

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 08/26/2024
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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to promptly resolve resident grievances and provide written grievance decisions for 3 out of 3 sample residents (Resident 2, 6, 7), reviewed for grievances. In addition, the facility failed to establish a grievance policy with all the required components. These failures placed the residents at risk of having unresolved grievances and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the June 2024 through August 2024 Grievance Report Log showed blank spaces under the disposition of grievances for the following:</p> <ul style="list-style-type: none"> -06/11/2024 Resident 7 aid concerns -06/17/2024 Resident 2 ants -07/29/2024 Resident 6 missing glasses -08/13/2024 Resident 7 activities and wound rounds -08/14/2024 Resident 7 nurse concerns -08/14/2024 Resident 7 food -08/15/2024 Resident 7 color urine <p>In an interview on 08/23/2024 at 10:59 AM Resident 7 stated they had filed multiple complaints about their care at the facility and had provided grievance forms to Staff D, Social Services, and Staff F, Resident Care Manager, but the facility had never responded to any of their concerns.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the associated grievance forms showed Resident 2's ants concern had been followed up with pest control, but no resolution was provided to the resident. The associated grievance form for Resident 6's missing glasses documented the resident's representative was verbally informed the facility would reimburse the missing property. A sticky note on the form documented needs to be reimbursed. Of the five listed grievances for Resident 7, one did not have an associated grievance form, one was marked as resolved but no follow-up for the resident was listed, and three were marked as resolved with verbal follow-up provided to the resident.</p> <p>In an interview on 08/23/2024 at 12:13 PM Staff A, Administrator, stated the facility was still in the process of following up on reimbursement for Resident 6's glasses.</p> <p>At 12:38 PM the same day Staff A stated Resident 2's grievance had been followed up with the resident/resident's representative verbally but had not been documented. Staff A also stated Resident 7 had many grievances and not all of them had been resolved yet as the investigations required additional information from multiple departments. Per Staff A, the facility had identified issues with timeliness of grievance follow-ups several months previously and were still in the process of fixing the grievance system.</p> <p>In an interview at 3:53 PM Staff A and Staff B, Director of Nursing, stated they did not know that written grievance resolutions were required to be provided to residents and was not listed in the facility's policy.</p> <p>The facility's policy related to grievances was requested but not provided.</p> <p>Reference WAC 388-97-0460</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 develop a care plan to address assessed risks for accident hazards for 2 of 8 sample residents (Resident 2 and 8) reviewed for care planning. This failure placed residents at risk of unmet care needs.</p> <p>Findings included .</p> <p><Resident 2></p> <p>Review of the 06/10/2024 hospital discharge orders showed Resident 2 had dementia (group of symptoms affecting memory, thinking, and social abilities) and was at risk for falls.</p> <p>A facility fall assessment dated [DATE] showed the resident received a fall risk score of 11, which indicated they were at risk for falls.</p> <p>Review of the care plan initiated 06/13/2024 showed no interventions related to the resident's identified fall risk.</p> <p>In an interview on 08/26/2024 at 1:07 PM Staff E, Resident Care Manager, stated Resident 2 was at risk for falls due to their fall assessment score and confirmed a care plan related to fall prevention was not present in Resident 2's record.</p> <p><Resident 8></p> <p>Review of a 08/12/2024 facility wander risk assessment for Resident 8 showed they had a diagnosis of dementia and received a wandering/elopement risk score of 9, which placed them in the category of at risk for wandering/elopement. The care plan section of the assessment was marked as no.</p> <p>Review of the August 2024 progress notes for Resident 8 showed on 08/14/2024 the resident reported to Staff C, Social Services, that they did not belong in the facility and I just want to be free, I want to go home. Per the note the resident was severely confused but agreed to wait for staff to arrange a safe discharge.</p> <p>Review of Resident 8's care plan, initiated 08/12/2024, showed interventions related to risk for wandering and elopement were added on 08/24/2024.</p> <p>In an interview on 08/26/2024 at 11:30 AM, Staff A, Administrator, and Staff B, Director of Nursing, confirmed Resident 8 was assessed as at risk for wandering/elopement on 08/12/2024. Staff B stated the staff member who completed the assessment felt the resident was not at risk for wandering/elopement, despite their assessment score, due to the resident following directions at that time. Staff A and B confirmed a care plan with interventions to prevent wandering/elopement was not developed until after the resident had an elopement on 08/24/2024.</p> <p>Reference: WAC 388-97-1020(1), (2)(a)(b)</p>		