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	01/29/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45117 Based on interview and record review, the facility failed to implement written abuse policies and procedures for identification of and protection of further abuse for 1 of 1 resident (Resident 1) reviewed for abuse. This failure placed residents at risk for further abuse. Findings included . Review of a policy titled, Freedom From Abuse, Neglect, and Exploitation Preventing and Prohibiting Abuse, revised 09/13/2022, showed the facility would maintain and implement policies and procedures to prohibit and prevent abuse that would include screening, training, prevention, identification, investigation, protection, reporting, and coordination with Quality Assurance Performance Improvement (QAPI). Facility staff would be trained to identify the different types of abuse. Review of a policy titled, Freedom From Abuse, Neglect, and Exploitation, dated 09/13/2022, showed when the facility has identified abuse, they would take appropriated steps to protect residents from additional abuse immediately. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including traumatic ischemia of muscle (a condition where a muscle experiences inadequate blood supply due to a traumatic injury, causing tissue damage from lack of oxygen and nutrients), diabetes (a disease that occurs when the body doesn't produce enough insulin or can't use insulin properly) and chronic pain. The 11/13/2024 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living. The assessment also showed Resident 1 had an intact cognition. During on interview on 01/28/2025 at 11:12 AM, Resident 1 stated Staff F, Nursing Assistant, had been rough with their care a few nights ago. They stated Staff F used wash cloths to clean their private areas and was too rough. Resident 1 stated they told Staff F the way they were cleaning their private areas hurt me and they continued to wipe them. Resident 1 stated on Monday, 01/27/2025, they told Staff G, Scheduler, they did not want Staff F working with them anymore. Resident 1 stated Staff G told them they would have a talk with Staff F. (continued on next page)

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.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 9:37 AM, Staff G stated on Monday, 01/27/2025, Resident 1 asked them if Staff F was scheduled to work that night. They stated Resident 1 told them they did not want Staff F to change their brief because they wiped them too many times. Staff G stated after that conversation, they went home and sent a text message to Staff F advising them not to provide brief changes to Resident 1, but they could do other tasks for Resident 1. Staff G stated they did not feel it was an allegation of abuse. Staff G stated they did not feel like Resident 1 was afraid or scared, they just did not want Staff F to do their personal cares. During a follow-up interview on 01/29/2025 at 9:27 AM, Resident 1 stated Staff F provided care for them a second night after they had reported the rough cares to Staff G. Record review of the staff working schedule dated 01/27/2025 showed Staff F worked the night shift, on the [NAME] Hall, where Resident 1 resided. During an interview on 01/29/2025 at 12:11 PM, Staff A, Administrator, stated Resident 1's concerns were an allegation of abuse, and it was inappropriate for Staff F to provide any cares for Resident 1 after they had reported their concerns to Staff G. Reference: WAC 388-97-0640(1)(6)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45117 Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the State Agency as required for 1 of 1 resident (Resident 1) reviewed for abuse. The failure to report an allegation of abuse placed the residents at risk for additional abuse. Findings included . Review of the Nursing Home Guidelines titled, The Purple Book, dated October 2015, showed the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse .are reported immediately to the administrator of the facility and to other officials in accordance with State law .including to the State survey and certification agency. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including chronic pulmonary respiratory disease [(COPD) a group of lung diseases that block airflow and make it difficult to breathe], chronic pain, and depression. The 11/13/2024 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living. The assessment also showed Resident 1 had an intact cognition. During an interview on 01/28/2025 at 11:12 AM, Resident 1 stated they had told Staff G, Scheduler, that Staff F, Nursing Assistant, had been rough with their cares and they did not want Staff F working with them anymore. During an interview on 01/29/2025 at 9:37 AM, Staff G stated Resident 1 had reported Staff F had wiped them too much when providing personal cares and they did not want Staff F working with them anymore. Staff G stated they did not feel that this was an allegation of abuse and did not report it to Staff A, Administrator. Staff G stated they felt Resident 1 was not afraid or scared. Staff G stated that looking back, they maybe should have reported it. During an interview on 01/29/2025 at 12:11 PM, Staff A stated Resident's 1 reported concern was an allegation of abuse, and they would have expected Staff G to report the incident as such. Reference: WAC 388-97-0640(2)(b)(5)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to obtain registry verification to ensure staff met competency evaluation requirements while allowing them to serve as a nursing assistant for 1 of 5 staff (Staff F), reviewed for staff qualifications. This failure placed the residents at risk for abuse/neglect and unmet care needs. Findings included . Review of the Washington State Board of Nursing guidance titled, OBRA [(Omnibus Budget Reconciliation Act) a database that includes the names of individuals who met the federal requirements to provide caregiving to residents in skilled nursing facilities or nursing homes in Washington State] Registry, undated, showed a nursing assistant (NA) must be active on the OBRA Registry in order to work in skilled nursing facilities or nursing homes. The OBRA Registry also informs skilled nursing facilities of people that are ineligible to work in a skilled nursing facility or nursing home due to findings of abuse, neglect or misappropriation of property. <Staff F> Review of Staff F's, NA, personnel file showed their date of hire was [DATE]. The file showed no documentation of a current OBRA registration for Staff F. During an interview on [DATE] at 1:15 PM, Staff G, Scheduler, stated their process for ensuring staff had their OBRA registration was keeping a copy of all OBRA registrations in a binder and writing the NAs name on their white board (hanging in their office) when they were coming due for renewal. They stated they knew for sure they had a current OBRA registry for Staff F but could not find it. During an interview on [DATE] at 1:55 PM, Staff A, Administrator, stated the process for ensuring OBRA registry was to obtain the registry on date of hire and when due for renewal. They stated they did not know why the registry for Staff F was missing. A follow up email received from Staff A, dated [DATE] at 9:59 AM, showed the facility had located the OBRA registry for Staff F, however it had expired on [DATE]. Reference: WAC [DATE]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45117 Based on observation, interview, and record review, the facility failed to ensure standard infection prevention and control precautions were implemented for 3 of 3 staff (Staff C, D, and E) reviewed for hand hygiene [(HH) handwashing with soap and water or use of an alcohol-based foam or gel hand sanitizer]. This failure placed the residents at risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of the Centers for Disease Control and Prevention guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024, showed HH protected both the healthcare personnel and resident. HH should be performed immediately before touching a resident, moving from work on a soiled body site to a clean body site, after touching a resident or their surroundings, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Review of a policy titled, Infection Prevention and Control Program, revised 06/08/2022, showed staff would perform hand hygiene, even if gloves were used, before and after contact with a resident, after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident room, and after removing personal protective equipment [(PPE) equipment worn to minimize exposure to hazards such as gloves, gowns, and a mask]. <Staff C and Staff D> An observation on 01/28/2025 at 10:53 AM, showed Staff C, Nursing Assistant (NA), and Staff D, NA, entered a resident room. Both Staff C and Staff D performed HH and put clean gloves on. Staff D approached the resident, that was lying in bed and rolled them towards Staff C. Staff D pushed a visibly soiled pad, that was under the resident's hip, towards Staff C and placed a fabric sling for the mechanical lift under the resident. Staff C rolled the resident back towards Staff D and removed the soiled pad, placed it on the end of the bed, and positioned the sling under the resident. Staff C, while wearing the soiled gloves, obtained the mechanical lift from the entrance of the doorway and pushed it towards the bed. They picked up the soiled pad, placed it into a trash bag, and placed the bag on top of the trash can. Both Staff C and Staff D, still wearing soiled gloves, attached the straps of the sling to the mechanical lift and adjusted the residents clothing. Staff D, with soiled gloves on, operated the mechanical lift remote control to lift the resident from the bed while Staff C, still wearing soiled gloves, guided the lift and the resident over the resident's wheelchair. Staff D, using the remote control, lowered the resident into their wheelchair, while Staff C, holding the back straps of the sling, guided the resident into position in their wheelchair. While wearing the soiled gloves, both Staff C and Staff D adjusted the resident's legs and clothing in the wheelchair. Staff C, while wearing the same gloves, made the residents bed and placed their call light and bed remote control on the bed. Staff D removed the mechanical lift from the resident room and parked it in the hallway outside the room, removed their soiled gloves and performed HH. Staff C removed their gloves, performed HH, obtained the trash bag with soiled pad, and disposed of it in the soiled room. Staff C performed HH upon exiting the soiled room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 10:50 AM, Staff C stated they should have changed their gloves and performed HH after touching the soiled pad, then put on clean gloves. They stated their normal process was to change gloves and either wash their hands or use hand sanitizer between glove changes. Staff C stated I don't know why I didn't follow the process. <Staff E> An observation on 01/29/2025 at 8:22 AM, showed Staff E, Registered Nurse, performed a wound dressing change on a resident's right heel wound. Staff E entered the resident room, performed HH, and put on two pairs of gloves. Staff E placed the wound care supplies on a barrier on the resident's bed. They cleansed the wound with wound cleanser and gauze pads. Staff E removed the top pair of gloves and applied the clean dressings over the wound. Staff E placed all used dressing supplies in the trash, removed their gloves, and performed HH. During an interview on 01/29/2025 at 11:13 AM, Staff E stated their normal process for wound care included gathering all the necessary supplies and placing them on a clean barrier in the resident room. They performed HH and put clean gloves and any other necessary PPE. They removed the soiled dressing, cleaned the wound, and removed their gloves. Staff E stated they put clean gloves on, wrote the date on the dressing and put the dressing on the wound. They removed their gloves and performed HH before leaving the resident room. Staff E stated during the observed dressing change that morning, they double gloved (wearing two pairs of gloves on top of each other) because it was hot in the resident rooms and it's just easier to pull the outer glove off. Staff E stated that practice was not the training they had received for HH but one of the physician assistants had taught them that technique. Staff E stated the top gloves were dirty and removed, leaving the bottom gloves clean to finish the dressing change. During an interview on 01/29/2025 at 12:05 PM, Staff B, Infection Preventionist, stated the process for HH included using hand sanitizer or washing hands prior to entering a resident room, before and after providing resident care, and before leaving the resident room. Staff B stated all staff should be removing soiled gloves and performing HH before putting on clean gloves to perform clean tasks. Staff B stated the facility needed to do more education on HH. During an interview on 01/29/2025 at 12:11 PM, Staff A, Administrator, stated the process for proper HH included washing hands before entering and exiting a resident room, and changing gloves and performing HH between soiled and clean tasks. They stated for wound care, staff should wash their hands prior to gloving, perform the soiled part of the wound care, remove the soiled gloves, perform HH, put on clean gloves and continue with the clean dressing. Staff A stated they did not know why the process was broken and had failed. Reference: WAC 388-97-1320(1)(a)(c)