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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505496 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/28/2024 |
| NAME OF PROVIDER OR SUPPLIER Avalon Care Center at Northpointe | | STREET ADDRESS, CITY, STATE, ZIP CODE 9827 North Nevada Spokane, WA 99218 | |

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) |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 2) and/or their representatives, reviewed for quality of care, received timely notification of a transfer to the hospital when the resident's condition declined. This failure placed the resident at risk of delayed access to care, inability to participate in care planning, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of a 05/17/2024 nurse progress note showed Resident 2 was transferred to the hospital at 1:15 AM that day due to a change of condition. Per the note the resident was less alert than usual, disoriented, was pale, and their vital signs were outside the normal range, including a blood pressure that was unobtainable. The note showed the nurse on the oncoming shift was notified of the resident's transfer later that morning, and a voicemail was left for the resident's representative. There was no documentation showing the time of the representative notification.</p> <p>In an interview on 05/28/2024 at 10:42 AM a representative for Resident 2 stated they were not notified of the resident's transfer to the hospital until more than five hours afterwards, after they had already started receiving automated messages from the hospital showing tests were being completed for the resident.</p> <p>In an interview at 10:49 AM the same day Resident 2 stated they were shipped out of the facility for an emergency in the middle of the night and that they were under a lot of physical and mental stress. The resident stated they were not sure where they were or what was happening and needed a representative when they arrived at the hospital.</p> <p>In an interview on 05/30/2024 at 1:15 PM, Staff D, Licensed Practical Nurse, stated they had called emergency medical services to transport the resident to the hospital on 05/17/2024 due to a rapid decline in their medical condition. Staff D stated after the resident was transferred they attempted to call the resident's representative, but it was a busy night and they were not able to call until later in the shift. Staff D was not able to provide a time and stated they called and left a message later in the morning.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 05/28/2024 at 11:38 AM Staff A, Resident Care Manager, stated if a resident had a non-emergent issue in the middle of the night staff could wait until the morning to notify their family of the issue, but if a resident was transferred to the hospital their family/representative should be notified immediately. Staff A stated Resident 2 was self-responsible and had gone back and forth on how much they wanted their representative involved in decision-making, but since the resident had an altered mental status and was not able to advocate for themselves, their representative should have been notified of the hospital transfer immediately.</p> <p>Reference: (WAC) 388-97-0320 (1)(b)(d)</p> |

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| <p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527</p> <p>Based on interview and record review the facility failed to assess for and accommodate resident preferences and intolerances for 1 of 3 sampled residents (Resident 2) reviewed for nutrition. This failure placed the resident at risk for dissatisfaction with food, decreased nutritional intake, unplanned weight loss, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the admission assessment dated [DATE] showed Resident 2 had a diagnosis of Crohn's disease (chronic inflammatory bowel disease), had an ostomy (an opening in the abdominal wall for intestinal waste to bypass portions of the intestine), and was at risk for malnutrition. Per the assessment the resident did not have a specialty diet ordered.</p> <p>Review of Resident 2's nutrition care plan, initiated 04/24/2024, showed the Registered Dietician (RD) would evaluate and make diet change recommendations as needed.</p> <p>According to the National Institutes of Health (https://www.niddk.nih.gov/health-information/digestive-diseases/crohns-disease/eating-diet-nutrition) dietary changes could help reduce symptoms of Crohn's disease. Recommendations included avoiding popcorn, vegetable skins, nuts, and other high-fiber foods, eating smaller meals more often, and eating high-calorie and low-fat diets.</p> <p>Review of Resident 2's Diet Requisition Form, dated 04/24/2024, showed they had a regular diet ordered, with regular textures and regular fluids. The diet requisition listed the resident's allergies but did not list their food preferences and/or intolerances.</p> <p>Review of the 04/29/2024 Nutritional Screen and 05/06/2024 Nutritional Evaluation for Resident 2 showed the resident was assessed for meal intake, weight loss/gain and energy needs. The resident's food preferences and/or intolerances were not included.</p> <p>In a telephone interview on 05/28/2024 at 10:42 AM a representative for Resident 2 stated the resident had been receiving foods that they could not eat with their current diagnoses while at the facility, including salads and high-fiber foods. The representative stated the resident was sent to the hospital from the facility and was found to have signs of malnourishment, which they attributed to the resident's diet.</p> <p>In a telephone interview at 10:49 AM the same day Resident 2 stated they needed certain foods due to their intestinal surgery and had attempted to talk to several staff about their dietary needs but did not see changes to the meals that they received.</p> <p>(continued on next page)</p> | | |

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| <p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview on 05/28/2024 at 11:18 AM, Staff B, Dietary Manger, stated dietary staff reviewed resident diet tickets during meal service to see what foods individual residents could or could not be served, and the diet tickets were based upon the information listed on the Diet Requisition Form. Staff B reviewed Resident 2's dietary form and stated the resident was ordered a regular diet and the only thing the resident could not have was blue dye per their allergy list. Staff B stated they had not been able to complete an assessment of the resident's preferences and intolerances during the resident's stay at the facility and were not aware of Resident 2's concerns with being served foods they could not tolerate.</p> <p>In an interview at 1:03 PM the same day, Staff C, RD, stated they would attempt to interview residents during their nutritional screening and evaluations, but Resident 2 was asleep during their attempts, so their evaluations were based upon chart review only. Staff C stated the dietary manager was responsible for interviewing the resident regarding their food preferences and intolerances. Staff C stated they received an electronic communication from Resident 2's representative on 05/10/2024 listing foods the resident could and could not tolerate, which they discussed with Staff B. Staff C stated a new Diet Requisition Form based upon the reported concerns was not completed as Staff B stated they were already aware of the resident's food intolerances.</p> <p>Reference: (WAC) 388-97-1100 (1); - 1120 (3)(a); -1140 (6)</p> | | |