

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

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 C 08/08/2012
NAME OF PROVIDER OR SUPPLIER YAKIMA VALLEY SCHOOL			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This amended report is the result of an unannounced Abbreviated Survey conducted at Yakima Valley School on 8/07/12 and 8/08/12. A sample of 3 residents was selected from a census of 90. The sample included 3 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#12-07-23178 #12-07-23131</p> <p>The survey was conducted by:</p> <p>Priscilla Becker, R.N.</p> <p>The survey team was from:</p> <p>Department of Social & Health Services Aging & 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> 9/20/12</p>	F 000		
F 225 SS=D	<p>Residential Care Services Date</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT</p> <p>ALLEGATIONS/INDIVIDUALS</p>	F 225		9/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Superintendent* (X6) DATE *9/21/12*

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 225	<p>Continued From page 1</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 225	<p>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.</p> <p>F225</p> <p>1) This deficiency will be corrected by following the Nursing Home Guidelines on reporting outlined in Yakima Valley School, (YVS), Standard Operating Procedures (SOP) 2.01, "<u>Reporting of Abuse and Neglect/Financial Exploitation of Residents</u>." Mandated reporters will immediately protect the resident, report to supervisor and call Complaint Resolution Unit (CRU) hotline. A facility report will be made; an incident report will be completed and an investigation will be completed within five (5) working days. Resident #1 was discharged on [REDACTED]</p>	
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F 225	<p>Continued From page 2</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 allegations of potential resident abuse or neglect was reported in a prompt manner to allow for a timely investigation and subsequent protection of the residents during the investigation as required by 42 CFR 483.13(c) (2)-(4). Deficient practice was identified for Resident #1. Staff were reportedly pouring water into the cap of a water bottle and then into Resident #1's mouth while he was sleeping causing him to cough and choke. Findings include:</p> <p>Resident #1: Review of the medical record revealed the resident had multiple medical diagnoses including [REDACTED]. According to the plan of care, including the Nursing Assistant (NA) care directives, the resident was to be monitored for choking. Resident #1 was to have a one-on-one caregiver to prevent danger or harm to himself or others. The resident had a known history of [REDACTED]. Additionally, he had orders for Tylenol for pain management and an anti-anxiety medication to calm him if he was agitated.</p> <p>The July 2012 Medication Administration Record identified that at 11:45 p.m. the resident received Tylenol for aggressive behaviors. The early morning 7/08/12 nursing entry documented that at midnight the resident had thrown a standing fan to the floor and had grabbed several staff. He continued to throw other items. At 12:15 a.m. on 7/08/12 the anti-anxiety medication was administered for aggressive behavior.</p> <p>Review of the one-on-one log for 7/07/12 and</p>	F 225	<p>2) To protect residents in similar situations, the Nursing Home Guidelines on reporting outlined in YVS, SOP 2.01 "Reporting of Abuse and Neglect/Financial Exploitation of Residents" will be followed. Mandated reporters will immediately protect the resident, report to their supervisor and call CRU hotline. A facility report will be made, an incident report will be completed and an investigation will be completed within 5 working days.</p> <p>3) Measures that will take place to ensure the problem does not recur: training will continue to be given to YVS staff on SOP 2.01, "Reporting Abuse and Neglect/Financial Exploitation of Residents" upon hire and on an annual basis. A power point presentation will be revised and presented as an in-service to YVS staff. A quick reference card will be given to YVS staff with instructions on reporting abuse, neglect/financial exploitation to include examples. New employees will receive training on YVS SOP 2.01, "Reporting of Abuse and Neglect/Financial Exploitation of Residents" during New Employee Orientation (NEO) or when hired prior to the NEO scheduled date, the employee will receive training from new supervisor.</p>	

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F 225	<p>Continued From page 3</p> <p>early morning 7/08/12 noted the resident manifested physical aggressive at 9:30 p.m., at 11:30 p.m., and between 11:30 p.m. and 12:30 a.m.</p> <p>According to facility investigative documents, on 7/25/12 Staff Member A, an Administrative Licensed Nurse (LN), documented she had finished giving a new employee orientation training when Staff Member B, a NA, approached her. Staff Member B stated that on 7/07/12 (18 days earlier) she had witnessed two NAs, Staff Members C & D, pouring water into a water bottle cap and then pouring it into Resident #1's mouth as he was sleeping. Their action resulted in Resident #1 'choking, spitting, and sputtering.' Staff Member B stated at the time of the incident she was unaware that this type of occurrence was reportable as abuse.</p> <p>A 7/26/12 investigative statement, revealed on 7/14/12 Staff Member E, a NA, worked with Staff Member B during the evening of 7/14/12, Staff Member B started a conversation about an incident that had taken place earlier that week. Staff Member B had stated Resident #1 was sleeping and Staff Member C was pouring water into his mouth. Staff Member E asked if she had reported it to the person in charge and she said she had not. Staff Member E told her she needed to tell her supervisor. Staff Member E left for vacation thinking the other staff member planned to make the report.</p> <p>When interviewed on 8/08/12 at approximately 2:30 p.m., Staff Member B stated Resident #1 was a respite resident. He had a history of [REDACTED] Staff were to redirect</p>	F 225	<p>4) A Quality Assurance (QA) review will be done quarterly by randomly selecting staff and providing a questionnaire on the reporting requirements and recognition of abuse and neglect/financial exploitation of residents.</p> <p>5) Corrective Action will be completed by September 21, 2012</p> <p>6) The Director of Nursing is responsible to ensure correction.</p>		

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F 225	<p>Continued From page 4</p> <p>██████████ Staff were to redirect him to his bedroom as a part of his planning for placement in another living setting. On 7/07/12 Resident #1 fell asleep on the couch at about 7:30 p.m. to 8:00 p.m. Staff Member C was his one-on-one caregiver but Staff Member D was also there. Staff Member C reportedly poured water from the lid of a water bottle into his mouth causing the resident to cough and sputter. Staff Member C & D were laughing. The actions were repeated two times. Resident #1 was agitated when he awoke. Staff Member B attempted to calm the resident but he bit her arm (without breaking the skin).</p> <p>Staff Member B further stated she had come from another nursing facility where reporting to the State was discouraged. When she began working at the current facility she had missed the initial training module nearer the time of her employment on abuse, neglect, and mandatory training. On 7/24/12 she took the training and realized she should have reported and so proceeded to report at that time to Staff Member A.</p> <p>According to personnel files, Staff Members C and D were reassigned to areas that did not allow resident contact, 18 days after the incident reportedly occurred. The staff had continued to work with residents until 7/25/12.</p>	F 225		