STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505496	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center at Northpointe	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46033 Based on interview and record review, the facility failed to notify the provider of a change in a resident's oxygen saturations for 1 of 4 sampled residents (Resident 1) reviewed for notification of changes. Failure to notify the provider of low oxygen saturations did not allow for interventions to be put in place prior to the resident's departure to the hospital. Findings included . A review of the record documented Resident 1 had diagnoses including pneumonia and heart failure (inability for the heart to pump blood efficiently to meet the needs of the body). The 08/22/2024 admission assessment documented Resident 1 was cognitively impaired, wandered and had behavioral symptoms. The 08/17/2024 care plan documented Resident 1 had altered cardiovascular status; Staff were instructed to assess the resident for shortness of breath, monitor vital signs and notify the provider of significant abnormalities, and apply oxygen at 2 liters by nasal cannula as needed. The 08/16/2024 hospital discharge orders included to give oxygen at 1-2 liters as needed for oxygen saturations less than 92%. The 08/17/2024 facility provider orders instructed staff to check oxygen saturations and give oxygen at 2 liters as needed for dyspnea (difficulty breathing). A review of Resident 1's oxygen saturations obtained daily from 08/17/2024 to 08/25/2024 showed the resident's oxygen saturations were maintained above 90% on room air until 08/25/2024. Saturations documented on 08/25/2024 showed oxygen saturations were maintained at 92% with the use of supplemental oxygen administration. The 08/24/2024 at 6:39 PM progress note by Staff G, Licensed Practical Nurse (LPN), documented Resident 1 had increased anxiety and was unable to follow simple commands. The family was requested to come and sit with the resident. At 8:13 PM, Resident 1's oxygen saturation was checked and was found to be low at 85%. Oxygen was applied, and their saturation improved to 94%. The progress note did not include if the provider was notified of the low oxygen level. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/25/2024 at 2:55 AM progress note by Staff H, LPN, documented a loud noise was heard and Resident 1 was found standing in the corner of their room and had knocked over their oxygen concentrator (the machine that delivers supplemental oxygen). The note detailed that the resident was assisted back to bed, was uninjured but was visibly exerted. At 4:50, Staff H documented Resident 1's oxygen saturation was 83% on the concentrator that was knocked over. The concentrator was replaced, and when rechecked, Resident 1's oxygen saturation was 92% on 2 liters of supplemental oxygen, but their saturation dropped to 88% when mouth breathing. The note did not include if the provider had been notified of the low oxygen saturations. During an interview on 09/30/2024 at 8:57 AM, Staff G stated on the night of 08/24/2024, Resident 1 was in bed and was grabbing at something in the air, so Staff G checked their oxygen saturation, and it was low. Staff G stated they already had an order to apply oxygen so they did and the resident's saturation level came up so they did not attempt to notify the provider. Staff G stated the resident's breathing was normal and there was no other indication of a change in their status except that they were grabbing at the air. During an interview on 09/30/2024 at 11:34AM, Staff H stated on 08/25/2024, Resident 1 had a low oxygen saturation but would not leave their oxygen on. Staff H stated the resident kept repeating phrases over and over until they were out of breath, so their saturations would go low. Staff H stated they had not discussed the low oxygen saturations with the provider. During an interview on 10/02/2024 at 10:02 AM, Staff B, Director of Nursing, stated Resident 1 was easily agitated and impulsive. Staff B stated the resident's oxygen saturations were fine if they left their oxygen on, but they kept pulling it off. The Resident's confusion and low oxygen saturations could have been a sign that there was something else going on with Resident 1 so should be discussed with the provider. Reference: WAC 388-97-0320

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on interview and record review, the facility failed to provide supervision for 1 of 3 sampled residents (Resident 1) reviewed for accidents. Resident 1 was harmed when they wandered unassisted in to the hall, intercepted fall (occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person - this is still considered a fall) and sustained a fractured humerus (the upper arm bone). This failure put residents at risk for injuries and decreased quality of life. Findings included . A review of the 08/22/2024 admission assessment documented Resident 1 had diagnoses including dementia and anxiety. Resident 1 was moderately cognitively impaired, had disorganized thinking and inattention, had verbal and other behaviors, rejected care and wandered. The resident required substantial assistance for bed mobility, going from sitting to standing positions and transfers from bed to a chair. The 08/17/2024 care plan documented the following care areas: -Activities of Daily Living (ADL) self-care deficit; the resident required substantial/max assistance of one staff for transfers using an Apex (a mechanical device that helps a resident transfer from their bed to a chair or wheelchair). On 08/20/2024, the care plan was updated to include the resident required touching assistance of one staff for transfers. -Risk for falls related to confusion, deconditioning, gait/balance problems and unaware of safety needs; staff were instructed to anticipate and meet the resident's needs, be sure the call light was in reach and the resident was encouraged to use it for assistance as needed. The resident needed prompt response to all requests for assistance, bed against the wall, fall mat, ensure commonly used items were within reach prior to leaving the resident's room, and ensure the resident was wearing appropriate footwear when ambulating. On 08/19/2024, the care plan was updated to include conduct frequent rounding (checking on the resident's condition or whereabouts). A review of nursing progress notes documented Resident 1 arrived at the facility on 08/16/2024 at approximately 4:30 PM for therapy and strengthening needs and was anxious. The resident was educated on the use of their call light and staff were to anticipate the resident's needs. On 08/17/2024 at 6:28 PM, the resident was found lying on their fall mat with a pillow under their head. The resident appeared comfortable, did not know how they got there and had no injuries. The resident was toileted then placed near the nurse's station in their wheelchair. A review of the 08/17/2024 fall investigation documented Resident 1 was found on their fall mat resting their head on a pillow with their pants partially down. The resident had been incontinent of stool, was provided care, and was positioned in their wheelchair within eyesight of the nurse. The cause of the fall was documented as a lack of safety awareness. The care plan was updated to include frequent rounding on 08/19/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes documented on 08/19/2024 at 12:16 PM, Resident 1 was very anxious and cooperative with staff and that staff did at times anticipate the resident's needs. On 08/20/2024 at 6:05 AM, staff documented the resident was restless most of the night and was in their wheelchair with the nurse; the resident tried to get out of bed and ambulate without assistance. The resident verbally repeated sentences over and over for two hours and was given medication for anxiety, then eventually slept for two hours. At 7:13 AM, the resident was medicated for anxiety as they were very anxious, tried to get out of their chair and repeated the same sentences over and over. At 9:57 AM, the resident was very anxious, repeated things over and over and was not easily redirected. The same day it was noted that the resident had difficulty adjusting to the facility and the resident's family representative had been contacted, an interdisciplinary care plan (IDT) meeting was scheduled for 08/21/2024 and the family representative had agreed to stay with the resident until they adjusted to the facility. On 08/23/2024, progress notes indicated the facility called other facilities to attempt to have the resident transferred but none had accepted Resident 1. The census section of the electronic medical record documented that on 08/20/2024 Resident 1 was moved from room [ROOM NUMBER], a semi-private room near the nurse's station to room [ROOM NUMBER], a private room further down the hall away from the nurse's station. A review of the 08/21/2024 IDT Care Plan Conference note documented Resident 1's family representatives were present, as well as Staff C, Social Worker, Staff D, Physical Therapy Aide (PTA), and Staff E, Resident Care Manager. The care plan was updated to reflect the resident's difficulty adjusting to the facility and the family desired a discharge to a memory care facility. There was no documentation regarding the level of supervision the resident required to prevent further falls. Review of a progress note, dated 08/24/2024 at 6:39 PM, showed Resident 1 had been one on one with staff; the resident stood up from their wheelchair and ran through the halls. Staff requested the family come sit with the resident. Resident 1 was given anti-anxiety medications that were only effective after the family arrived. Resident 1 was unable to follow simple commands. On 08/25/2024 at 2:56 AM, the nurse on duty documented they heard a loud noise and found Resident 1 standing in the corner of their room. Resident 1 began to stumble, tried to use the wall to steady themself and was assisted to the floor. The resident was assisted back to bed, was not injured, and stated they had been attempting to go to the bathroom. At 3:00 AM, Resident 1 got out of bed and ambulated halfway to the nurse's station. Per the documentation, Resident 1 seemed to have an altered level of consciousness momentarily and was leaning all their weight into a staff member's lower legs. The resident was lowered to the floor until staff could retrieve the resident's wheelchair. The resident was assisted into their chair by three staff and began to complain continuously of right arm pain. At 3:37 AM, an order was received to obtain an x-ray of the resident's arm and to give the resident medication for their anxiety. The staff were directed to send the resident to the emergency room if the medication was ineffective. Resident 1's Power of Attorney was notified at 3:58 PM that the resident's upper arm was broken and was to be transferred to the local emergency department. The resident left the facility at 5:04 PM via emergency medical services. Review of progress note dated 08/25/2024, documented acute humeral neck fracture. A review of the 08/25/2024 fall investigation documented Resident 1 fell because of the recent change in their room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/30/2024 at 5:20 AM, Staff I, Nursing Assistant, stated they had helped provide care to Resident 1. They stated Resident 1 would be seated in their wheelchair, and then would suddenly take off running. They had staff stay with the resident 1 to 1 for one night, then stated there was not enough staff. Staff I stated the resident's family was supposed to help but were not always there. They positioned Resident 1 by the desk but Resident 1 was unable to follow instructions. During an interview on 09/30/2024 at 8:00 AM, Staff C, Social Worker, stated an IDT meeting had been held with Resident 1's family on 08/21/2024 and the family representatives had concerns about the level of supervision being provided for the resident. Staff C stated at that time, the family requested Staff C look at other placement arrangements. During an interview on 09/30/2024, Staff F, Licensed Practical Nurse (LPN), stated they provided care for Resident 1. Staff F stated Resident was very impulsive and would jump up from their wheelchair and take off running. Staff F stated someone made a decision to place Resident 1 in a private room to enable the family to sit with the resident because the facility did not provide 1 to 1 supervision, but Staff F was uncertain how often the family came to the facility. During an interview on 09/30/2024 at 8:57 AM, Staff G, LPN, stated they cared for Resident 1 the evening of 08/24/2024, which was the same night the resident fell a second time. Staff G stated Resident 1 was not able to understand what their call light was for and did not follow instructions. Staff G stated on 08/24/2024, Resident 1 had been grabbing at something in the air. Staff G checked, and Resident 1's oxygen saturation was low at 85%. (Normal oxygen saturations, the amount of oxygen available in the blood, range from 95-100% on room air.) Staff G applied supplemental oxygen to the resident and their saturation improved. Resident 1's family member was present at that time, but the family did not stay with Resident 1 at all times. Staff G had not notified the provider of the low oxygen saturation. During an interview on 09/30/2024 at 10:10 AM, Staff E, LPN, Resident Care Manager, stated they had been told that Resident 1's family would be with the resident everyday but when that had not happened, Staff E asked and was told by Administration staff that there was no law that required the family to be there. Staff E stated they had discussed the level of supervision Resident 1 required with the resident's family during the 08/21/2024 IDT meeting. Staff E stated Resident 1 was impulsive and ran down the hall at times, but the facility did not provide 1 to 1 supervision and Staff E stated it was their understanding that was why the family agreed to sit with the resident. Staff E stated it was the facility's responsibility, however, to provide the appropriate level of supervision the residents required. During an interview on 09/30/2024 at 10:43 AM, Staff D, Physical Therapy Aide (PTA), stated they had been present at the 08/21/2024 IDT meeting and recommended that Resident 1 needed 1 to 1 supervision for their safety. Resident 1 was impulsive, and very anxious. When ambulating, Resident 1 abandoned their walker, was unsteady and unable to understand how to use their call light. The resident's family questioned whether the facility was able to provide the correct level of supervision the resident required, so had requested the resident be transferred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/30/2024 at 11:30 AM, Staff H, LPN, stated they provided care for Resident 1 on 08/25/2024 when they fell . Staff H stated Resident 1 would become fixated on a phrase and repeat it constantly and would only remain reoriented for about 5 seconds. Staff H stated on the night the resident fell , Resident 1's family was not present, the activity on the unit was chaotic and staff were unable to keep their eyes on the resident at all times. Staff H heard a loud noise and saw Resident 1 in their room in the corner. They had knocked over their oxygen concentrator. The resident kept taking off their oxygen and their oxygen saturation was low so Staff H and an NAC helped the resident back to bed and reapplied their oxygen. Staff H stated before they got back down the hall to the nurse's station, Resident 1 was out of bed running down the hall and the NAC that was near by helped lower the resident to the floor. Staff H stated after that Resident 1 complained of their arm hurting and the provider was notified of the arm pain but Staff H did not remember telling the provider the resident's oxygen saturations were low. During an interview on 10/02/2024 at 10:02 AM with Staff A, Administrator and Staff B, Director of Nursing, Staff B stated Resident 1 was impulsive, lacked safety awareness and had trouble acclimating to the facility. Staff had been instructed to provide frequent rounding, and to keep Resident 1 in areas where more staff were present. Staff A stated the facility did not provide 1 to 1 supervision and there had been confusion among some of the staff regarding providing 1 to 1 supervision but it was the facility's responsibility to provide the appropriate level of supervision for their residents safety. During a telephone interview on 10/02/2024 at 11:39 AM, Resident 1's Representative stated Resident 1 was admitted on a Friday to a room next to the nurse's station and had a roommate. When they came in the next morning, they were notified Resident 1 had fallen. Resident 1 was very agitated and had a terrible Sunday. On Monday, 08/19/2024, they waited over 5 hours for information regarding the resident's plan of care and were unable to talk to the Social Worker. On 08/20/2024, they were called and told they had to have someone stay with Resident 1 twenty-four hours a day and Resident 1 was moved away from the nurse'sstation to a room at the end of the hall where they were alone. Then during the IDT meeting on 08/21/2024, the Representative stated Staff D and Staff E disagreed about what level of supervision Resident 1 needed and what level the facility was able to provide, so the family requested the resident be transferred and the resident fell , broke their arm and was sent to the hospital before the arrangements were made. Reference: WAC 388-97-1060(3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527 Based on observation, interview and record review, the facility failed to assess a resident for removal of an indwelling urinary catheter (a small flexible tube inserted into the bladder to drain urine) for 1 of 3 sampled residents (Resident 9), reviewed for catheter use. Additionally, the facility failed to ensure indwelling urinary catheters were properly secured for 2 of 3 sampled residents (Resident 8 and 9). This failure placed the residents at increased risk of acquiring potentially preventable catheter associated urinary tract infections, pain, and urethral trauma. Findings included . Per the Centers for Disease Control 03/25/2024 Summary of Recommendations of the Guideline for Prevention of Catheter-Associated Urinary Tract Infections (https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html) indwelling catheters should be properly secured after insertion to prevent movement and urethral traction (pulling). <Resident 9> Review of the facility's policy titled, Urinary Catheterization, dated April 2021, showed a resident who entered the facility with an indwelling urinary catheter would be assessed for removal of the catheter as soon as possible unless their condition indicated that catheterization was necessary. Per the policy the resident would be involved in the discussion of the risks and benefits of the use of the catheter and the medical provider would document the rationale for the use of the catheter. Review of the 06/12/2024 admission assessment showed Resident 9 had an indwelling urinary catheter, no diagnosis of a neurogenic bladder (condition that affects bladder function due to nervous system damage or disease), and no prognosis of life expectancy less than six months. Review of a bowel and bladder evaluation, dated 06/06/2024, showed Resident 9's urinary continence was not rated due to use of a catheter. The assessment was marked as no for a current toileting program or trial. Review of the progress notes from June 2024 to September 2024 showed no documentation regarding whether Resident 9's urinary catheter had been assessed for removal and/or was determined to be necessary. Additionally, the notes showed no documentation the use of the urinary catheter had been discussed with the resident. In an interview on 09/10/2024 at 4:04 PM Resident 9 stated they had major problems with their urinary catheter including pain and bleeding for the past month. The resident stated they were not sure why the catheter was still in place or whether the facility was arranging for a urinary specialist to review their use of the catheter. Observation showed the resident's catheter bag and tubing had bright red urine with red sediment (particles in the urine). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview at 4:18 PM the same day, Staff N, Resident Care Manager, stated Resident 9 had blood in their catheter for two days and had complained of urethral pain, and the provider had ordered a urinary laboratory test that day. Staff N stated the resident had recurrent urinary tract infections and they were not sure why the resident had a catheter as they did not have a diagnosis requiring one. On 10/02/2024 at 1:26 PM Resident 9's urinary catheter was observed with Staff O, Licensed Practical Nurse. The urinary catheter tubing was not secured, and the resident jerked in bed and exclaimed, Oh! when Staff O touched the tubing. Staff O applied a securement device to the resident's leg then secured the catheter tubing and asked the resident if they were having pain. The resident stated they got a sharp pain in their bladder whenever the catheter was touched/moved, and Staff O stated the securement device should help. <Resident 8> Review of the admission assessment dated [DATE] showed Resident 8 had a diagnosis of benign prostatic hyperplasia (enlarged prostate; a condition that can block the flow of urine out of the bladder) and used an indwelling urinary catheter. Review of the May and June 2024 progress notes showed Resident 8 had a catheter inserted for difficulty emptying their bladder and a failed attempt at bladder re-training. Per the notes the resident had irritation to the catheter insertion site, discomfort to their penis, and bloody urine in the catheter collection bag intermittently. The notes did not indicate if the resident's catheter tubing was secured when the resident had complaints of urethral pain. Review of the 06/12/2024 urology (doctor who specializes in care of the urinary tract) notes showed the resident continued to report discomfort associated with their urinary catheter. Per the urology notes, the catheter was uncomfortable due to lack of securement and an adhesive securement device was applied. In an interview on 09/09/2024 at 5:47 PM a representative for Resident 8 stated the resident had reported concerns about the care of their urinary catheter while at the facility, including frequent bloody urine and pain associated with their catheter. In an interview on 09/10/2024 at 4:25 PM, Staff C, Social Services, confirmed Resident 8 did have complaints about pain and blood in their catheter throughout the course of their stay at the facility. Reference: WAC 388-97-1060 (3)(c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46033 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to ensure showers were completed as careplanned and call lights were answered timely for 3 of 4 sampled residents (5, 6, 7) reviewed for activities of daily living (ADLs). This failure put residents at risk for skin breakdown, incontinence episodes, or unmet care needs. Findings included . <Resident 6> The 08/28/2024 quarterly assessment documented Resident 6 had diagnoses including morbid obesity and diabetes. Resident 6 was cognitively intact, and was dependent on staff for toileting, personal hygiene and bathing. The 11/29/2022 care plan documented Resident 6 had an ADL self-care deficit; They required substantial/maximum assistance of 1 staff to provide bathing/showering. Resident 6 preferred showers twice weekly and as necessary. The undated Nursing Assistant Care Card (KARDEX) documented Resident 6 preferred twice weekly showers on Tuesdays and Fridays. The Nursing Assistant Showering Task documentation reviewed for the previous 30 days from 08/29/2024 to 09/27/2024 documented Resident 6 received showers on Fridays 08/30/2024, 09/06/2024, 09/13/2024 and 09/20/2024. During an interview on 09/25/2024 at 2:07 PM, Resident 6 stated the facility staff were mostly helpful, some were not, but the resident declined to mention any names. Resident 6 stated they used to get showered twice a week but lately it was only once a week on Fridays because the facility had no shower aide. They preferred to be showered at least twice a week. Resident 6 stated it took staff time to get to them when they rang their call bell, and then the staff had to change their whole bed because it took too long for the staff to come and by then their linens were soiled. Resident 6 stated they have gotten used to waiting 30 minutes for their call light to be answered. Resident 6 stated they would be given a washcloth and water to wash their hands and face but only if they requested it. <Resident 5> The 09/02/2024 annual assessment documented Resident 5 had diagnoses including rheumatoid arthritis (painful swelling in joints that can cause the joints to be deformed) and macular degeneration (eye disease that causes vision loss). Resident 5 was cognitively intact, able to participate in their care decisions and was independent for most ADLs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/08/2023 care plan documented Resident 5 was resistive to care by refusing showers. Staff were to allow the resident to make decisions about their care, offer assistance, and if refused, offer again in 5-10 minutes, provide a consistent routine and caregivers as much as possible. On 09/25/2024 at 1:50 PM, Resident 5 was observed in their room in their wheelchair. Their fingers were curled in, and the resident communicated by writing on a white board. Resident 5 stated the staff showered them every three days or so, but they were more concerned about their call light not getting answered. Resident 5 stated they waited up to 30 minutes for their call light to be answered, and if not, they had to get in their wheelchair and go down the hall and look for staff if they felt it was something urgent. They stated this happened most often on the overnight shift. <Resident 7> The 07/13/2024 annual assessment documented Resident 7 had diagnoses including stroke with paralysis on one side of their body. Resident 7 was cognitively intact, did not refuse care, and required substantial assistance for toileting, personal hygiene and was dependent on staff for showering. The 08/24/2023 care plan showed Resident 7 had an ADL self-care deficit; they required maximum assistance of 1 staff to provide showers twice weekly and as necessary. The Nursing Assistant Showering Task documentation reviewed for the previous 30 days from 08/29/2024 to 09/27/2024 documented Resident 7 received showers on Friday 08/30/2024, Saturday 09/07/2024, Friday 09/13/2024, Thursday 09/19/2024and Tuesday 09/24/2024. During an interview on 09/30/2024 at 5:20 AM, Staff I, Nursing Assistant (NAC), stated they had just worked a double shift to help with staffing. Staff I stated it depended on who they worked with if they were able to get all their tasks done. During an interview on 09/30/2024 at 7:20AM, Staff P, NAC, stated there were normally two or three NACs for the [NAME] unit because there were many call-ins. Staff P stated they tried to do what they could for showers; residents were supposed to have two showers a week but they had not had any shower aides lately. They tried to answer call bells timely but it depended on how many staff they had. During an interview on 09/30/2024 at 9:55 AM, Staff Q, NAC, stated at the beginning of their shift, they had four NACs, but one was pulled to do showers, so now they had an assignment of 17 residents. Staff Q stated residents were to be showered twice weekly but both the shower aides were gone so showers were not getting done. During an interview on 10/02/2024 at 10:02 AM, Staff B, Director of Nursing, stated both of the shower aides were out on leave and a new one had just been hired. The facility had also provided bonus moneys when staff picked up an extra shift. The facility was also working with a staffing agency to bring in 5 additional NACs. Staff B stated they had no way on the [NAME] unit to track how long call bells rang like they did on the East unit, but all staff were expected to answer call bells. Staff B stated they expected call bells to be answered in 10 minutes or less and expected residents to get showered twice weekly as care planned. Reference: WAC 388-97-1080(1), 1090(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505496	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center at Northpointe	9827 North Nevada Spokane, WA 99218

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 38527 Based on interview and record review the facility failed to ensure 3 of 5 Licensed Nurses (Staff J, K, and L) were evaluated by the facility for competency with skills and techniques prior to working with residents with indwelling urinary catheters (flexible tube inserted into the bladder to drain urine). This failure placed residents at risk for clinical complications. Findings included . Review of the May 2024 Treatment Administration Records (TAR) for Resident 8 showed Staff K and L, Licensed Practical Nurses (LPNs) were responsible for care and monitoring of the resident's indwelling urinary catheter. Review of the May 2024 progress notes showed Staff J, LPN, was responsible for monitoring Resident 8's bladder and potentially placing a urinary catheter based upon the resident's status. Review of the June 2024 TAR for Resident 10 showed Staff J, K, and L all provided care and monitoring of the resident's indwelling urinary catheter. Per the TAR, each LPN flushed and irrigated the resident's catheter (procedure to remove any substances clogging the catheter). In an interview on 09/09/2024 at 5:47 PM a representative for Resident 8 stated the resident had concerns related to the competency of the staff who inserted and monitored their urinary catheter. In an interview on 09/11/2024 at 10:02 AM Resident 10 stated they had concerns regarding the competency of the nurses who provided them urinary catheter care. In an interview on 10/02/2024 at 12:41 PM Staff M, Registered Nurse/Staff Development Coordinator, stated new staff were paired with an experienced staff member for training and evaluation of their clinical skills, which were then documented on a two-to-three-page skills check off sheet, then turned in to Staff M for evaluation. Staff M stated staff were to be evaluated by another staff of equal or higher competency before independently performing skills (such as urinary catheter care). Information regarding competency evaluations for Staff J, K, and L was requested. In a follow-up interview at 1:34 PM the same day, Staff M stated Staff J and K no longer worked for the facility and did not have any documentation of clinical skills competency evaluations in their files. Staff M stated Staff L also did not have any documentation of a clinical skills competency evaluation in their file, and Staff M had reached out to them on 08/05/2024 (approximately two months prior) to come in for a skills evaluation. In an interview at 4:46 PM on 10/02/2024 Staff A, Administrator, and Staff B, Director of Nursing, stated Staff M was new to the position and was working on staff skills and competency evaluations. Refer to F-690 for additional information. Reference (WAC) 388-97-1080(1)(9)(10)(c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46033 Based on interview and record review, the facility failed to ensure blood pressure medications were held when indicated for 1 of 3 sampled residents (Resident 1) reviewed for medication administration. This failure put residents at risk for unintended health consequences related to low blood pressures. Findings included . A review of the record documented Resident 1 had diagnoses including hypertensive kidney disease (kidney damage caused by long term high blood pressure) and primary pulmonary hypertension (high blood pressure that affects the arteries of the lungs and causes the heart to work harder to pump blood to the lungs). The 08/22/2024 admission assessment documented Resident 1 was cognitively impaired and relied on assistance of staff for most of their activities of daily living (ADLs). A review of the 08/2024 medication administration record (MAR) documented Resident 1 had the following medication orders: -Lisinopril 40 milligrams (mg) once daily for hypertensive kidney disease; hold medication and notify the provider if the systolic blood pressure (SBP, the upper number of a blood pressure reading) is below 100 or if the heart rate is less than 50. -Metoprolol Succinate 24 hour extended release 25mg once daily for hypertensive kidney disease; hold medication and notify provider if SBP is less than 100 or heart rate is less than 50. On 08/20/2024, the MAR showed Resident 1's blood pressure reading was 99/59, and the Lisinopril and Metoprolol were held. Further review of the MAR revealed that on 08/21/2024, Resident 1's blood pressure reading was 94/55, indicating the Lisinopril and the Metoprolol were to be held for a SBP of less than 100 as ordered. The medications were checked that they were administered. A review of nursing progress notes had no documentation that the provider was notified that Resident 1's medications were held for a low SBP on 08/20/2024, or that the Resident's medications should have been held on 08/21/2024 but were not. A review of the provider communication binder (a book staff used to notify the provider group of non-emergent occurrences related to resident cares or requests) had no entries regarding Resident 1's low SBP on 08/20/2024 and 08/21/2024, or that the medications should have been held but were not on 08/21/2024. During an interview on 09/30/2024 at 10:10 AM, Staff E, Resident Care Manager, stated if there were instructions to hold medications for certain parameters, they expected the staff to hold the medications and notify the provider. Staff E reviewed Resident 1's record and was unable to find documentation that Resident 1's SBP was low and the medications were held, or that the medications were given but should have been held. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/2024 at 10:02 AM, Staff B, Director of Nursing stated if there were parameters for medications to be held, they expected staff to hold the medications and notify the provider. Staff B stated it was important to hold the medications when indicated to prevent a resident's blood pressure from getting even lower. Reference: WAC 388-97-1060(3)(k)(iii)