STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on observation, interviews and record review, the facility failed to provide the necessary care and services to maintain the resident's highest practicable level of well-being for 1 of 1 resident (Resident 1) reviewed for seizure activity. The failure to initiate Vagus Nerve Stimulation (VNS) therapy (a treatment for epilepsy, a chronic brain disorder that causes seizures, that involved a stimulator which was connected inside the body to the left vagus nerve in the neck, it sends regular, mild electrical stimulations through the nerve to help calm down the irregular electrical brain activity that leads to seizures therapy. When there is a warning of a seizure a special magnet could be passed over the stimulator to give a stronger stimulator for a longer period of time) in accordance with physician's orders, placed the resident at risk for an increased number, length and severity of seizures. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses which included epilepsy. Review of the comprehensive assessment, dated 04/30/2024, showed Resident 1 was rarely/never understood. The resident required total assistance by staff for all activities of daily living. Review of physician's orders, dated 08/28/2024, showed VNS therapy magnets were to be swiped over Resident 1's upper left chest when they were experiencing seizures as needed related to epilepsy. Review of a Progress Note (PN), dated 09/28/2024 at 6:31 PM, showed Resident 1 had a total of seven seizures prior to be transferred to the hospital. Review of a PN, dated 10/16/2024 at 4:16 PM, showed the the resident had one seizure. There was no documentation staff had utilized VNS therapy as ordered. During an interview on 10/21/2024 at 10:20 AM with the Nurse Practitioner, they stated they prescribed the VNS therapy order with the magnet to be applied during Resident 1's seizure or right after the seizure. The intent of the order was for it to be applied with each seizure. The NP stated staff had not called them to clarify the order. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 10:05 AM with Staff A, Registered Nurse, they stated they had only used the magnet once on 08/27/2024 (prior to the physician's order), and the seizure had stopped but then started again. They stated they did not know about the magnets for a while until the resident's representative explained the use to them. During an interview with Resident 1's representative on 10/22/2024 at 12:23 PM, they stated the magnet was not being used by staff when the resident had a seizure. Observation of Resident 1's room on 10/22/2024 at 10:10 AM, showed the magnet used with VNS therapy, was hanging on the wall behind the bedside table to the right side of the resident's bed. Reference (WAC) 388-97-1060(1) This is a repeat deficiency from the Statement of Deficiencies dated 03/15/2024.

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Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00242 Based on interviews and record review, the facility failed to identify, assess for changes, report and implement interventions to prevent the development of pressure injuries (PI, injury to the skin and underlying tissue due to prolonged pressure) for 1 of 2 residents (Resident 2) reviewed for PIs. This failed practice placed residents at risk for PIs, decreased mobility and a diminished quality of life. Findings included . <Resident 2> Review of the medical record showed Resident 2 was readmitted to the facility on [DATE] with diagnoses of dementia and Parkinson's disease (a chronic, progressive brain disorder that affects the nervous system). The resident was discharged to their home on 09/30/2024. Review of Resident 2's comprehensive assessment, dated 07/24/2024, showed they rarely/never understood. Review of the Initial Nursing Admission/Readmission Evaluation, dated 07/18/2024, showed Resident 2 had a Stage II (partial thickness skin loss with exposed top inner layers of skin) PI to the right upper buttocks; was dependent on two staff for turning/repositioning in bed and transfers; dependent on one staff for dressing, personal hygiene and oral care. During an interview on 10/21/2024 at 3:14 PM with Staff B, Nursing Assistant, they stated an intact, dark purple, blister (considered a Stage II PI) was observed on Resident 2's right heel. They reported the skin issue to Staff C, Registered Nurse, the same day they made the observation. Staff B was unable to recall the date of the observation. Staff B stated Resident 2 wore protective boots to both feet when they were in bed, however some staff left them on when the resident was in a wheelchair. During an interview on 10/21/2024 at 5:35 PM with Staff C, they stated they recalled Staff B reporting an issue with Resident 2's heel. Staff C was unable to recall the date the issue was reported by Staff B, which heel was showing skin problems and if the resident wore preventative boots. Staff C stated when they looked at the heel, following the report by Staff B, it showed some bogginess (a heel with an abnormal tissue texture that feels spongy due to a high fluid content which can be an indication of a heel PI) and was pink in color, initial stages of their skin getting worse. Staff C stated they informed Staff B to elevate the heel. Staff C's observation was not reported to any other Licensed Nurses. Review of the resident's medical record showed no assessment by Staff C of their observation of Resident 2's heel. There were no documented plan to monitor the heel for changes and no preventative plan was developed to prevent further skin injury. Reference (WAC) 388-97-1060(3)(b) This is a repeat deficiency from the Statement of Deficiencies dated 04/23/2024.