

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  12/10/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38527</p> <p>Based on interview and record review, the facility failed to ensure allegations of potential misappropriation were reported immediately to facility administration and the State Survey Agency as required, for 1 of 5 sampled residents (Resident 9) reviewed for abuse/neglect. This failure placed the resident at risk for abuse.</p> <p>Findings included .</p> <p>Review of Resident 9's November 2024 progress notes showed an entry on 11/14/2024 by Staff C, Social Services, which documented the resident reported an allegation that a staff member was rough with the resident.</p> <p>Review of the facility's Incident Log for November 2024 did not show any entries related to Resident 9.</p> <p>In an interview on 12/10/2024 at 2:29 PM Staff C confirmed Resident 9 reported an allegation of abuse to them on 11/14/2024. Staff C stated they reported the resident's allegation the same day and unidentified staff were investigating the incident while Staff C was out of the facility. Staff C stated they returned to the facility on [DATE] and were directed to report the allegation of abuse to the State Survey Agency at that time. Staff C stated they typically reported abuse allegations to Staff A, Administrator, but they were unable to recall who they reported the initial abuse allegation to and/or who directed them to report the incident.</p> <p>In an interview at 2:55 PM the same day, Staff A stated they were notified of Resident 9's allegation of abuse during a clinical meeting on the morning on 11/18/2024 and they immediately reported the incident to the State Survey Agency as required. Staff A was asked for any additional information related to the delay in reporting after the initial allegation on 11/14/2024. Staff A reviewed the documentation present in Resident 9's progress note (see above) and stated they had not previously aware of the delay in reporting.</p> <p>Reference: (WAC) 388-97-0640 (5)(a)</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38527</p> <p>Based on interview and record review the facility failed to provide the necessary care and services for 1 of 4 residents (Resident 3), reviewed for wound care. Failure to perform wound treatments as ordered placed the resident at risk for delayed wound healing, worsening of wounds, and/or potential infection and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the October 2024 Treatment Administration Record for Resident 3 showed an order for wound vacuum therapy (treatment consisting of a specialized dressing and a machine that applies gentle suction to a wound to aid in healing) at 125 mmHg (millimeters of mercury; a unit of pressure). The order showed the dressing was to be changed every Tuesday, Thursday, and Saturday.</p> <p>Review of Resident 3's October 2024 progress notes showed the following: - On 10/09/2024 the resident admitted to the facility with an open surgical wound to their abdomen that required a wound vacuum dressing, which would be applied by the wound nurse the following day (10/10/2024). - On 10/11/2024 Staff D, Registered Nurse, documented the resident's wound vacuum dressing was removed and replaced with a wet-to-dry dressing. The note did not include why the ordered wound vacuum dressing was removed, when it would be reapplied, and/or if the medical provider was notified of the change in dressing type.-On 10/12/2024 Staff E, Licensed Practical Nurse, documented the resident was concerned about the removal of their wound vacuum dressing after eight hours when they were supposed to receive it for 24 hours.</p> <p>In an interview on 10/23/2024 at 2:31 PM Staff B, Director of Nursing, stated they were notified on 10/12/2024 that Resident 3 had concerns with the care of their abdominal wound and their wound vacuum dressing, so they came into the facility to investigate. Staff B stated staff caring for Resident 3 were not familiar with wound vacuum therapy and did not know the wound vacuum dressing and machine were to be applied continuously. Staff B stated staff had interpreted the dressing change days (Tuesday, Thursday, and Saturday) as the only days the wound vacuum was to be applied. Staff B stated they applied the resident's ordered wound vacuum treatment and educated the assigned nurse on the resident's wound vacuum therapy.</p> <p>In an interview on 12/10/2024 at 3:01 PM Staff A, Administrator, stated the facility had identified concerns with skin/wound care and had been providing staff with additional training. Documents related to staff wound education were requested.</p> <p>On 12/11/2024 the facility submitted a document titled, ONE-ON-ONE EDUCATION, dated 10/12/2024, which showed wound vacuum therapy education was provided to Staff F, Licensed Practical Nurse. No documentation was provided showing education on wound vacuum therapy for Staff D, Staff E, and/or additional staff responsible for wound care.</p> <p>Reference: (WAC) 388-97-1060 (1)</p>		