD staff were concerned about safety and .went back on the agreement. Staff B stated that Resident 44 had behaviors, but the resident was cognitively intact, had the ability to understand/learn, was receptive towards education, had already previously expressed interest in working with MOD and been safe mowing and had one-on-one AC staff supervision. Staff B stated the resident had the right to perform voluntary work regarding mowing lawns and that it had already been implemented int the resident's care plan.During a follow-up interview on 04/30/2026 at 11:52 AM, Staff V stated that Resident 44's program development regarding mowing/performing yard work with MOD had begun back in February 2026, before the spring season started. Staff V stated they had a heart to heart (a serious and honest conversation between two people) about the regulation of the resident's behaviors/emotions, acting respectful towards other people/property and showing responsibility in the preparation for working with MOD on mowing/landscaping around the facility. Staff V stated Resident 44 volunteered because they wanted to understand and see what it would be like to have a job, and to gain knowledge from the experience, which was why both Staff V and Resident 44 had completed all the work safety agreement requirements before signing the document on 03/27/2026. Staff V stated the work safety agreement was an opportunity for the regulation of Resident 44s emotions, not even give the opportunity to fail.During an interview on 04/30/2026 at 1:13 PM, Staff A, Superintendent, stated that Resident 44 had been completing mowing and other tasks last year (2025) and very positive experience. Staff A stated there had been some miscommunication and misunderstanding of the work safety agreement completed on 03/27/2026 between MOD, Staff V and Resident 44. Staff A stated the facility did not provide for the resident to perform the work services like they had chosen and had been planned for in the work safety agreement. Staff A stated, We failed (Resident 44) in that situation.Reference: WAC 388-97-0420(2)(a)(b)(d)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were given the opportunity to formulate advanced directives (AD, a legal document in which an individual person specifies what actions should be taken for their health care and/or finances in the event they were no longer are able to make decisions for themselves because of illness or incapacity) nor notify a resident of their right to formulate an AD when the resident was able to make the decision regarding their rights for 1 of 3 residents (Resident 44) reviewed for AD. This failure denied the resident the right to make an informed decision regarding formulation of an AD and placed residents at risk for losing the right to have their preferences and choices honored regarding emergent/end-of-life care.Findings included .Review of the facility's policy titled, Resident Rights, revised January 2025, showed the facility resident had the right .to participate in the development of the plan for services and medical treatment, including the right to formulate Advance Directives, and to approve or reject any parts .Review of the facility's policy titled, Resident Participation in Medical Treatment and Advance Directives, revised October 2025, showed the facility would provide written information to adult residents concerning their legal right to participate in decisions regarding their medical care, including the right to formulate AD. The policy showed the advanced directives would be honored only for a resident who was 18 years or older. The policy showed that if a resident was unable to make a decision regarding their care and treatment but later becomes able to, the facility would discuss AD at that time. Additionally, AD included Physician's Orders for Life Sustaining Treatment (POLST, a medical order form that summarized a resident's wishes regarding treatment) and a living will. Review of Resident 44's medical record showed they were admitted to the facility on [DATE] with diagnoses including Autistic Disorder (a condition related to the brains development which can affect and individuals' communication, social interaction and can cause behaviors), Attention-Deficit Hyperactivity Disorder (a developmental disorder characterized by inattention, hyperactivity, and impulsivity [to act on a whim without reflecting on consequences] that interferes with daily functioning) and intermittent explosive disorder (a mental health condition characterized by recurrent, sudden, uncontrollable outburst of aggression that are inappropriate and lack justification) and problem related to education and literacy (the ability to read, write and use information). The 03/04/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Additionally, the medical records showed the resident became their own responsible person/decision maker in January 2026 and no AD were noted. Record review of a social service questionnaire showed that on 03/05/2026 Resident 44's representatives signed/completed the documents questions regarding AD choices and elected No to all ADs.During an interview on 04/28/2026 at 2:25 PM, Staff B, Director of Nursing Services (DNS), and Staff K, Registered Nurse/Resident Care Coordinator, stated Resident 44 was cognitively intact, able to make their own decisions and was their own responsibility party since they had become an adult.During an interview on 04/29/2026 at 11:36 AM, Resident 44 stated that facility staff had started approaching the resident for decisions regarding resident choices and plan of care now and they no longer had a guardian in place since they turned [AGE] years old. Resident 44 stated they were unaware of what an AD was and no staff had asked them if they had wanted to fill out a POLST form or formulate other AD. Resident 44 stated they would like some more information/education on ADs so they could decide on whether to formulate one or not.During an interview on 04/29/2026 2:53 PM, Staff I, Social Services, stated their process for offering AD was to send out an AD questionnaire document annually, the document was also in the admission documents, and Staff K, Resident Care Manager, offered to formulate AD during the quarterly care conferences. Staff I stated they send the AD questionnaire document to resident representatives/guardians and do not send/review the AD (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questionnaire document with the residents. Staff I stated that if someone wanted an AD, they would give the individual more AD information but did not provide assistance in completing AD. Staff I stated they did not send, review or educate on formulating AD with Resident 44 and sent out the AD questionnaire document to Resident 44 previous guardian. Staff I stated Resident 44 was cognitively intact, was their own responsible person and able to make their own decisions.During an interview on 04/29/2026 at 3:20 PM, Staff K stated they were charged with reviewing the POLST form quarterly, with the resident representatives/guardians, during the care conference. Staff K stated Staff I went over all the other AD forms. Staff K stated that Resident 44 was cognitively intact, was their own responsible person and able to make their own decisions but had not reviewed the POLST form with Resident 44. Staff K stated that Resident 44 had the right to formulate an AD, facility staff should be educating/offering on AD to the resident, and assisting the resident in the process if they were to choose to formulate an AD.During an interview on 04/30/2026 at 10:32 AM, Staff B stated that facility staff should be offering to assist in formulating AD with Resident 44. Staff B stated when Resident 44 became an adult they could make their own decisions and AD should have been reviewed at that time. Staff B stated the correct process was not followed for providing Resident 44 with the opportunity to make a choice on formulating AD documents or notifying the resident of their right to formulate an AD when the resident became able to make the decision regarding their rights.Reference: WAC 388-97-0280(1)(3)(c)(d)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 of 3 residents (Resident 38) reviewed for abuse/neglect. This failure placed the residents at risk of experiencing fear, intimidation, mental anguish, and emotional distress. Findings included . Resident 38 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses which included severe intellectual disabilities (condition that involves limitations on intelligence, learning and everyday abilities to live independently),ˆ osteoarthritis (changes in bone shape and cartilage that causes inflammation which results in pain in joints, stiffness and loss of mobility), obsessive compulsive disorder (a pattern of unwanted thoughts and fears known as obsessions that lead to repetitive behaviors called compulsive acts that interfere with daily living).ˆThe 03/11/2026 quarterly nursing assessment showed the resident was unable to communicate verbally but can state some words.ˆResident 38 required assistance with most Activities of Daily Living (ADL). The resident can get in and out of bed and used a wheelchair for outside activities. Resident 38 is visually impaired with impairment of vision in their left eye and visual cloudiness in their right eye due to cataracts (cloudy area in the lens of the eye).ˆThe resident had a decline in vision which staff were to monitor for ability to participate in activities. Resident 38's care plan showed that they could state simple words like pop but was not able to write or participate in social conversations or voice opinions.ˆThe resident will yell at the presence of pain with screams and tears.ˆDuring cares the staff were to communicate using soothing voices, use favorite music when stabilizing for nursing treatment of a part of their body, (example treatment of a skin tear).Review of the 06/11/2026 behavior care plan showed behaviors due to intellectual disabilities interventions included to redirect the resident if rummaging in other resident's rooms. Redirect Resident 38 from approaching other residents and stay between Resident 38 and other residents if they were experiencing behaviors. A list of familiar target behaviors exhibited include screaming and yelling, biting and scratching, physical aggression and dropping to the floor. Resident 38 would threaten to bite and have bitten staff in the past and would attempt to scratch another person. The direction was to not approach the Resident or try to redirect, stay back and give the resident some space and time to calm down and ensure the resident was safe. Additionally, Therapeutic Options techniques were to be followed by staff. Therapeutic positive behavior supported in knowing the individual and their way of responding to staff for their wants and needs.Review of a 04/22/2026 incident showed Resident 38 was visited by Staff L, Collateral Contact 1 (CC1), who was contracted with the facility to provide additional community service activities to the residents at the facility. On 04/22/2026 at 9:15 AM CC1 entered Cottage 403 to visit Resident 38 who had been seated in their chair at their table. Staff F Attendant Counselor (AC, a nursing assistant-certified), forcefully removed Resident 38's hand from Staff L's hand and forcefully made Resident 38 go back to their chair across the room.ˆStaff F had placed their hands on Resident 38's shoulder and waist while the resident was screaming and resisting Staff F. Staff L stated in the investigation that another Staff M, AC, came to assist Staff F, and they forced Resident 38 onto the chair and Resident 38 sat down hard on the chair.During an interview on 04/27/2026 at 3:34 PM, Staff L stated on 04/22/2026 at 9:30 AM, Staff F came to the table where they were seated and stated that Staff L should be aware that Resident 38 had a bad morning and did not sit next to Resident 38.ˆStaff L sat across the table from Resident 38 and brought out a large, pieced puzzle for the resident to put together.ˆResident 38 stood up from the table and was not interested in the puzzle.ˆStaff L then stood up and Resident 38 reached to hold Staff L's wrist to walk with them without any struggle or outburst.ˆStaff L had had many previous contacts with Resident 38 in the past and this was not an unusual action by the resident.ˆStaff L stated Staff F immediately and forcefully grabbed Resident 38's hand and removed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it from Staff L's wrist and forcefully placed their hands on Resident 38 shoulder and waist and had forced Resident 38 back towards the resident's chair.ˆResident 38 was screaming and resisting Staff F's forcing Resident 38 back to their chair.ˆStaff L stated Resident 38 arched their back and tried to get away from Staff F and began to fall when Staff M came up on the left side of Resident 38 and forcefully held Resident 38's shirt collar along with Staff F to the resident's chair and forcefully plopped (a sound made like something falling or dropping) Resident 38 in their chair.During the same interview Staff L reported they then sat across from Resident 38 and brought out the puzzle for the resident which they played for a few seconds then became uninterested along with a magazine Staff L tried to interest Resident 38 with to divert Resident 38's anxiety. Staff L then played music on their cell phone for Resident 38. Resident 38 eventually left the table and Staff L left the building. Staff L met with their supervisors on 04/22/2026 at 12:15 PM, Staff L's supervisors reported the incident with Resident 38 to a state division and law enforcement. Staff L stated there was no report of Resident 38's incident to the facility staff or administration.During an interview on 04/27/2026 at 11:30 AM, Staff G, AC, who worked with Resident 38 on 04/22/2026 stated they did not witness the initial contact with Staff L and Staff F with the resident but did witness Staff F and Staff M turned Resident 38 while Resident 38 was resisting them by arching their back and yelling. Staff F let Resident 38 fall onto the chair with a loud thump. Staff G stated that the Resident would hold their wrist and hand at times. During an interview on 04/27/2026 at 11:45 AM, Staff M stated they saw Staff F directing Resident 38 back to the chair by placing hands on the resident's shoulder and hip. Resident 38 was resisting and arching their back while yelling. Staff M stated Resident 38 fell towards their left side and they went to assist Staff and the resident so they would not fall. Staff M stated they directed Resident 38 to the chair and the resident sat down hard due to resisting by arching their back.During an interview on 04/28/2026 at 3:00 PM, Staff F stated that on 04/22/2026 at 9:30 AM, Staff L had entered the facility Cottage 403 where Resident 38 lives and stated they wanted to take the resident out. Staff F stated Resident 38 had a bad morning and was taking their clothing off and putting other clothing on themselves. Since it was raining outside Staff L sat with Resident 38 and pulled out a puzzle. Staff F stated they instructed Staff L not to sit close to Resident 38. Staff F stated Resident 38 was not interested in the puzzle and stood up then Staff L stood up from across the resident's table and took Staff L's wrist/hand and started walking from the resident's table toward the window on the opposite side of the room. Staff F stated they immediately went towards Resident 38 and quickly removed the resident hand from Staff L's hand. Staff F immediately placed their right hand on resident 38's shoulder and Staff F placed their left hand on Resident 38's left hip and moved the resident toward the resident's chair. Staff F stated the resident was screaming and resisting them by arching their back. Staff M came to help Staff F when Resident 38 was leaning towards their left side and began to fall. Staff F stated they got Resident 38 to their chair and the resident fell into the chair. Additionally, Staff F stated they thought Resident 38 was going to injure Staff L and stated they were walking towards another resident who could have acted out because those two don't get along. Staff F stated they did not consider the act of abrupt removal of resident's hand from Staff L's wrist/hand when there was no danger, placing hands on and forcibly redirecting Resident 38 while they were yelling and resisting and act of abuse or mistreatment. Staff G and M did not report the incident to their supervisor.During an interview on 04/29/2026 at 11:00 AM, Staff DD, Therapeutic Options Supervisor, (instruction required for all staff a comprehensive approach to reducing violence and the use of restraints. The purpose of training is to be a source of healing, encouragement and safety). Staff DD stated that all staff at the facility were trained on hire and every two years on how to recognize and approach residents with behaviors and teaching intervention skills that are designed to prevent injury to staff and people receiving services. During the interview with Staff DD, they recommended looking at why the resident/client would grab a wrist or hand was usually not an attack but an attempt to communicate. Staff DD stated if there was no immediacy or danger and the other individual did not perceive it as a danger the act of abruptly removing a hand and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forcibly redirecting a resident would trigger negative behaviors.During an interview on 04/30/2026 at 1:03 PM, Staff C, Licensed Practical Nurse (LPN), stated that they were on duty on 04/22/2026 and had heard something about the incident but did not chart anything.During an observation on 04/30/2026 at 1:15 PM, Staff H, AC, was standing by Resident 38 when the resident grabbed Staff H's arm and walked with Staff H to the window across the floor to the other side of the room. Resident 38 while holding Staff H's hand opened the window curtain looked out and closed the curtain. Staff H and Resident 38 calmly walked back to Resident 38's chair and the resident sat down.During an interview on 04/27/2026 at 3:00 PM, Staff B, Director of Nursing Services, was unaware of the 04/22/2026 incident with Resident 38 until law enforcement called them on 04/24/2026 and informed them of the incident.Reference: WAC 388-97-0640(1)

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Yakima Valley School	609 Speyers Road Selah, WA 98942

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse policy regarding identifying, reporting, and investigating potential allegations of abuse for 1of 1 sampled residents (Resident 38), reviewed for abuse. This failure to recognize abuse, to timely report allegations of potential abuse, and to conduct timely and thorough investigations based all residents in the facility at risk for abuse. Findings included. Review of the 07/2024 policy 15.3, Protection from Abuse: Mandatory Reporting, showed when identifying abuse or a reasonable cause of good faith intent of the circumstances presented to report to Residential Care Services for adults to the Complaint Resolution Unit (CRU) as mandated for incidents of abuse and supervisor/ administration of the facility that provides services to these residents/clients involved. The scope of the policy 15.3 showed that the policy was to be given to all contractors, volunteers, employees, interns, residential service providers on the requirements of mandatory reporting requirements.Review of the 12/2024 number 2.02 Standard Operating Procedures titled, Resident Incident Management, purpose was to ensure that the resident's incident report for the first phase of the investigation for Abuse resident/client mistreatment due to staff action was identified, protection of the resident/clients ensuring everyone is safe.Resident 38 Review of the medical record showed that the resident had been in the facility since 10/01/1996 with diagnoses which included severe intellectual disabilities (condition that involves limitations on intelligence, learning and everyday abilities to live independently), visual impairment and multiple mental health behavioral issues. The 03/11/2026 quarterly nursing assessment showed the resident was unable to communicate verbally but can state some words.ˆResident 38 required assistance with most Activities of Daily Living (ADL). The resident can get in and out of bed, transfer to and from a chair and walk short distances.Review of the 06/11/2026 behavior care plan showed behaviors due to intellectual disabilities interventions included were to redirect Resident 38 from approaching other residents and stay between Resident 38 and other residents if they are having behaviors. A list of familiar target behaviors exhibited include screaming and yelling, biting and scratching, physical aggression and dropping to the floor.Review of the 04/24/2026 incident report showed an allegation of abuse was called to a state agency and local law enforcement on 04/22/2026 by a community service contract provider of the facility. Staff L, Collateral Contact 1 (CC1), had contacted their supervisors about an incident with Resident 38 at the facility where Staff F Attendant Counselor/Nursing Assistant-certified (AC), and another Staff M, AC had abruptly and forcibly removed Resident 38 from holding Staff L's hand while walking to a window in the main activity/dining room. Staff L stated Staff F then placed their hands on Resident 38 forcibly redirecting the resident towards the resident's chair. Staff M then came on the left side of Resident 38 to hold the resident who was starting to fall and assist Staff F. Resident 38 was then resisting the move and yelling. Staff L stated Staff F had Resident 38's collar and pulled it while Resident 38 was arching their back and forcibly let Resident 38 fall hard into their chair.During an interview on 04/27/2026 at 3:34 PM, Staff L confirmed the incident and stated that Resident 38 had grabbed their hand to walk in the past and did not find it an aggressive act. Staff L stated Resident 38 was calm walking with them towards the window. Staff L stated that Staff F was aggressive and forced Resident 38 towards their chair and put hands on the resident to direct the resident to their chair. The resident was yelling and arching their back and almost fell until another Staff assisted Staff F into the chair where Resident 38 sat hard onto the chair. Staff L did not know the name of Staff M at the time of the complaint. Staff L later reported the incident to their supervisors who called the state agency and law enforcement. During the conversation the surveyor asked if Staff L had any orientation by the facility concerning reporting abuse and they stated no they had not. Staff L was unaware of the administration or the name of the Superintendent of the facility.During an interview on 04/27/2026 at 11:30 AM, Staff G, AC, who worked with Resident 38 on 04/22/2026 stated they did not witness the initial contact with Staff L and Staff F with the resident but did witness Staff F and (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff M turn Resident 38 while Resident 38 was resisting them by arching their back and yelling.ˆStaff F let Resident 38 fall onto the chair with a loud thump. Staff G stated that Resident would hold their wrist and hand at times. Staff G did not report the incident they observed and was not aware of the potential mistreatment of Resident 38.During an interview on 04/27/2026 at 11:45 AM, Staff M stated they saw Staff F directing Resident 38 back to the chair by placing hands on the resident's shoulder and hip.ˆResident 38 was resisting and arching their back while yelling.ˆStaff M stated Resident 38 fell towards their left side and they went to assist Staff and the resident so they would not fall.ˆStaff M stated they directed Resident 38 to the chair and the resident sat down hard due to resisting by arching their back. Staff M stated that they did not think it was abuse.During an interview on 04/28/2026 at 3:00 PM, Staff F stated that on 04/22/2026 at 9:30 AM,ˆalong with Staff B, Director of Nursing Services (DNS), Staff F showed how they handled Resident 38's grabbing Staff L's wrist/hand and peeled Resident 38's fingers from the wrist of Staff L's wrist. Staff F stated they thought Resident 38 would hurt Staff L. Staff F then added that another resident was seated in their chair against the wall of where Resident 38 and Staff L were walking nearby and was afraid of a resident outburst since the two residents do not like each other. Staff F showed how they placed their hands on Resident 38's shoulder and waist forcing Resident 38 back to their chair. Staff F stated Staff M had to assist them back to their chair and Resident 38 sat hard onto the chair. Staff B also did suspend Staff F to the main building away from resident contact but failed to identify Staff M who was part of the potential mistreatment of Resident 38. Staff M continued to work from 04/22/2026 through 04/30/2026 and were not removed from working with residents until the investigation was finalized.During an interview on 04/30/2026 at 4:21 PM, Staff A, Superintendent, stated that they did notˆorient contracted agencies on mandated reporting of abuse and was unaware Staff M was involved in the incident with Resident 38 and failed to remove them from resident contact pending investigation. Additionally, staff did not consider the 04/22/2026 Resident 38 incident as potential abuse/mistreatment and failed to document Resident 38's behavior responds and report the incident.Reference: WAC 388-97-0640(2)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nurses consistently documented the condition of a pressure injury (PI, localized damage to the skin as well as underlying soft tissue that occurs due to sustained pressure, often over bony areas) that included an initial wound assessment and periodic follow up assessments for 1 of 2 residents (Resident 15) reviewed for PI. In addition, the facility failed to open a plan of care that included specific interventions to promote healing of the PI. This failure placed Resident 15 at risk of delayed healing having unevaluated changes to their pressure injury to inform the provider for assessment and treatment orders. Findings included. Record review of the facility's policy titled, Pressure Sore-Decubitus Ulcer (PI) care and prevention dated 08/29/2025, showed the purpose of the policy was to prevent and treat further pressure injuries, the licensed nurse (LN) was responsible to document the condition of the wound including stage, size, site, depth, color, drainage, and odor as well as the treatment provided. A wound assessment in resident record would be completed by a LN when a pressure injury was first noted. The description of pressure injury stages included: - Stage 1: a persistent area of skin redness that does not disappear when pressure is relieved or does not turn white when pressure is applied, - Stage 2: a partial thickness of skin is lost may present as blistering surrounded by an area of redness, - Stage 3: a full thickness of skin is lost, exposing the subcutaneous (deepest skin layer contains fat cells) tissues, - Stage 4 a full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone Resident 15 Review of Resident 15's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth), quadriplegia (paralysis of all four limbs), diabetes mellites (DM, metabolic disorder in which the body has high sugar levels for prolonged periods of time) and anxiety disorder. Review of a 02/23/2026 comprehensive assessment showed Resident 15 had moderate impaired cognition, a suprapubic catheter (device that drains urine from the bladder through a tube inserted into the lower abdomen), a colostomy (an opening in the abdomen that connects the end of the large intestine to the skin where stool is passed) and was dependent on staff for their bed mobility and transfers. Resident 15 was at risk for PIs and none present at the time. During an interview and observation on 04/27/2026 at 3:20 PM, Resident 15 was observed lying on their bed with an alternating air mattress (a mattress that utilize air bladders that constantly inflate and deflate, which helps to reduce pressure on the skin and promote blood flow), stated they had a small open area on their bottom. During an observation on 04/28/2026 at 9:00 AM, Resident 15 had their pressure injury dressings changed by Collateral Contact 2 (CC 2 -contract wound provider) with the assistance of two Attendant Counselor (AC, Nursing Assistant-Certified) staff and Staff O, Licensed Practical Nurse (LPN). Staff O stated that Resident 15 did not have wounds on their buttocks when they were admitted to the facility. They stated that Resident 15's wound on their right buttock started a few months ago and the wound on the left buttock started about two to three weeks ago. Resident 15 often refused to lay down during the day and preferred to stay up in their wheelchair. The wounds were observed to be free of drainage and odor, the resident denied discomfort. Record review of the 02/18/2026 care plan, in the medical record, showed Resident 15 had potential/actual for impaired skin integrity related to DM Type 2, quadriplegic cerebral palsy, history of rashes, dermatitis due to bodily fluids, scar from chest to abdomen, scars on hands from pushing wheelchair through doors, extreme self-neglect. Resident 15's PIs with interventions were not included in the care plan. Record review of a 03/07/2026 24-hour shift report showed a temporary problem (TP, designated what and how often to chart) was opened for Resident 15's skin bleeding right backside between buttock and thigh. Record review of a 03/08/2026 at 3:28 AM progress note (PN) showed the resident had scar tissue between the right buttocks and thigh that appeared macerated (skin that has become soft, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrinkled, and weakened due to prolonged exposure to moisture) and was bleeding. Record review of a 03/12/2026 at 1:03 PM PN showed the open area to right lower buttock continued, no bleeding or signs of infection (no measurements or stage identified). Record review of a 03/16/2026 facility provider initial 30-day assessment showed no nurses report of the open wound on Resident 15's right buttock. Record review of a 03/18/2026 at 9:15 PM PN showed the right lower buttock crease was improving without signs of infection (no measurements or stage identified). Record review of a 03/20/2026 at 12:08 PM PN showed the open area to right lateral upper thigh continued without signs of infection but continued with raw skin. A new order was noted and processed, betadine (an antiseptic solution used to treat wounds) applied (no measurements or stage identified). Record review of a 03/22/2026 at 8:37 PM PN showed betadine was applied to right lower buttock upper thigh area, no drainage or signs of infection (no measurements or stage identified). Record review of a 03/24/2026 at 1:13 PM PN by Staff O showed the area to right lower buttock was approximately 6 centimeters (cm) by 4 cm, no drainage or signs of infection (first measurement 17 days after skin opened, no depth or stage identified). Record review of a 03/28/2026 at 9:24 PM PN by Staff C, LPN, showed open area remained on right lower buttock, no bleeding or signs of infection (no measurements or stage identified). Record review of a 03/31/2026 at 1:11 PM PN showed betadine was applied to right thigh open area, measured 6 cm by 4 cm, no signs of infection, a small amount of blood was noted. On calendar for 04/01/2026 for provider to reassess (review of provider calendar and medical record showed no note the provider reassessed Resident 15's PI on 04/01/2026). Record review of a 04/09/2026 at 1:12 PM PN showed the open area to right lower buttocks had a small amount of light green drainage on the dressing, the wound base was moist, no active drainage, no complaints of pain or discomfort (no measurements or stage identified). Record review of a 04/10/2026 facility provider 30 day assessment showed Staff reports [Resident 15] has a non-healing pressure sore (injury) to right ischial tuberosity (a rounded bump on the back part of the pelvis bone that supports body weight when sitting) The provider documented the wound bed was clean and the dressing had a foul smell, no redness, swelling, no slough (dead skin tissue that appears yellow or white and can cover parts or the entire wound bed), no granulation (specialized connective tissue that emerges during wound healing phase), and the wound bed was pale (34 days after wound first documented by nursing). Record review of a related nursing 04/10/2026 PN showed the provider planned to refer Resident 15 to wound care specialist. Record review of a 04/14/2026 at 12:59 PM PN by Staff O showed the open areas to right lower buttock had no signs of infection (no measurements or stage identified). Record review of a 04/17/2026 initial wound evaluation by CC 2 showed the wound to the right buttock measured 3 cm by 2 cm by 0.2 cm and was a stage 3 PI. The plan included the wound would be evaluated and treated every five days by CC 2 and the facility staff were instructed to reinforce the dressing as needed. Record review of a 04/20/2026 at 12:51 PM PN showed the dressing to the right buttock was in place and a new 2.5 cm by 1 cm open area noted on left buttock. Record review of a 04/22/2026 at 12:58 PM PN by Staff O showed the open wound to the left buttock was approximately 3 cm by 3 cm and they expected provider CC-2 to see the resident later that day. Record review of a 04/22/2026 wound report by CC 2 showed that the right buttock wound was 2.5 cm by 2.0 cm by 0.2 cm with 100% granulation, no odor and skin around the wound was dry. No description of the left buttock wound; however, directions were written to leave the dressings to the left and right buttock until next visit in five days. Record review of a 04/23/2026 at 1:21 PM PN by Staff O showed the dressing to the right lower buttock was intact, clean and dry. The dressing to the lower left buttock came off, was redressed and minimal amount of light green drainage was noted on the dressing. Record review of a 04/28/2026 dressing change and wound evaluation by CC 2 showed the right buttock wound bed measured 2.0 cm by 2.0 cm by 0.2 cm and had 100% granulation tissue. The left buttock wound bed measured 2.5 cm by 2.0 cm by 0.1 cm with 100% granulation. Both wounds were estimated to heal in three months. During an interview on 04/30/2026 at 11:00 AM, Staff K, Registered Nurse/Resident Care Coordinator (RN/RCC), stated that Resident 15 was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted without pressure injuries and was a risk, so they had an alternating air mattress placed on their bed. Staff K stated that Resident 15 should have an acute care plan in their paper record that included interventions. New problems were usually added to the care plan during their quarterly review; however, the PIs probably should have been added to the care plan. During an interview and record review on 04/30/2026 at 12:00 PM, Staff Q, RN, opened Resident 15's paper chart under the care plan tab and stated that was where the acute care plans were written, and they could not find one for Resident 15's PI. During an interview on 04/30/2026 at 12:50 PM Staff R, RN, stated they were the day shift charge nurse, and they were not aware Resident 15 had a stage 3 PI. Staff R stated there should be a care plan in the medical record. They stated the unit nurses provided the residents treatments, and they rotated to a new unit every 30 days. During an interview on 05/01/2026 at 8:00 AM, Staff C stated that they rotated through Resident 15's unit last month and documented on the open wound on their buttocks. They stated that the wound was on the right buttocks and did not change much. They stated they did not measure the wound, probably should have, and was surprised there was not wound assessment opened and stated, the nurse who identified the wound should have opened an assessment. During an interview on 05/01/2026 at 9:48 AM, Staff B, Director of Nursing Services, stated that when Resident 15's wound first opened there should have been an incident report, a wound assessment opened and a care plan opened with interventions. Staff B stated Resident 15's wounds were the first facility acquired PIs that they ever had, the few PIs here were admitted with them. Reference: WAC 388-97-1060 (3)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program that ensured, A) the Legionella (a waterborne bacteria that can cause a severe respiratory disease) Water Management Program (WMP) identification and monitoring of control measures within acceptable ranges and what ways to intervene when control measures were not met for 1 of 1 WMP, reviewed for infection control and B) the facility staff implemented the cleaning/disinfecting of the general environmental surfaces and resident rooms with an Environmental Protection Agency (EPA) registered disinfectant 3 of 4 staff (Staff AA, CC, BB), reviewed for environmental cleaning/disinfection. This failure increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases.Findings included .Review of the facility's WMP, dated March 2026, showed where control measures should be applied and required to be monitored for the facility's seven sets of cottages (a small house that a limited number of residents reside within) and main building. The WMP showed that examples of chemical and physical control measures were testing chlorine levels, maintaining water heaters at regulated temperatures, and decorative fountains were not allowed. The WMP showed control measures parameters (limits or acceptable ranges) would be ensured through monitoring and action taken when outside parameters. The WMP showed the water management team had chosen to monitor control measures by flushing the three unoccupied cottages every Wednesday and in the event that systems performed outside of control limits, action would be taken. The WMP did not show how the other set of four resident occupied cottages/main buildings control measures were to be monitored, when they were monitored, the frequency of monitoring, acceptable ranges of the implemented control measures, nor the actions that would be taken when control measures were not with acceptable ranges for any of the cottages/main building. Review of the facility's policy titled, Legionella Water Management Program, revised March 2026 showed the WMP would include Specific control measures used to control the introduction and/or spread of Legionella. Acceptable ranges for each control point that were being monitored and a system to monitor control limits and ethe effectiveness of the control measures. A plan for when identified control measures were not being met (outside of acceptable ranges) or not effective.Additionally, the policy showed the WMP team included the Infection Preventionist (IP), Maintenance Supervisor and Superintendent. Review of the facility's policy titled, Cleaning and Disinfecting, revised January 2025, showed the cleaning and disinfecting of the living environments. The policy showed that environmental surfaces within resident cottage such as walls, floors and other surfaces would be properly cleaned/disinfected with an EPA registered disinfectant. Additionally, the manufacturer instructions were to be followed when using an EPA registered disinfectant.WMPDuring an interview on 04/29/2026 at 7:52 AM, Staff Z, Maintenance Supervisor, stated the WMP control measures they were monitoring/documenting for all the cottages/main building was chlorine (a chemical element) and potential for Hydrogen (pH, a specific scale measurement for water solutions). Staff Z stated they did not have acceptable ranges or parameters for the chlorine or pH levels, .just writing down the levels. Staff Z stated they were unsure of what actions/steps would be needed if the control measures were outside of the acceptable ranges.During a concurrent observation and follow-up interview on 04/29/2026 at 9:05 AM, showed Staff Z displaying the process for testing the chlorine levels. Staff Z tested the water from the main building lower basement office sink. The chlorine levels showed 0.11 milligrams (a unit of measure) per milliliter (a unit of measure). Staff Z was unsure if the chlorine level was within acceptable ranges or not.During an interview on 04/29/2026 at 10:26 AM, Staff EE, IP, after reviewed the facility's WMP document, stated they did not see specifics (like when being monitored or the frequency of monitoring) on control measure for the set of four resident occupied cottages/main building, .might being missing a paragraph. Staff DD stated they could not find acceptable ranges for control measures on the WMP or what actions would be taken if the control measures were not within (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acceptable parameters. Staff DD stated the identification/monitoring of the control measures, acceptable ranges, ways to intervene when control measures were not met should be on the WMP. Staff DD stated staff would need to know the control measure parameters so when they are outside of that it could be communicated and actions could be taken. Staff DD stated the WMP did not have the correct information and needed to be updated. During an interview on 04/29/2026 at 1:50 PM, Staff A, Superintendent, stated they would have expected the WMP to have the specific control measures, how they were to be monitored, the frequency of monitoring, acceptable ranges of the implemented control measures and the actions that would be taken when control measures were not with acceptable ranges. Environmental CleaningDuring a concurrent observation and interview on 04/29/2026 at 7:30 AM, showed Staff AA, Custodian, in the main building of the facility cleaning the general environment. Staff AA stated they cleaned the main building and would also be cleaning resident cottages 405 and 406. Staff AA stated they utilized three main chemicals to clean/disinfect environmental surface within the facility's cottages and buildings. Staff AA showed the surveyor the chemicals they used and noted a Waxie (a specific company) pink colored 330 odor controller/degreaser solution, a Waxie blue colored 730 Hydrogen Peroxide (HP, a chemical compound) disinfectant cleaner solution and a Waxie yellow colored 210 neutral floor cleaner solution within the custodial closet. Staff AA stated they used the 330 solution within resident rooms on all the surface areas, the 210 solution was used on all the resident room floors and throughout the facility, and the 730 solution was utilized for surfaces within the resident kitchen areas, dining areas and family areas of the cottages. Staff AA stated when using the 730 chemical they would spray the chemical on wipe of right away.Record review of Waxie Solutions Station production sheets, dated 2023, showed the Waxie 330 chemical solution was an odor controller/degreaser and not a registered disinfectant. The Waxie 730 HP chemical solution was an EPA registered disinfectant and required a contact time (a term used for the duration a disinfectant must remain visibly wet on a surface to effectively kill a specific bacteria or virus) that ranged from one minute to five minutes to kill viruses and ten minutes for bacteria. The Waxie 210 chemical solution was a daily floor cleaner and not a registered disinfectant.During an interview on 04/29/2026 at 8:36 AM, Staff CC, Custodian, stated they used the Waxie 210 chemical solution on all floors within the resident cottages and throughout the facility. Staff CC stated they did not change the 210 chemical solution used for the floors when cleaning/disinfection a resident Transmission Base Precautions (TBP, safeguards put in place for a resident with a known or suspected infectious disease to help prevent cross contamination) room.During a concurrent observation and follow-up interview on 04/29/2026 at 11:56 AM, showed Staff AA in cottage 406 wiping down handrails/doors outside of resident room with the Waxie 330 chemical solution. During an interview on 05/01/2026 at 7:22 AM, Staff BB, Custodian, stated they used the Waxie 210 chemical solution on all floors within the resident cottages and throughout the facility. Staff BB stated they utilized the Waxie 730 chemical solution for disinfecting high touch surface areas by spraying on the chemical on the surface and wipe it up right away.During an interview on 05/01/2026 at 7:47 AM, Staff EE, IP, stated the facility's process was to utilize the Waxie 730 HP chemical solution to disinfect all resident rooms, floors, surfaces and all the high touched surface areas throughout the facility. Staff EE stated that facility staff should be using the Waxie 730 HP chemical solution to disinfect all floor within resident cottages. Staff EE stated that using the Waxie 210 floor cleaner, which was not an EPA registered disinfectant, was not the correct process for environmental surface disinfection of the resident rooms. Reference: WAC 388-97-1320(1)(a)(2)(b)(5)(c)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information postings were posted on daily basis at the beginning of each shift in prominent locations readily accessible to residents and visitors for 4 of 4 units (203/4, 401/2, 403/4, 405/6), reviewed for Nurse Staffing Information. These failures placed residents, family members and visitors at risk of not being fully informed of current nurse staffing levels and resident census information.Findings included.The nurse staffing data was observed posted on the second floor of the Main Building (MB) across from the Director of Nursing Services (DNS) office on 04/27/2026, 04/28/2026, 04/29/2026, 04/30/2026 and 05/01/2026. There were no staff posting observed on the six living units where residents and visitors would have access during the dates listed. During an interview and observation on 04/28/2026 at12:31 PM Staff B, DNS, stated the staff posting was updated at the beginning of each shift and posted outside their office. Review of a sign dated June 2016 hung outside the DNS office showed Yakima Valley School maintains a current, daily posting in a uniform manner, in a clearly visible place on 2 North outside room [ROOM NUMBER] (DNS office) Staff B stated these signs were posted on the units to inform visitors where to find the staff information. During an interview and observation on 04/29/2026 at 10:10 AM on unit 203/4 showed no sign posted that staffing data was available in the MB on the second floor. Staff FF, Registered Nurse, stated they had not seen any signs that directed visitors and families to find the staff posting, for a long time. During an interview on 05/01/2026 at 10:05 AM Staff A, Superintendent/NH Administrator, stated the staff data postings were only on the second floor of the MB (locked on nights and weekends) and they were not aware the signs directing visitors and families where to find the staff posting were no longer on the living units.Reference: WAC 388-97-1620(2)(b)(i)