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

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	50A261		C 07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAKIMA VALLEY SCHOOL	609 SPEYERS ROAD SELAH, WA 98942

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Yakima Valley School on July 25, 2012. A sample of 2 residents was selected from a census of 92 residents. The sample included 1 current resident and the records of 1 former and/or discharged resident. The following were complaints investigated as part of this survey: 12-07-21662 12-07-21666 12-07-21697 The survey was conducted by: Patti Rose, R.N. The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, Washington 98902 Telephone (509) 225-2800 Fax (509) 574-5597 Residential Care Services Date	F 000	Received Yakima RCS AUG 17 2012	
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	F 309		

8/7/12.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Superintendent — 8/17/12

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 309	Continued From page 1 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide the necessary care and services to 1 of 2 sampled residents (#1) with indwelling urethral catheters utilzing a leg bag. Staff did not ensure the leg bag (a small collection bag for urine that attaches by straps to the leg) was applied correctly thus causing skin breakdown and possibly urinary tract infection. Findings include: Resident #1: Admitted to the facility on [redacted] for respite (short term) care with diagnoses which included [redacted] Review of physician's orders on admission noted the resident was to utilize a leg bag during the day and staff was to change to a large urinary drainage bag at night. Review of a nursing assessment dated 6/22/12 (day of admission) revealed the resident had just completed a course of antibiotics for a urinary tract infection approximately one week before admission to the facility. Review of Progress Notes dated 6/29/12 revealed when Staff Member A (Licensed Nurse) changed the resident's leg bag to his large collection drainage bag at bedtime she observed a small, round, superficial skin tear to his left anterior thigh area. In addition to the skin tear documentation stated the cloth/elastic band that held the catheter	F 309	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 F309 1) This deficiency will be corrected by revising Yakima Valley School (YVS) Standard of Practice (SOP) V.A.15, Changing Urinary Drainage and Leg Bags. Leg bags will be included to the SOP with a description of how to change and apply the leg bag with extension tubing to a resident as well as monitor for impaired skin integrity. Resident #1 discharged from YVS on [redacted] 2) To protect residents in similar situations, YVS SOP V.A.15, Changing Urinary Drainage and	

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F 309	Continued From page 2 in place left small, light, red marks on his skin indicating the band must have been applied too tightly and rubbed his skin causing the skin breakdown. An inservice was conducted on 6/29/12 for staff regarding ensuring the leg straps are not applied too tight in order to prevent skin breakdown. An interview on 7/25/12 at 2:40 p.m. with above Staff Member A revealed the resident's leg bag was positioned on the resident's ankle utilzing a long, clear extension tubing attached to the catheter. She stated the leg bands had been applied too tight on 6/29/12 which caused skin breakdown on the resident's left thigh area. Three days before the resident was discharged to his home she had observed a leg bag with rubber straps rather than cloth/elastic straps (brought in by the resident's caregiver on admission) being used on the resident. Progress Notes dated [redacted] noted the resident was discharged from the facility to home. Review of a facility investigation report dated 7/12/12 noted that following the resident's discharge his home caregiver noted the catheter strap was applied "harsh to the skin" and open wounds were noted to both upper thighs. Review of documentation in the resident's medical record on 7/6/12 did not evidence any skin problems to the resident's right, upper thigh. A telephone interview with the home caregiver on 7/19/12 at 12:05 p.m. revealed she picked the resident up at 6:00 p.m. on 7/6/12 to take him home. When she was getting him ready for bed that night at 8:00 p.m. she observed three open	F 309	Leg Bags, will be revised to include changing and applying legs bags with extension tubing to a resident as well as monitoring the skin for impaired integrity. Licensed nurses (LN) will be in-serviced on the revision to this policy. All LN will be required to follow this revised policy. 3) Measures that will take place to ensure that the problem does not recur: Training will be given to LN staff on YVS SOP V.A. 15, Changing Urinary Drainage and Leg Bags. The training on this policy will include changing and applying leg bags with extension tubing to a resident as well as monitoring for skin integrity. The training will be completed by September 7, 2012. 4) Plan to monitor that YVS SOP V.A. 15, Changing Urinary Drainage and Leg Bags will be monitored by LN supervisory staff and their designees to ensure the SOP is being followed. All residents with urinary catheters will be monitored weekly times 4 weeks and then monthly for 3 months.	

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F 309	Continued From page 3 sores on his right, anterior thigh where a rubber strap had come into contact with his skin. She stated staff had used a leg bag with rubber straps rather than the cloth/elastic straps that had been sent with the resident on admission. The rubber straps had been applied very tight causing the skin breakdown. The catheter was connected directly to the leg bag as the clear extension tubing was missing. Without the extension tubing when the resident was in the sitting position the middle of the leg bag would be positioned directly over his knee rather than at the ankle area. (To prevent urinary tract infections drainage bags must be positioned lower than the bladder so urine does not flow back into the bladder). A telephone interview on 7/26/12 at 10:42 a.m. with Staff Member B (Licensed Nurse) revealed when she went to change the resident's night time urinary collection bag to the leg bag on [redacted] day of resident's discharge) the leg bag with cloth/elastic straps was missing thus she used a leg bag with rubber straps. In addition, the clear extension tubing was also missing thus she connected the catheter directly to the leg bag. Despite the resident's recent urinary tract infection just prior to his admission, current treatment of pressure ulcer, and recent skin breakdown on 6/29/12 secondary to the tight application of the leg straps, staff did not ensure the leg bag was applied correctly.	F 309	5) Corrective Action will be completed by September 7. 2012 6) Director of Nurses is responsible to ensure correction.	

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