

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50A261</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/26/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>YAKIMA VALLEY SCHOOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>609 SPEYERS ROAD</b> <b>SELAH, WA 98942</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Yakima Valley School on 10/24/12 and 10/26/12. A sample of 4 residents was selected from a census of 89. The sample included 3 current residents and the record of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2683772 #2687488 #2688384 #2688489</p> <p>The survey was conducted by:  Priscilla Becker, R.N.</p> <p>The survey team is from:  Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 11/8/12 Residential Care Services Date</p>	F 000	<p style="text-align: center;"><i>Received Yakima RCG NOV 16 2012</i></p>	
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>Supervisor</i>	(X6) DATE  <i>11/16/12</i>
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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.

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F 225 SS=D	Continued From page 1 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.  F225  1) The cited deficiency will be corrected as it relates to this resident by the facility following the Nursing Home Guidelines and the Yakima Valley School (YVS) Employee Standard Operating Procedure, (SOP) 2.02 Resident Incident Management. As soon as found, Nursing Assistant Certified (NAC) staff will report all bruises and other skin lesions to licensed nursing staff. Licensed nursing staff will document, assess and investigate all such injuries and include a plan of prevention. Resident #1 was discharged on [REDACTED]	

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F 225	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate and report an injury of unknown source, a bruise in an area not generally vulnerable to trauma, as required by 42 CFR 483.13(c)(2)-(4). Deficient practice was identified for 1 of 4 sampled residents (#1). Failure to investigate disallowed the opportunity for identification of a potential cause and implementation of preventative interventions. Findings include:  Resident #1: Review of the medical record revealed the resident was admitted for a respite stay on [REDACTED]. Resident #1 had multiple medical diagnoses including [REDACTED]. The [REDACTED] admission nursing assessment noted she had a rash on her buttocks but no bruising was documented. The resident's plan of care noted she required assistance with walking if her gait was unsteady such as when walking on stairs or uneven surfaces. Additionally, the resident was noted to have self-injurious behaviors (SIB). Staff were to document incidents of SIB if evidenced. Problematic behaviors included: 1) falling to the floor, 2) banging body parts on the wall, 3) slapping self on face or legs, and 4) yelling for more than 30 seconds. The September 2012 Target Behavior Monitor Sheet documented some episodes of slapping self on face and legs and yelling only.  A 9/17/12 nursing entry identified the resident had bruises on both of her sides, 5 centimeters (cm) by 2 cm on the right side (approximately 2 inches	F 225	2) To protect residents in similar situations the facility will follow the Nursing Home Guidelines and YVS Employee SOP 2.02 Resident Incident Management. As soon as found NAC staff will report all bruises and other skin lesions to licensed nursing staff. Licensed nursing staff will document, assess and investigate all such injuries and include a plan of prevention.  3) Measures that will take place to ensure that the problem does not recur: Training will be given to licensed nursing staff and NAC staff on Nursing Home Guidelines and YVS SOP 2.02 Resident Incident Management. This training will cover the definitions of superficial and substantial injury as well as completing First Phase investigation within 24 hours, calling the hotline and protecting the resident immediately if abuse or neglect is suspected and completing Second Phase investigations within 5 working days. This will be completed by December 10, 2012.  4) Quality Assurance Nurse and their designees will conduct random chart reviews to ensure all superficial and substantial injuries have been		

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F 225	<p>Continued From page 3</p> <p>by 3/4 inch) and 7 cm by 2 cm on the left side (nearly 2 3/4 inches by 3/4 inches). Review of the facility investigative documents revealed the bruised areas were on her "bilateral sides/back." The facility concluded the bruising might have been caused by the resident flopping into her chair over the arm rests. On 9/17/12 staff received training directing them to assist the resident in sitting down to prevent injury including moving or turning the chair to avoid injury.</p> <p>A 9/24/12 nursing entry, 7 days after discovery of the bruises, documented "Bruising to bilateral sides fading (sic) healing (without) complication cont (continue to) monit (monitor)."</p> <p>According to the 9/30/12 nursing entry, the resident was being discharged and a body check was performed by Staff Member A, a Licensed Nurse (LN). The body check identified "older bruises on L (left) side and L breast-slowly resolving."</p> <p>Further review of the medical record failed to note any documentation related to discovery, assessment/size, monitoring, possible cause of the bruising on the resident's left breast and/or preventative interventions.</p> <p>Review of the Facility Reporting Log failed to reveal documentation related to the left breast bruise.</p> <p>On 10/26/12 at 10:40 a.m. Staff Member B, an Administrative LN, stated no Incident Report (Investigation) was completed in relation to the left breast bruising. Staff Member B stated Resident #1 had a history of [REDACTED]</p>	F 225	<p>investigated. These reviews will be done weekly for six weeks, then monthly for three months.</p> <p>5) Corrective action will be completed by December 10, 2012.</p> <p>6) Director of Nursing is responsible to ensure this correction.</p> <p>F309</p> <p>1) The cited deficiency will be corrected as it relates to resident #2 by following the Yakima Valley School (YVS) Employee Standard Operating Procedure, (SOP) 4.01, Nursing Service, and Yakima Valley School (YVS) Nursing Standard Operating Procedure (SOP), II.A.7 Charting, Licensed Nursing and Yakima Valley School's "Illness Protocol 2012". Licensed nurses will document, report and assess changes in resident conditions and open nursing care plans to further assess and monitor resident's condition. Standard orders and notifying the physician will be used in combination with good nursing judgment. Resident #2 was treated for his medical condition and continues to be monitored by licensed nurses and properly documented and reported.</p>	
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F 225	Continued From page 4  On 10/27/12 at approximately 10:19 a.m., Staff Member C, a Nursing Assistant, stated she had bathed the resident the day of discharge and was present for the discharge body check. Staff Member C recalled the resident had two faded yellow bruised areas, one on her left breast near her arm-pit area and a second on the resident's left rib/waist area. She recalled seeing both bruises before but was unable to recall when she first saw them.  Staff Member A, the discharging LN, was interviewed on 10/27/12 at approximately 10:26 a.m. and stated he had performed a discharge body audit and recalled the bruising. The LN stated there were bruises on the resident's left side and on the left outer breast. The resident was reportedly, "hard on herself." Staff Member A stated he thought the left breast bruise had already been reported (based on the older appearance of the bruise).	F 225	2) To protect residents in similar situations the facility will follow the Yakima Valley School (YVS) Employee Standard Operating Procedure, (SOP) 4.01, Nursing Service, and Yakima Valley School (YVS) Nursing Standard Operating Procedure (SOP), IIA.7 Charting, Licensed Nursing and Yakima Valley School's "Illness Protocol 2012". Licensed nurses will assess, document and report changes in resident conditions and open nursing care plans to further assess and monitor resident's condition. Standard orders and notifying the physician will be used in combination with good nursing judgment.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 309	3) Measures that will take place to ensure that the problem does not recur: Training will be given to licensed nursing staff on YVS SOP 4.01, Nursing Service and YVS SOP IIA.7, Charting, Licensed Nursing and YVS "Illness Protocol 2012". This training will cover licensed nurses' responsibilities of physical assessment, documentation in the resident's medical record and carrying out the necessary action as a result of the physical examination, e.g.: notifying the physician and/or referral to other disciplines, writing nursing orders and in-servicing the orders when	

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F 309	<p>Continued From page 5</p> <p>failed to ensure 1 of 3 residents (#2) reviewed for changes of condition received appropriate care in a timely manner. Failure to provide timely, necessary care placed the resident at risk for further physical decline. Findings include:</p> <p>Resident #2: Review of the medical record revealed the resident had multiple medical diagnoses including [REDACTED]</p> <p>[REDACTED] Resident #2's plan of care noted the resident had a feeding tube with nutritional feedings and was at risk for aspiration (fluids entering his respiratory tract). The resident required total assistance for his activities of daily living.</p> <p>According to the September 2012 medication administration record (MAR), on 9/30/12 at 3:30 p.m. the resident received Tylenol 650 milligrams for a fever of 103 degrees Fahrenheit. No follow-up temperature reading was recorded and there was no documentation of a nursing assessment to attempt to identify any other symptoms that might account for the high fever.</p> <p>The 9/30/12 10:30 p.m. nursing entry documented that upon entering the resident's cottage, Staff Member E, the oncoming Licensed Nurse (LN), received a report from the Lead Nursing Assistant (NA) on the evening shift that Resident #3 had an elevated temperature all evening. Staff Member F had just rechecked his temperature and it was 103.3 degrees (when checked in his ear). The night shift LN had a night shift NA recheck the resident's temperature rectally and it was 103.2 degrees Fahrenheit.</p>	F 309	<p>appropriate. This will be completed by December 10, 2012.</p> <p>4) RN3 nursing supervisors will monitor changes in resident's conditions on daily routine rounds and report them to the interdisciplinary team. The Quality Assurance nurse and RN3 supervisors and will randomly review residents' medical record to ensure residents receive necessary services and those services are documented and reported properly. These reviews will be done weekly for six weeks, then monthly for three months.</p> <p>5) Corrective action will be completed December 10, 2012.</p> <p>6) Director of Nursing is responsible to ensure this correction.</p>		

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F 309	<p>Continued From page 6</p> <p>The night shift LN administered Tylenol at 10:20 p.m. and assessed the resident's condition. In addition, Staff Member E also called for another LN, Staff Member G, to evaluate and assume care for the resident.</p> <p>Review of the facility Illness Protocol, Fever, revealed that a fever was "a temperature greater than or equal to 100 degrees Fahrenheit." Staff were to "Recheck (sic) the temperature immediately, preferably verify with rectal temperature." Specific doses of Tylenol were outlined based on resident weight were to be given every 4 to 6 hours as needed per nursing judgment. "Re-check temperature every 4 hours until afebrile (without a fever) without the use of antipyretics (medications to lower the temperature).</p> <p>When interviewed on 10/26/12 at approximately 3:00 p.m., Staff Member H, the assigned NA on 9/30/12 during the evening shift, stated she mistakenly thought Resident #2 was on the list for vital signs so she took his vital signs (at approximately 3:30 p.m.) She recalled his temperature was approximately 101 degrees so she reported the resident's elevated temperature to Staff Member D, the unit LN, and to the lead NA, Staff Member F. Staff Member H recalled she rechecked the resident's temperature approximately 1/2 hour later and it was 102 degrees. She reported the increased temperature reading to the unit LN. At approximately 7:00 p.m. Staff Member D, the unit LN, reportedly came to the cottage and asked for a thermometer. Staff Member H showed her where they were kept. When the LN returned, the NA asked how the resident's temperature was</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>the LN reportedly stated it was 97 or 98 degrees.</p> <p>Staff Member H stated she had never dealt with a resident with an elevated temperature and she didn't know she was to keep checking the resident's temperature throughout the shift. She did not receive any direction from the LN, Staff Member D. The lead NA, Staff Member F came over and rechecked the resident's temperature at the end of the shift and found it was 103 degrees. By that time, Staff Member D had already left the unit. The lead NA directed Staff Member H to get cool wash cloths and attempt to cool the resident while the lead LN went in search of a LN to assist.</p> <p>On 10/26/12 at approximately 10:26 p.m., the night shift LN on 9/30/12, Staff Member E, recalled being met at the door by the lead NA, Staff Member F, who reported Resident #2's elevated temperature. Staff Member E recalled the evening shift LN, Staff Member D, stated there was nothing to report during the change of shift report. Staff Member E began to take action as outlined in her nursing entry above and transferred the resident's care to Staff Member G, another LN, while Staff Member E cared for the remainder of her assigned residents.</p> <p>Staff Member G documented on 9/30/12 at 11:00 p.m., the resident had some congestion in his throat and abnormal lung sounds but he had no respiratory distress. At 11:45 p.m. congestion was noted in the right lower lung field and a respiratory treatment was provided with some noted relief.</p> <p>As the night shift progressed, additional</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>medication was administered for a continued temperature elevation and a chest x-ray was ordered per a physician's protocol. The x-ray findings revealed bronchitis. A Nurse Practitioner ordered an antibiotic for the resident to treat the bronchitis.</p> <p>Review of the 5-Day Investigation, dated 10/08/12, revealed Staff Member D, "did not provide appropriate and timely medical treatment for (Resident #2) when he had a 100 degree plus temperature on 9/30/12 (B shift)."</p>	F 309		

*[Handwritten signature]*