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	06/23/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies to include not reporting allegations of abuse to facility administration and the State Agency (SA) within the required timeframe, and completing thorough investigations, for 5 of 7 sampled residents (Resident 5, 38, 69, 117, and 131), reviewed for abuse/neglect. This failure placed the residents at risk for unidentified abuse/neglect. Findings included .Review of the facility's policies titled Preventing and Prohibiting Abuse and Abuse Reporting and Responsibilities of Covered Individuals, revised 09/13/2022, showed staff were to report alleged abuse to the facility administrator and SA immediately, but not later than two hours after the allegation was made if abuse was alleged and there was serious bodily injury. All other allegations were to be reported within 24 hours. Additionally, the facility would investigate the allegation and document evidence of the investigation.Review of a handwritten note by Staff G, Registered Nurse, dated 05/25/2026, showed that day Staff U and BB, Nursing Assistants (NA), had reported concerns with Staff CC, NA, to Staff G. The concerns included an allegation that Staff CC left the building at an unidentified time and did not provide care to multiple residents including Residents 5, 38, 69, 117, and 131 for an unidentified period. Additionally, it was alleged that Residents 5 and 117 were completely soaked and food debris from the prior day was under Resident 5. Per the note Resident 38 stated they fell and hurt their arm and reported the fall to Staff CC, which was not reported to the nurse. Review of the May and June 2026 facility incident logs showed no reported abuse allegations for Residents 5, 38, 69, 117, and/or 131 after 05/25/2026.In an interview on 06/23/2026 at 1:20 PM Staff B, Director of Nursing, stated the handwritten note by Staff G was placed under the door to their office, and they did not receive it until 05/26/2026. Staff B stated they followed up with Residents 5, 38, 69, 117, and 131 on 05/26/2026 and provided a handwritten note dated the same. The note did not address all the allegations listed by Staff G and did not include all the components of a thorough investigation. In an interview at 1:30 PM the same day, Staff A, Administrator, confirmed the abuse allegations in the handwritten note dated 05/25/2026 by Staff G were not investigated and reported as required. Reference WAC 388-97-0640(2)(a)(b)

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