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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 01/28/2014
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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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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Yakima Valley School on 1/24/14 and 1/28/14. A sample of 6 residents was selected from a census of 78 residents. The sample included 6 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2931334 #2935843</p> <p>The survey was conducted by: [REDACTED], R.N. [REDACTED], R.N.</p> <p>The survey team was from: Department of Social & Health Services Aging & Long-Term Support 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> 2/4/14</p> <p>Residential Care Services Date F 323 483.25(h) FREE OF ACCIDENT</p>	F 000	<p style="text-align: center;">Received Yakima RC6 FEB 14 2014</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Centering Superintendent	(X6) DATE 2-17-14
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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 323 SS=D	<p>Continued From page 1 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to provide sufficient supervision to prevent a fall for 1 of 3 sampled residents with falls (#1). Resident #1 was left in the bathroom unattended after receiving a sedative earlier in the shift. She got up and fell sustaining a laceration to her [redacted] eyebrow area and bruising on her [redacted] hand and [redacted] foot. Findings include but were not limited to:</p> <p>Resident #1: Review of the medical record revealed the resident had multiple diagnoses including severe [redacted] disabilities, a [redacted] impairment, a [redacted] disorder, [redacted], [redacted], and [redacted]. The resident's plan of care documented that when using the toilet "she does not like the door or curtain completely shut. Staff to stand in doorway to protect her privacy." The resident was on a LOS 3 supervision plan. "Supervision must be positioned in a manner to protect from or deter danger. Resident to be in line of sight when awake." "Monitor closely after dental or medical appointment sedation." The plan of care also noted the resident had behavioral symptoms including physical assault and self injurious</p>	F 323	<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>323 This deficiency will be corrected as it relates to resident #1 by in servicing staff that provide direct services to the resident on Yakima Valley School (YVS) Standards Operating Procedure (SOP) # 1.08 Levels of Supervision (LOS). Should this resident's LOS need to be revised, the interdisciplinary team will meet and recommend a LOS to the Director of Nurses. If this resident's LOS needs to be reviewed or revised outside of business hours the Director of Nurses or designee will adjust as appropriate. Staff #C was separated from employment.</p> <p>To protect other residents in similar situations staff that provide direct services to the residents will be in serviced on YVS SOP #1.08 Levels of Supervision. A Level of Supervision (LOS) will be assigned to provide an appropriate degree of supervision for each resident. A LOS will be assigned to promote the free exercise of the resident's rights, while ensuring the safety of the resident and staff to the maximum extent reasonable.</p>	

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F 323	<p>Continued From page 2 behaviors.</p> <p>On 12/30/13 the Nurse Practitioner (ARNP) examined the resident. The resident had experienced recent falls and had pain and swelling on her [redacted] ankle. Subsequently, the ARNP ordered [redacted] (an anti-anxiety medication) 6 milligrams (mg) orally for anxiety, to be given 60 minutes prior to a [redacted] foot and ankle x-ray and a blood draw.</p> <p>According to the December 2013 medication administration record, the resident received [redacted] 6 mg orally (a large sedating dose) on 12/30/13 at 9:55 a.m.</p> <p>When interviewed on 1/28/14 at approximately 12:30 p.m., Staff Member A, a Licensed Nurse (LN) recalled that on 12/30/13 she had administered the sedating medication to Resident #1 prior to a foot x-ray and blood draw. Staff Member A had informed the two Nursing Assistants (NA) working in the cottage, Staff Member C and Staff Member D, as well as the Lead NA, Staff Member B, who worked in both cottages. Staff Member A had alerted staff so they could provide close supervision of the resident.</p> <p>According to a 12/30/13 nursing entry, Resident #1 fell on her [redacted] side while being toileted. The resident received a laceration to her [redacted] eyebrow, 0.5 centimeter (cm) by 2 cm (nearly 1/4 inch by approximately 3/4 inch), and purple bruises on her [redacted] hand (approximately 1 1/2 inches by nearly 1 1/4 inches) and a bruise on her [redacted] foot 4 cm by 4 cm (approximately 1 1/2 inches by 1 1/2 inches). First aid was provided.</p>	F 323	<p>Assignment of an initial LOS will be integrated with the admission procedures directed by the "Admission Committee."</p> <p>Measures that will take place to ensure that this does not recur are staff that provide direct services will be in serviced on YVS SOP # 1.08 Levels of Supervision and supervisory staff will monitor implementation of LOS and perform competency testing of staff as well as routinely discuss LOS at staff meeting to ensure staff continue to be aware and understand LOS status and how to implement.</p> <p>To ensure this solution is sustained, RN3 Supervisors and Attendant Counselor Managers will monitor YVS SOP # 1.08 Levels of Supervision are being followed and report their findings to the Director of Nurses.</p> <p>Corrective Action will be completed by March 14, 2014.</p> <p>Director of Nurses is responsible for ensuring this deficiency is corrected.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 3</p> <p>A 12/30/13 evening shift nursing entry noted there was slight swelling to the  eyebrow. APAP () 650 mg was administered for comfort. The neurological checks were normal at that time.</p> <p>Review of a 12/30/13 investigative statement from Staff Member C revealed she had placed the resident on the toilet and then left to go the clean utility room to obtain new clothes for the resident. While in the clean utility room she heard a thump, looked out, and saw the resident had fallen. Staff Member C then called for the LN, Staff Member A.</p> <p>The investigative conclusion found it "likely that (Staff Member C named) was not providing appropriate supervision for (Resident #1) when she fell on 12/30/13 at approximately 2:10 p.m."</p> <p>According to 12/31/13 emergency room records, the resident had a CT study of her head the day after the fall. There was no evidence of acute bleeding.</p> <p>Observations were conducted on 1/24/14 at approximately 3:50 p.m. with Staff Member E, a LN who provided assistance after Resident #1's 12/30/13 fall. Staff Member E identified the bathroom Resident #1 had used on the north side of the cottage and the adjacent hallway area outside the bathroom where the resident was found on the floor approximately ten feet from the toilet. The clean utility room was on the west side of the hallway further down the hallway from where the resident was found.</p> <p>On 1/29/14 at approximately 9:35 a.m., Staff Member D, a Nursing Assistant, was interviewed.</p>	F 323		
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F 323	<p>Continued From page 4</p> <p>Staff Member D recalled Staff Member A had notified the caregiving staff that Resident #1 had received sedating medication that morning. Staff were watching the resident closely due to her noted sedation. Near the end of the day shift she and Staff Member C had assisted the resident onto the toilet. They had three residents who required line of sight supervision, including Resident #1. One resident was being observed by an evening shift caregiver who had just arrived out in the day room. After assisting Staff Member C with Resident #1's transfer onto the toilet, Staff Member D observed another resident who required line of sight supervision disrobed in the hallway. Staff Member D went to assist the unclothed resident. Shortly thereafter, Staff Member D heard a thud and observed Resident #1 on the floor in the hallway beyond the bathroom. Staff Member C was in the clean utility room. Staff Member D stated she felt that if they had not left Resident #1 alone she "wouldn't have fallen."</p> <p>Staff failed to provide the necessary level of supervision to ensure the resident's safety. Her plan of care noted staff were to stay in the doorway of the bathroom due to privacy issues. However, on 12/30/13 Resident #1 required enhanced supervision following the sedative she had received. Instead of staying with the resident in the bathroom close enough to ensure safety, staff left her in the bathroom unattended. The resident got up, attempted to ambulate independently, and fell on her  side outside the bathroom in the hallway area.</p>	F 323			