

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

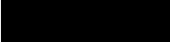
PRINTED: 08/26/2013
FORM APPROVED
OMB NO. 0938-0391

8810

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 08/15/2013
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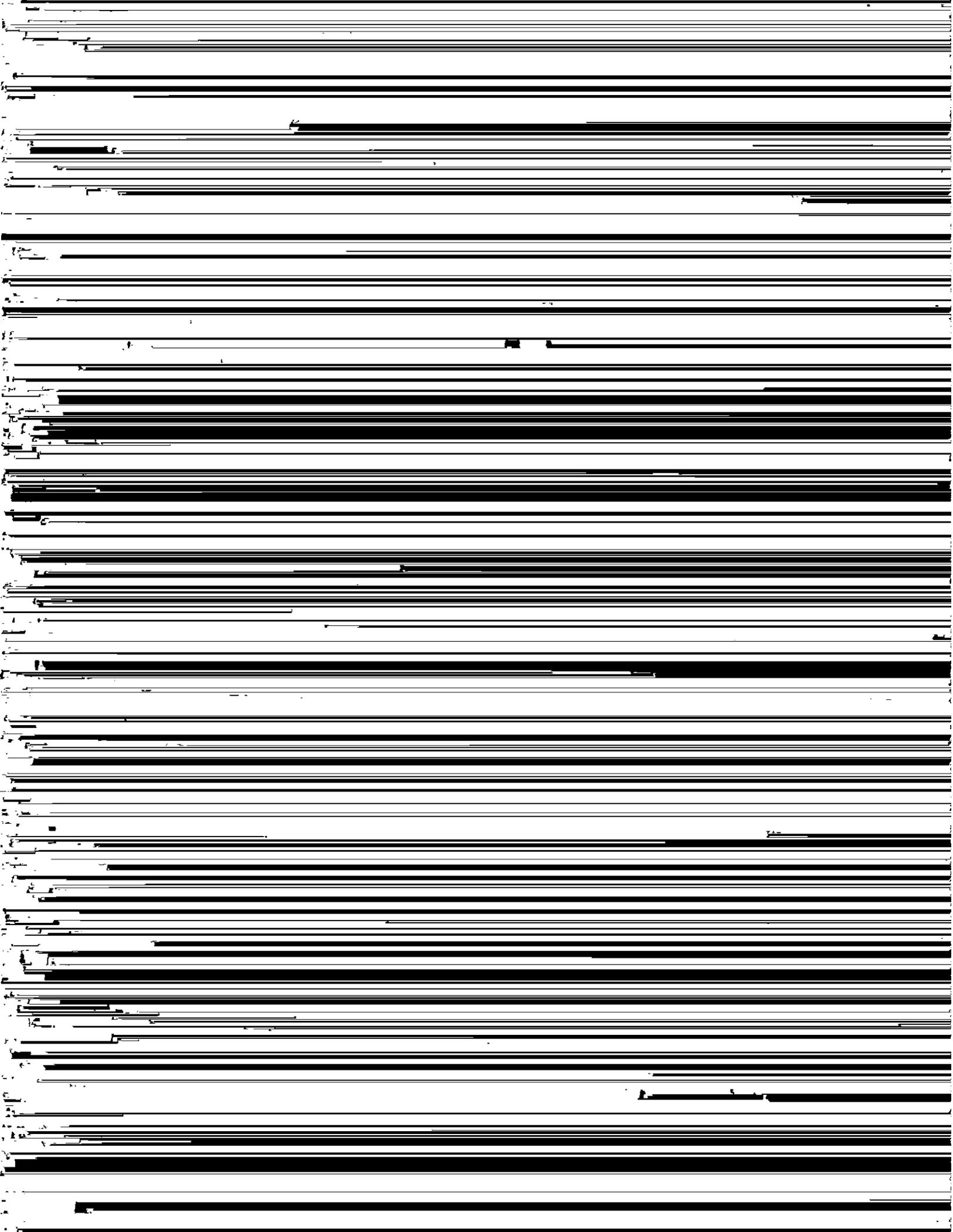
NAME OF PROVIDER OR SUPPLIER YAKIMA VALLEY SCHOOL	STREET ADDRESS, CITY, STATE, ZIP CODE 609 SPEYERS ROAD SELAH, WA 98942
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Yakima Valley School on 8/13/13 and 8/15/13. A sample of 3 residents was selected from a census of 82. The sample included 3 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2837780</p> <p>The survey was conducted by:</p> <p> R.N.</p> <p>The survey team was from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of 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>Robert Gutierrez</i> 8/27/13 Residential Care Services Date</p>	F 000	<p>Received Yakima RC6 SEP 10 2013</p>	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jill McPherson</i>	TITLE Interim Superintendent	(X6) DATE 9-10-13
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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	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to thoroughly investigate injuries of unknown origin for 3 of 3 sampled residents (#1, #2, & #3) in accordance with CFR 483.13(c)(3). Failure to perform thorough investigations disallowed an opportunity to determine whether the resident's plan of care was followed by caregivers to rule out neglect/abuse, gather data to potentially identify the etiology of the injury, and implement appropriate protective interventions to prevent recurrence. Findings include:</p> <p>Resident #3: Review of the medical record revealed the resident had multiple diagnoses including an [REDACTED] visual impairment, and [REDACTED]. According to June 2013 HSOs (NA care directives) the resident walked and toileted independently but required assistance when walking on uneven or unfamiliar surfaces. The resident would also resist care and refuse to follow directions at times.</p> <p>According to a 6/28/13 9:30 p.m. nursing entry, the resident received APAP (Tylenol) for right foot pain. There was right foot swelling present. The resident refused to bear weight and did not want to get up off the floor.</p> <p>Review of the 6/28/13 facility investigation revealed an x-ray was obtained and acute fractures of the metatarsals two through four (bones in the foot) were identified. Although the investigation identified the injury and changes to the plan of care after discovery, staff interviews obtained did not discuss the resident's condition or activities prior to identification of the injury to</p>	F 225	<p>plan of care was followed and rule out abuse/neglect.</p> <p>4) The Director of Nursing will monitor all fractures suffered by residents to ensure the plan of care was followed and whether any incident involving another resident or staff was considered. This correction will be monitored under the Director of Nursing.</p> <p>5) Corrective action will be completed by September 29²⁶, 2013.</p> <p>6) Director of Nursing is responsible to ensure this correction.</p>		

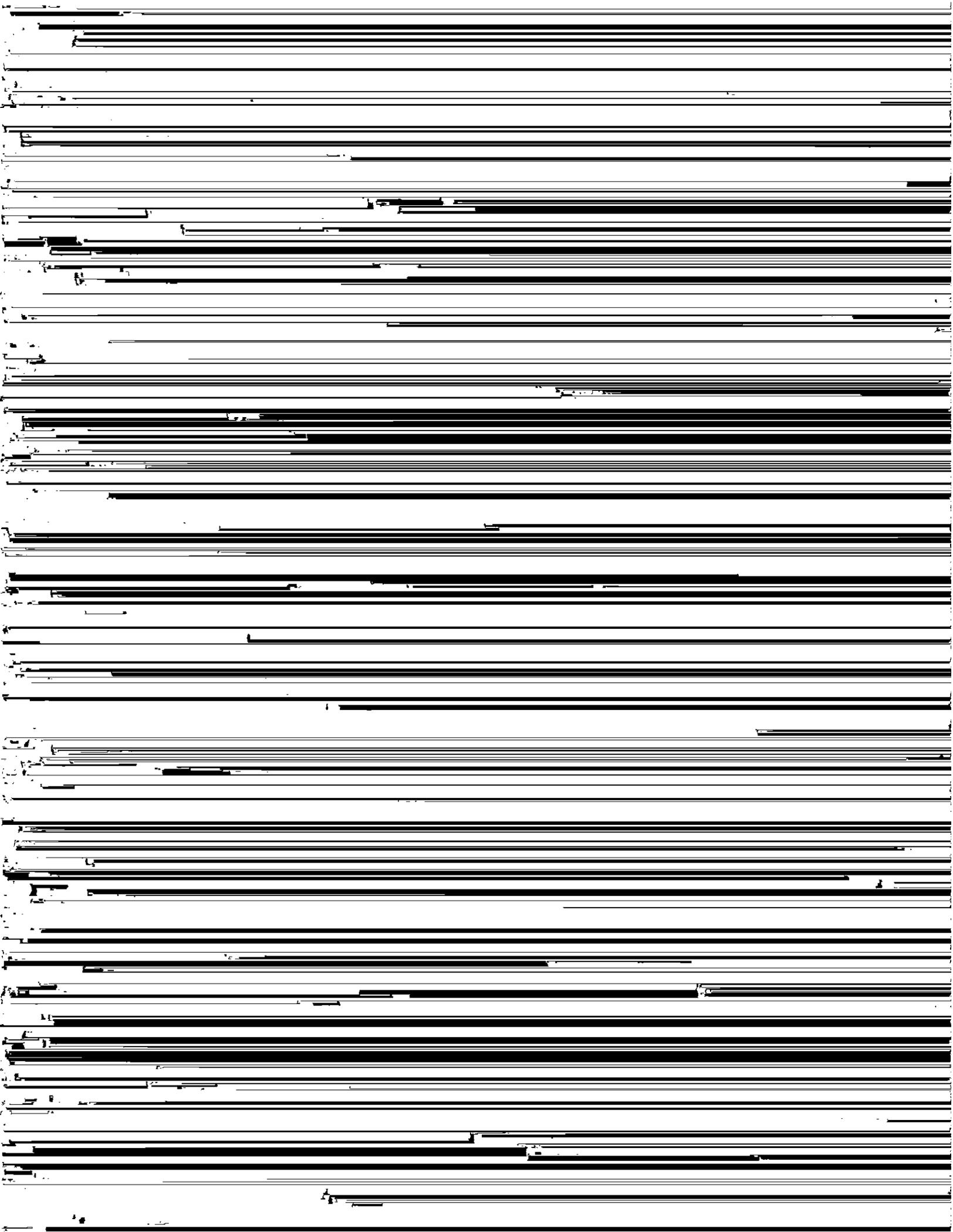
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F 225	<p>Continued From page 3</p> <p>attempt to identify what might have been the specific cause of the injury. Staff interviews only addressed what the resident's typical behavior entailed. The investigation concluded his fractures were reasonably related to his usual behaviors of crossing his legs and bouncing up and down on a firm surface or his blindness and striking his foot against a hard surface, without first attempting to establish that his care plan was followed and/or whether there had been an incident involving another resident or a staff member.</p> <p>Observations on 8/13/13 at approximately 10:12 a.m. noted a staff member assisted the resident into a stuffed chair in the living room. The resident sat with his legs crossed while seated in the chair.</p> <p>On 8/15/13 at approximately 10:40 a.m., Staff Member G, an Administrative Licensed Nurse, reviewed the facility investigation and stated she only saw interview data describing the resident's usual behavior, not what had happened the evening prior to discovery of the resident's injury. She stated she was unsure which staff members were on-duty.</p> <p>Resident #2: Review of the medical record revealed the resident had multiple diagnoses including a [REDACTED]</p> <p>[REDACTED] The resident's plan of care noted she required total staff assistance for her activities of daily living including bed mobility and transfers with two persons via a mechanical lift.</p> <p>According to a 5/20/13 nursing entry, at 1:00 p.m. a Nursing Assistant (NA) had reported the</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>Staff Member D with repositioning the resident but they had not fully uncovered the resident's feet during repositioning the resident. They uncovered the resident's feet only when they were getting her ready to place on the bathing gurney. The resident had not been out of bed on their shift. Staff Member E stated she had not been interviewed or asked for information pertaining to the resident's care on 5/20/13.</p> <p>Also interviewed on 8/15/13 at approximately 3:10 p.m., was Staff Member F, a NA, identified on the schedule as working the evening shift before discovery of the resident's injury/fracture. Staff Member F stated she had no recall of the timeframe or of her assignment or care for the resident.</p> <p>Resident #1: Review of the medical record revealed the resident was cognitively impaired and had diagnoses that included a [REDACTED] disorder and [REDACTED]. A 3/24/13 nursing entry by Staff Member A at 8:30 p.m. documented the resident was sitting on the floor next to her bed refusing to stand. The resident was transferred to bed with a mechanical lift and two caregivers. The resident's crying stopped when she returned to bed. No injuries were noted upon assessment. The resident had been next door in an adjacent cottage four hours that shift.</p> <p>A nursing entry, dated 3/24/13 at 10:20 p.m., noted an AC (a NA) reported the resident had pain in her left leg. On assessment, the resident had swelling to her left upper leg and thigh area. The area was warm and tender to touch, resulting in her crying out. The resident was sent to the hospital via ambulance at 11:15 p.m. A 3/25/13 entry at 1:45 a.m. documented the resident was</p>	F 225		

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