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	02/07/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 46115 Based on interview and record review the facility failed to ensure the resident and/or the resident's representative was informed of and consented to a new medication for 2 of 3 sampled residents (Residents 54 and 90), reviewed for care planning. This failure disallowed the resident and/or the resident representative to make an informed decision regarding treatment and placed the resident at risk of diminished quality of life. Findings included Review of the facility policy titled, Resident Rights Notification of Changes of Condition dated July 2018, showed the facility would keep the resident and/or the resident representative informed of changes in health status. <Resident 90> According to the 11/26/2024 admission assessment Resident 90 had diagnoses including dementia, traumatic brain injury (TBI- brain damage caused by an external force), anxiety, and depression. Resident 90 had severe cognitive impairment with fluctuating inattention, disorganized thinking and no altered level of consciousness. Review of the 11/20/2024 hospital discharge medication list showed Resident 90 was to be administered Seroquel (antipsychotic, medication that affected the mind, emotions, and behaviors) 25 milligrams (mg) twice daily after discharge. Review of the 11/21/2024 facility order summary showed Resident 90 was to be administered Seroquel 25 mg twice daily for psychophysical visual disturbances, violent behavior, restlessness and agitation. (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

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 02/07/2025
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 11/21/2024 provider progress note showed Resident 90 was started on low dose Seroquel due to dementia with behavioral disturbances. The provider's treatment plan included continued use of Seroquel at 25 mg twice daily. The provider's note also included the following general recommendations for environmental treatment of agitation: frequent orientation with cues, staffing consistency, communicate with short clear statements and requests, maintain day/night structure especially with lighting, minimize noise/stimuli especially at night, ensure the resident had freedom of mobility within confines of medical treatment and plan, ensure pain was addressed related to resident may not be able to vocalize which may lead to agitation, and correct any sensory deficits by ensuring the resident wore hearing aides and/or glasses as needed. Review of the 11/20/2024 self-care performance deficit care plan showed Resident 90 required partial staff assistance to perform most activities of daily living including bed mobility and transfers. The 11/21/2024 psychotropic medication use care plan instructed staff to administer medications as ordered, monitor for adverse side effects, orient to reality and clarify mistaken beliefs. The 11/27/2024 delirium (sudden and severe state of confusion) care plan instructed staff to call Resident 90 by their preferred name, encourage resident family, friends, and care givers to be at bedside during episodes of confusion. The 11/30/2024 impaired cognitive function care plan instructed staff to administer medications as ordered, monitor for potential side effects and medication effectiveness. Review of the 11/25/2024 provider progress note showed Resident 90 sustained a fall, was transferred to the hospital for evaluation and returned with multiple recommendations for behaviors. The provider's note further showed the hospital increased Resident 90's Seroquel from 25mg to 50mg twice daily and advised continued increase by 25 mg twice daily to reduce hyperactivity and agitation until symptoms were controlled or max dose of 750 mg/ 24 hours was reached. The provider noted Resident 90 was currently on Seroquel 75mg daily with reported increased fatigue and Resident 90 was more sedated today. The hospital also recommended starting use of Ativan (antianxiety medication) orally for anxiety and in an injectable form for severe agitation and combativeness. Review of the 12/10/2024 provider progress note showed Resident 90 reported intermittent sleep issues. The provider's plan was to increase Seroquel to 100mg twice daily and continue the as needed Ativan. The provider note did not document any behaviors Resident 90 experienced, if any. Review of the 01/08/2025 provider progress note showed Resident 90 had increased behaviors and impulsiveness. Resident 90 had been making more sexual inappropriate gestures, comments and just inappropriateness. Resident 90 had another fall due to impulsiveness. The provider's plan was to increase the Seroquel to 100 mg three times daily due to impulsiveness which leads to falls, inappropriate behaviors, and sexual inappropriateness. The note further showed the as needed Ativan was not effective at managing impulsiveness, Resident 90 continued to be a fall risk, and the provider scheduled Ativan 1 mg twice daily routinely. Review of the 01/22/2025 provider discharge summary showed Resident 90 sustained repeated falls secondary to impulsiveness. Resident 90 discharged the facility with provider orders to administer Seroquel 100 mg three times daily, Ativan 1 mg routinely twice daily and Ativan 1 mg every four hours as needed for agitation. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of November 2024 through January 2025 nursing progress notes showed Resident 90 was alert to self, not redirectable, was short with staff, cursed at times, self-transferred often, unsteady gait, experienced frequent falls, was confused, and anxious at times. The notes further showed Resident 90 was administered as needed Ativan for restlessness and anxiousness, minimal vague documentation was found to show what non-medication interventions were attempted prior to medicating, intervention effectiveness and/or specific details of the behaviors Resident 90 experienced. No documentation was found to show Resident 90's resident representative was informed of the numerous Seroquel dose increases or Ativan medication changes. In an interview on 02/05/2025 at 2:28 PM, Resident 90's POA stated the facility informed them Resident 90 was being administered medication to help with behavioral outbursts, the facility did not ask for medication consent. Resident 90's POA further stated they felt Resident 90 was overmedicated. The POA explained Resident 90 admitted to the facility requiring one person transfer assist using a walker but upon discharge Resident 90 could barely hold their head up and it took three persons to stand pivot transfer Resident 90 out of the wheelchair. The POA further stated they were not informed of Resident 90's psychotropic medication changes and were not aware Resident 90 had as needed medication ordered for an injectable medication. The POA stated the facility had a major communication issue. In an interview on 02/06/2025 at 12:38 PM, Staff L, Social Service Director, explained psychotropic medication use required consent prior to administering medication. Staff L explained consent was obtained from the resident if they were cognitively intact and the resident representative if the resident had cognitive impairment. Staff L acknowledged Resident 90's POA should have been notified of all the medication changes. In an interview on 02/26/2025 at 3:58 PM, Staff N, Registered Nurse, explained when medication changes occurred, the resident and/or their resident representative would be notified, a progress note documented, and the resident placed on alert charting to monitor the resident's tolerance to the medication changes, potential adverse side effects or complications. In an interview on 02/07/2025 at 8:47 AM, Staff C, Resident Care Manager, explained the nurse was expected to inform a resident or the resident representative when medication changes occurred and document a progress note. Staff C acknowledged Resident 90's POA should have been notified of all of Resident 90's medication changes because a POA could not fully participate in a resident's care if they were not being informed. In an interview on 02/07/2025 at 9:11 AM, Staff B, Director of Nursing, explained a self-responsible resident would be informed of medication changes, a POA was notified of changes if a resident had cognitive impairment, and a progress note was to be documented. Staff B stated they expected staff to notify a resident and/or resident representative each time a medication was changed. Staff B acknowledged a resident and/or resident representative could not fully participate in their care if they were not informed of changes made. <Resident 54> (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 10/22/2024 quarterly assessment showed Resident 54 had diagnoses which included multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves and causes pain), chronic pancreatitis (a progressive disease when the pancreas is permanently damaged by inflammation and causes abdominal pain), and depression. The resident was cognitively intact and able to make their needs known. In an interview on 01/28/2025 at 11:42 AM, Resident 54's representative stated the resident had times of confusion and that's why they became the power of attorney (POA- a person that assists with making health care decisions for a person with cognitive impairments). The representative stated the resident's pain medication had been decreased and they were unaware. Review of the December 2024 Medication Administration Record (MAR) showed an order for Xtampa (a medication used to treat pain) to be decreased from 18 mg to 13.5 mg was entered on 12/06/2024. Review of the December 2024 nursing progress notes showed no notes the resident or their representative had been notified of the decrease of the Xtampa. In an interview on 02/05/2025 at 2:26 PM, Resident 54 stated they were not aware changes had been made to the Xtampa. During an interview on 02/06/2025 at 2:05 PM, Staff C, RCM, stated when a medication was changed, the resident was placed on alert charting and the resident, or their representative was notified, and a progress note was made. In an interview on 02/06/2025 at 2:57 PM, Staff B, DNS, stated the resident or their representative should have been notified of the change in medication and a progress note should have been made to reflect this. Staff B stated this was important because they may not have wanted the medication changed. Reference WAC 388-97-0300 (3)(a), -0260, -1020(4)(a-b) Refer to F758 for additional information. 47328

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46033 Based on observation, interview and record review, the facility failed to ensure a resident was evaluated to self-administer their medications for 1 of 5 sampled residents (Resident 74) reviewed for medication administration. This failure placed the resident at risk for missed medication doses or unintended health consequences. Findings included . The 11/04/2024 quarterly assessment documented Resident 74 had diagnoses that included bipolar disorder (episodes of manic highs and depressive lows), high blood pressure and cervical cancer. Resident 74 was cognitively intact and took antidepressant medication daily. On 01/29/2025 at 9:35 AM, Resident 74 was observed in their room seated on their bed with their overbed table in front of them. Several loose pills were on the table lying on a surgical mask. Included were four round white tablets, one pink round pill, one orange oblong tablet, one blue capsule, and one football shaped pill that was red on one side and white on the other. The pills were not in a medication cup. Additionally, there was a small medication cup on the table that contained applesauce. Resident 74 stated they were unsure what the pills were because they took many. They stated the nurse gave them applesauce so they could put their pills in the applesauce to help them go down easier. Resident 74 stated the reason nurses watched them take their pills was to make sure they did not choke on them or drop them on the floor and miss a dose, but nurses did not always stay and watch them. During an interview on 02/05/2025 at 1:10 PM, Staff F, Licensed Practical Nurse, acknowledged they gave medications to Resident 74 on 01/29/2025. They stated they did not remember leaving the resident's medications without watching the resident take them. Staff F stated they might have been called to another room. They stated it was important to watch the residents take their medications; this ensured the resident did not throw them away, drop them or that a different resident took them. During an interview on 02/06/2025 at 8:43 AM, Staff C, Resident Care Manager, stated nurses were expected to stay with the resident when they took their medications unless the resident had an assessment completed to self-administer their pills, and the provider signed off on it. The assessment did not include all medications, only certain ones, and the assessment was to be re-evaluated regularly and if there was a change in the resident's condition. Staff C stated Resident 74 had not been assessed for self-administration of their medications. Reference: WAC 388-97-0440

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 37544 Based on observation and interview, the facility failed to ensure the weekly menus and/or alternative menus were provided for 3 of 9 sampled residents (Residents 23, 36 and 48), reviewed for food. This failure denied residents the right to choose their meal preference, had the potential to negatively affect their nutritional needs and create a diminished quality of life. Findings included . <Resident 23> The 11/21/2024 quarterly assessment documented Resident 23 was cognitively intact to make decisions regarding their care. On 01/31/2025 at 9:20 AM, Resident 23 was observed lying in bed watching television. When asked how breakfast was, Resident 23 stated it was good, had sausage, but one time the meal looked like scraps, like someone had eaten and they were served the left-over plate. When asked if the facility handed out menus, Resident 23 stated the menus were not handed out, you had to ask for them and it usually took a couple days to get it, so by then you had missed a couple days of being able to choose what you wanted for the meal. In an interview on 02/03/2025 at 12:08 PM, Staff O, Nursing Assistant, when asked if the weekly menus were passed out to the residents, Staff O stated a stack of the menus and always available menu (alternative menu) were always kept at the nurses station and they were handed out if the residents asked for them. In an interview on 02/05/2025 at 9:06 AM, Staff W, Dietary Manager, was asked what the process was for handing out the menus to the residents. Staff W stated they did not know what the policy was, the menus were printed out and given to the nursing staff to keep at the desk to hand out. Staff W stated a resident received the regular meal if a menu had not been filled out and currently for the week of 02/03/2025 through 02/09/2025, 14 residents had turned in menus. At the time of the interview, 96 residents lived at the facility. <Resident 36> The 12/16/2024 quarterly assessment documented Resident 36 was cognitively intact to make decisions regarding their care. During an interview on 01/28/2025 at 10:26 AM, Resident 36 stated the food was not good, the food was too salty and was not edible. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/05/2025 at 9:43 AM, Staff EE, Nursing Assistant, was asked if the menus were handed out to the resident. Staff EE stated the menus were not handed out, but a stack of them was kept at the nurses' station and would be given to the residents when they asked. When asked if Resident 36 had ever received a menu, Staff EE stated they had never asked for one that they were aware of. On 02/05/2025 at 11:43 AM, Resident 36 was observed lying in bed. When asked if the staff ever handed out the weekly menus, Resident 36 stated, They have menus? I did not know that. They never tell us things like that, I don't recall ever seeing a menu. <Resident 48> The 01/09/2025 comprehensive assessment documented Resident 48 had diagnoses which included gastroesophageal reflux disease (GERD, a chronic digestive disease that occurred when stomach acid or bile flowed into the food pipe and irritated the lining and created an esophageal ulcer, a sore that developed in the lining of the esophagus) with bleeding. The resident was cognitively intact to make decisions regarding their care. In an observation and interview on 02/03/2025 at 9:48 AM, Resident 48 was lying in bed resting. They stated the meals served all tasted the same. The resident stated that staff did not offer them alternative food choices. Resident 48 stated they had never ordered from or been offered a menu to select their food choices. In an interview on 02/04/2025 at 12:00 PM, Staff W stated the kitchen generally received only 10-20 menus from all the residents living at the facility. Staff W stated the facility had been unsuccessful in developing a solution in the past. Staff W stated that it was important for residents to make their own food choices so they were able to meet their nutritional needs by eating the foods they preferred. Reference (WAC): 388-97-0900(1-4) 50027

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 40845 Based on interview and record review, the facility failed to provide information on services and charges for those services not covered under the facility's per diem rate for 2 of 3 sampled residents (Resident 91 and 14), reviewed for advanced beneficiary notices. This failure placed residents at risk of incurring unknown debt, financial hardship and a decreased quality of life. Findings included . Record review showed a 12/31/2024 Notice of Medicare Non-coverage letter (NOMNC) had been given to Resident 91, which showed Medicare payment for physical therapy, occupational therapy, and skilled nursing care would end on 01/02/2025. Additional record review showed Resident 91 had received a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), however, the written notice was incomplete and failed to inform Resident 91 of the costs for continuing to reside in the facility. A NOMNC dated 12/20/2024 was given to Resident 14, which showed Medicare payment for physical therapy, occupational therapy, and skilled nursing care would end on 12/23/2024. No documentation was found on the SNFABN or other written notification had been provided to the resident or POA, to inform them of the costs for continuing to reside in the facility after the Medicare payment stopped. In an interview on 02/07/2025 at 8:42 AM, Resident 14's power of attorney (POA, person who can make healthcare decisions when one is unable to) stated the facility called and informed them of the Medicare ending but did not discuss the daily cost for care. The POA further stated they had not received or signed any documents pertaining to this change. In a telephone interview on 02/07/2025 at 8:21 AM, Staff J, Business Office Manager, confirmed Resident 91 and Resident 14's SNF/ABN forms had no documentation of the facility's per diem rate, including the cost of daily services as required Reference (WAC) 388-97-0300(1)(e), (5), (6)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46115 Based on observation, interview, and record review, the facility failed to provide a homelike environment for 4 of 8 sampled residents (Residents 14, 39, 46 and 83), reviewed for environment. Specifically Resident 14 had a wheelchair that was not maintained in a sanitary manner, Resident 39 had a hole in their drywall in their room, and Residents 39, 46 and 83 had drywall that was in disrepair. This failure did not allow residents to enjoy a homelike environment. Findings included . <Drywall> Per the 10/13/2024 quarterly assessment, Resident 39 was severely cognitively impaired and unable to make their needs known. During an observation on 01/28/2025 at 2:38 PM, Resident 39 was sitting in their recliner. There were gauges out of the drywall behind their recliner and a hole that was approximately six inches long and an inch wide near the headboard toward the floor. Similar observations were made on 01/30/2025 at 9:24 AM, 01/31/2025 at 9:00 AM, 02/03/2025 at 10:21 AM and 02/04/2025 at 8:53 AM. Per the 12/04/2024 quarterly assessment, Resident 46 was cognitively intact and able to make their needs known. In an observation on 01/31/2025 at 9:07 AM, Resident 46 was lying in bed asleep. There were gauges out of their drywall on the wall to the right as you entered the room, on the wall the head of their bed was facing and to the left of their bed. Similar observations were made on 02/03/2025 at 9:34 AM, 02/04/2025 at 9:02 AM and 02/05/2025 at 11:00 AM. Per the 09/26/2024 quarterly assessment, Resident 83 had severe cognitive impairments and was not able to make their needs known. During an observation on 01/30/2025 at 1:28 PM, Resident 83 was lying in bed. There were gauges out of their drywall near the resident's window and headboard. Similar observations were made on 01/31/2025 at 9:05 AM and 02/04/2025 at 8:59 AM. In an interview on 02/07/2025 at 9:52 AM, with Staff K, Maintenance Director and Staff A, Administrator, Staff A stated a room with holes and drywall in disrepair was not a homelike environment. Staff K stated the staff needed to inform them when repairs were needed. <Unclean wheelchair> Per the 12/03/2024 admission assessment, Resident 14 was severely cognitively impaired and was not able to make their needs known. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/30/2025 at 11:34 AM, Resident 14 was sitting in their wheelchair in the hallway. The wheelchair was unclean with white debris on the wheelchair cushion and wheels and a brown substance on the legs of the wheelchair. Similar observations were made on 01/31/2025 at 10:39 AM and 2:06 PM, 02/03/2025 at 9:43 AM, 11:02 AM, and 11:49 AM, 02/04/2025 at 8:57 AM and 1:26 PM and 02/05/2024 at 1:40 PM. During an interview on 02/07/2025 at 12:31 PM, Staff A stated everyone was responsible for cleaning the wheelchairs and it was important for sanitation and dignity for the resident. Reference WAC 388-97-0880

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observations, interview and record review, the facility failed to thoroughly investigate potential allegations of abuse for 2 of 3 sampled residents (Residents 30 and 83), reviewed for abuse. The facility further failed to investigate falls for 2 of 6 sampled residents (Residents 4 and 14) reviewed for falls. Specifically, Resident 30 had a fall in which they alleged the call light had been removed by staff and the call light concern was not investigated and Resident 83 had a scabbed area on their arm allegedly caused by staff and the cause of the scab was not investigated to rule out abuse. This failure placed residents at risk of further potential abuse and diminished quality of life. Findings included . Review of the facility policy titled, Freedom from Abuse, Neglect and Exploitation revised November 2017, showed staff would conduct a thorough investigation of allegations. <Resident 83> In an interview and observation on 01/28/2025 at 2:49 PM, Resident 83 stated a week or two ago a nursing assistant was rough when they repositioned them and bumped their arm on the tray table. The resident stated they did not think staff liked them because they had to call for things because they could not get out of the bed. The resident was lying in bed and had a scab similar in size to a sunflower seed on their right forearm. Per the 09/26/2024 quarterly assessment, Resident 83 had diagnoses of stroke with hemiplegia (paralysis that affected one side of the body) and anxiety. Resident 83 had severe cognitive impairments and was not able to make their needs known. The 06/20/2024 care plan stated the resident had an activity of daily living performance deficit and required substantial to maximal assistance with repositioning in bed. Review of the 01/28/2025 facility investigation showed Resident 83 had an older scab, a light purple/pink discoloration and a dark blue bruise to their right forearm. According to the investigation, Resident 83 was cognitively intact, and never stated someone was rough with them. The resident used their forearms to scoot and adjust themselves which would explain the bruising and scabbed areas. There were no staff interviews included in the investigation. It was determined that no abuse or neglect occurred. During an interview on 02/06/2025 at 1:01 PM, Staff L, Social Service Director, stated they asked Resident 83 how they got the scab, and the resident stated they got it from a girl. Staff L stated the resident was more cognizant since medications changes had been made. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In an interview on 02/06/2025 at 3:46 PM, Staff B, Director of Nursing, was notified of the statement made by Resident 83 regarding the scab during the conversation with Staff L and was asked how they were able to rule out abuse. Staff B stated they were unaware of the comment about the scab. Staff B read the progress note that staff L had made regarding the allegation of abuse, and it did not include the part about the scab or the girl.

During an interview on 02/06/2025 at 3:59 PM, Staff B was present, Resident 83 stated they were flipped in bed, and did not think it was an accident. Resident 83 stated the person had been rough in flipping them from left to right. Resident 83 gave Staff B a description of what the person looked like.

In an interview on 02/06/2025 at 4:11 PM, Staff B stated the investigation needed to be continued and they were going to look at staffing to see if a staff member fit the description, they were given by Resident 83.

During an interview on 02/07/2025 at 11:33 AM, Staff B stated it was important to do a thorough investigation to keep the resident safe and the expectation was for staff that did interviews related to the investigation needed to present complete information.

<Resident 30>

According to the 01/21/2025 admission assessment, Resident 30 had diagnoses including stroke with weakness and/or paralysis affecting one side of the body. Resident 30 was cognitively intact and able to clearly verbalize their needs.

A 01/20/2025 nursing progress note documented Resident 30 was told they activated their call light too often and the call light was removed from their reach. Resident 30 stated they were looking for their call light and fell out of bed.

The 01/20/2025 facility incident report documented Resident 30's family member reported Resident 30's call light was moved out of their reach and they fell on [DATE]. The investigation contained three resident and three staff interviews that asked three simple questions 1) who were falls reported to, 2) should residents always have access to a call light, and 3) were staff allowed to take away a resident's call light. The incident report did not include staff or witness statements about the specific nature of Resident 30's allegation that their call light had been taken away due to excessive use. A 01/24/2025 investigation conclusion showed abuse and/or neglect was ruled out through interviews and determined Resident 30's call light was placed in a way that it had most likely fallen off the bed and was not taken away from the resident.

In an interview on 01/31/2025 at 4:06 PM, Resident 30 stated the nurse told them they pushed their call light too much and took the call light away. Resident 30 explained they fell out of bed recently because they were trying to reach their call light.

In an interview on 02/07/2025 at 9:28 AM, Staff C, Resident Care Manager, stated when an allegation of abuse was received, resident safety was the first priority, then they would notify Staff A, Administrator, because they were the abuse coordinator. Staff C was unsure how an allegation of abuse was investigated. Staff C acknowledged reports of rough care and staff taking resident call lights away were potential allegations of abuse that needed to be investigated as such.

(continued on next page)

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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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/07/2025 at 11:19 AM, Staff B stated when allegations of abuse were received, they were reported to the State Survey Agency and investigated. Staff B explained abuse and/or neglect was ruled out by conducting resident and staff interviews. Staff B acknowledged reports of rough care and staff taking resident call lights away were potential allegations of abuse that needed to be investigated as such. In an interview on 02/07/2025 at 12:03 PM, Staff A, Administrator, stated they expected staff to complete thorough investigations for allegations of abuse and/or neglect. <Resident 4> According to the 12/05/2024 quarterly assessment, Resident 4 had diagnoses including a right hip fracture, dementia and high blood pressure. The assessment further showed Resident 4 had not sustained a fall since the most recent admission but had undergone a surgery to repair the fracture. Resident 4 was cognitively intact and able to make their needs known. Review of the 12/02/2024 fall risk evaluation showed Resident 4 had a history of falls and was at risk for additional falls. Review of the 12/02/2024 risk for falls care plan showed Resident 4 was at risk for falls related to confusion, balance problems, and history of falls. An 11/10/2024 progress note documented the resident was found lying on their floor mat in their room. The resident was sent to the hospital for behaviors. On 02/05/2025 the investigation for the fall on 11/10/2024 was requested and Staff A sent an email stating there was no investigation as the resident was sent to the hospital. In an interview on 02/07/2025 at 9:36 AM, Staff B stated the fall on 11/10/2024 should have been logged on the required incident log and investigated. <Resident 14> According to the 12/03/2024 admission assessment, Resident 14 had diagnoses including atrial fibrillation (irregular heartbeat), dementia and repeated falls. The assessment further showed Resident 14 had a fall prior to admission. Resident 14 was cognitively impaired and was able to make their needs known. Review of the 11/27/2024 fall risk evaluation showed Resident 14 had a history of falls and was at risk for additional falls. Review of the 11/27/2024 risk for falls care plan, last updated 01/30/2025, showed Resident 14 was at risk for falls related to deconditioning, balance problems, incontinence, vision and hearing problems and medication use. A 01/16/2025 progress note documented Resident 14 was found in their room on the floor mat next to the bed. (continued on next page)

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	505496	A. Building B. Wing	02/07/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/2025 at 12:30 PM the investigation for the fall on 01/16/2025 was requested and Staff A stated there was no investigation as they were not notified of the fall. In an interview on 02/07/2025 at 9:34 AM, Staff B stated the fall on 01/16/2025 should have been logged on the incident log and investigated and it was important to put interventions in place to help prevent falls and monitor the effectiveness of the interventions. Reference: WAC 388-97-0640 (6)(a)(b) 47328

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	505496	A. Building B. Wing	02/07/2025

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 46115 Based on interview and record review, the facility failed to ensure a resident's medical record contained documentation of a hospital transfer and/or that the receiving hospital had received information of the resident's condition, for 1 of 4 sampled residents (Resident 4), reviewed for hospitalization . This failure placed the resident at risk for a delay in treatment and unmet care needs. Findings included . The 11/23/2024 discharge assessment documented Resident 4 had cognitive impairment and had diagnoses which included diabetes, depression and anxiety. A review of Resident 4's transfer form dated 11/23/2024 documented the resident needed a proxy to make decisions and was being transferred to the hospital to be evaluated for behaviors such as agitation and psychosis. The area on the form which asked if the report had been called in to the hospital and to whom was blank.There was no further documentation that described what, if any, information was relayed to the hospital at the time of the resident's transfer. During an interview on 02/07/2025 at 9:01 AM, Staff M, Licensed Practical Nurse, stated they were expected to call the hospital and give a report when a resident was transferred. In an interview on 02/07/2025 at 9:36 AM, Staff B, Director of Nursing, stated the receiving hospital should have been notified of Resident 4's condition and this was important because they needed to know the status of the resident as well as their history. Reference: WAC 388-97-0120(2)(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review the facility failed to ensure the Office of the State Long-Term Care Ombudsman (a person who acted as an advocate for residents that lived in long-term care) received written notification of a hospital transfer and/or discharges, as required for 5 of 6 sampled residents (Resident 4, 30, 46, 71 and 90), reviewed for hospitalization and discharge. This failure placed residents at risk of not having access to additional advocacy services from the State Long-Term Care Ombudsman, unmet needs, and diminished quality of life. Findings included . Review of the facility policy titled, Admission, Transfer and discharge date d July 2018, showed the notifications to the Ombudsman office would occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The policy further showed emergency transfer notifications would be sent to the Ombudsman at least on a monthly basis. <Resident 4> The 12/05/2025 discharge assessment documented Resident 4 was cognitively impaired and unable to make decisions regarding their care, and had diagnoses which included diabetes, anxiety and depression. An 11/23/2024 progress note showed the resident had increased behaviors and was sent to the hospital. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. <Resident 46> The 11/23/2024 discharge assessment documented Resident 46 was cognitively intact and able to make decisions regarding their care, and had diagnoses which included diabetes, anxiety and chronic obstructive pulmonary disease (a group of lung diseases that made it difficult to breathe). Review of Resident 46's record showed an 11/23/2024 nursing progress note which documented the resident had a fall and was unable to recall what happened and was sent to the hospital. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. In an interview on 02/06/2025 at 11:09 AM, Staff A, Administrator, stated they were unaware the Ombudsman needed to be notified for hospital discharges and stated that was not a practice they were currently doing. 50027 <Resident 71> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the 12/11/2024 admission assessment, Resident 71 had diagnoses which included renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids) and diabetes (a group of diseases that result in too much sugar in the blood). The resident was cognitively intact to make decisions regarding their care. Review of Resident 71's record showed a 12/27/2024 progress note documented the resident had experienced vomiting, fever and high blood sugar and was sent to the hospital. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. 47328 <Resident 90> According to the 01/14/2025 quarterly assessment, Resident 90 required moderate staff assistance to complete most activities of daily living including transfers and ambulation. Resident 90 had severe cognitive impairment. Review of nursing progress notes showed Resident 90 was transferred to the hospital on the evening of 11/22/2024 for evaluation after a fall occurred, returning to the facility the same day, and again on the evening of 11/23/2024 returning to the facility the following day. No documentation was found to show the Ombudsman was notified of the hospital transfers, as required. <Resident 30> According to the 01/21/2025 admission assessment, Resident 30 admitted to the facility on [DATE] with diagnoses including stroke with weakness and/or paralysis affecting one side of the body. Resident 30 was cognitively intact and able to clearly verbalize their needs. Review of the 01/18/2025 provider progress note showed Resident 30 sustained a fall around 1:00 AM with redness and swelling noted to the right side of the head. Resident 30 reported 5 out of 10 pain (on a scale of 0-10, 0 being no pain and 10 being worst pain experienced). Resident 30 was transferred to the hospital for additional testing. Review of the January 2025 nursing progress notes showed Resident 30 was found on the floor on 01/18/2025 at 1:15 AM. The provider was notified of Resident 30's fall that morning, the provider assessed Resident 30, and Resident 30 was transported to the hospital for further evaluation. No documentation was found to show the Ombudsman was notified of the hospital transfers, as required. In an interview on 02/04/2025 at 2:32 PM, the Ombudsman stated the facility was not notifying them of hospital transfers or discharges, as required. The Ombudsman further stated the facility had only notified them when they presented a resident with a 30-day notice of eviction. In an interview on 02/05/2025 at 4:03 PM, Staff Q, Licensed Practical Nurse, stated they were unsure how the Ombudsman was notified of hospital transfers and/or discharges. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/06/2025 at 9:48 AM, Staff C, Resident Care Manager, stated they were unsure how the Ombudsman was notified of hospital transfers and/or discharges. In an interview on 02/06/2025 at 12:06 PM, Staff L, Social Service Director, stated the facility only informed the Ombudsman if and/or when the facility gave a resident a 30-day eviction notice. Staff L further stated Ombudsman transfer and/or discharge notifications were new to the facility and it was rarely done. In an interview on 02/06/2025 at 1:50 PM, Staff A, Administrator, acknowledged the facility had only been notifying the Ombudsman when a facility-initiated discharge occurred. Reference WAC 388-97-0120 (2)(a-d) -0140 (1)(a)(b)(c)(i-iii) Refer to F625 for additional information.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review the facility failed to provide a bed-hold notice, a notice that informed the resident of their right to pay the facility to hold their room/bed while they were hospitalized , to the resident and/or their representative at the time of discharge or within 24 hours of transfer to the hospital for 5 of 5 sampled residents (Resident 4, 30, 46, 71 and 90), reviewed for hospitalization . This failure placed residents at risk for a lack of knowledge regarding the right to a bed-hold while they were hospitalized . Findings included <Resident 4> The 12/05/2025 discharge assessment documented Resident 24 was cognitively impaired and unable to make decisions regarding their care, and had diagnoses which included diabetes, anxiety and depression. An 11/23/2024 progress note showed the resident had increased behaviors and was sent to the hospital. Additional record review found no documentation that showed the resident or their representative had been provided a bed-hold notice. <Resident 46> The 11/23/2024 discharge assessment documented Resident 46 was cognitively intact and able to make decisions regarding their care, and had diagnoses which included diabetes, anxiety and chronic obstructive pulmonary disease (a group of lung diseases that made it difficult to breathe). Review of Resident 46's record showed an 11/23/2024 nursing progress note which documented the resident had a fall and was unable to recall what happened and was sent to the hospital. An 11/25/2024 progress note showed Resident 46 was called about a bed hold, two days after their discharge. In an interview on 02/06/2025 at 11:09 AM, Staff A, Administrator, stated bed holds were offered when residents discharged to the hospital. Staff A stated admission staff notified the resident or their representative within the 24-hour time frame. Staff A stated it was important to offer the bed hold because the resident had a right to return to their room. 47328 <Resident 90> According to the 01/14/2025 quarterly assessment, Resident 90 required moderate staff assistance to complete most activities of daily living including transfers and ambulation. Resident 90 had severe cognitive impairment. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing progress notes showed Resident 90 was transferred to the hospital on the evening of 11/22/2024 for evaluation after a fall occurred, returning to the facility the same day, and again on the evening of 11/23/2024 returning the following day. No documentation was found to show a bed hold was explained or offered to the resident's representative, as required. <Resident 30> According to the 01/21/2025 admission assessment, Resident 30 admitted to the facility on [DATE] with diagnoses including stroke with weakness and/or paralysis affecting one side of the body. Resident 30 was cognitively intact and able to clearly verbalize their needs. Review of the January 2025 nursing progress notes showed Resident 30 was found on the floor on 01/18/2025 at 1:15 AM. The resident was sent to the hospital for further evaluation. No documentation was found to show a bed hold was explained or offered, as required. 50027 <Resident 71> Per the 12/11/2024 admission assessment, Resident 71 had diagnoses which included renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids) and diabetes (a group of diseases that result in too much sugar in the blood). The resident was cognitively intact to make decisions regarding their care. Review of Resident 71's record showed a 12/27/2024 progress note documented the resident had experienced vomiting, fever and high blood sugar. Resident 71 was assessed and sent to the hospital for evaluation. No documentation was found to show a bed hold was explained or offered, as required. In an interview on 02/07/2025 at 9:49 AM, Staff U, Resident Care Manager, reviewed Resident 71's medical record. Staff U confirmed there was no documentation a bed-hold was offered, as required. Staff U further stated a bed-hold should have been offered and this was important because residents had a choice if they wanted to keep their bed once they were discharged to a hospital. Reference WAC 388-97-0120(4) Refer to F623 for additional information.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 47328 Based on interview and record review the facility failed to routinely encode and transmit resident assessment data to the Centers for Medicare & Medicaid Services (CMS) within the required timeframe for 4 of 11 sampled residents (Residents 7, 12, 86 and 90), reviewed for timeliness in encoding and transmission of Minimum Data Set (MDS - an assessment tool). This failure affected federal health information data gathering and placed residents at risk for inaccurate monitoring of the residents' progress over time, untimely comprehensive review of residents' health data/information, and a diminished quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.11 revised October 2024, showed the RAI consisted of three basic components: the MDS, the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three component of the RAI yielded information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. Nursing homes were required to submit Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source. All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. When the transmission file was received by iQIES, the system performed a series of validation edits to evaluate whether or not the data submitted met the required standards. MDS records were verified to ensure clinical responses were within valid ranges and were consistent, dates were reasonable, and records were in the proper order with regard to records that were previously accepted by iQIES for the same resident. The provider was notified of the results of this evaluation by error and warning messages on a Final Validation Report. <Resident 86> According to the 08/25/2024 discharge assessment, Resident 86 discharged from the facility on 08/25/2024 with a return not anticipated. The assessment further showed it was signed as completed on 08/29/2024. <Resident 7> According to the 10/25/2024 discharge assessment, Resident 7 discharged from the facility on 10/25/2024 with a return not anticipated. The assessment further showed it was signed as completed on 10/29/2024. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 12> According to the 12/19/2024 quarterly assessment, Resident 12 was able to perform most activities of daily living independently. The assessment further showed the assessment observation end date was 12/19/2024 and was signed as completed on 02/04/2025. Review of the 12/20/2024 discharge assessment showed Resident 12 discharged from the facility on 12/20/2024 with a return not anticipated. <Resident 90> According to the 01/14/2025 quarterly assessment, Resident 90 required moderate assistance of staff to complete most activities of daily living. The assessment further showed the observation end date was 01/14/2025 and was signed as completed on 02/01/2025. Review of the 02/04/2025 MDS validation report showed 79 files were submitted with 49 error messages, 23 out of 79 accepted filed were submitted late, 14 days beyond the assessment completion date. The report included Resident 86's 08/25/2024, Resident 7's 10/25/2024, and Resident 12's 12/20/2024 discharge assessments and Resident 12's 12/19/2024 and Resident 90's 01/14/2025 quarterly assessments as accepted late submissions. In an interview on 02/05/2025 at 12:09 PM, Staff E, MDS Director, explained MDSs needed to be submitted to CMS and/or the health insurance providers within 14 days of the assessment reference or observation end date. Staff E acknowledged the facility was late on submitting MDS assessments as required. In an interview on 02/05/2025 at 12:29 PM, Staff B, Director of Nursing, acknowledged the facility had submitted MDS assessments late but they should be submitted per the required RAI timelines. In an interview on 02/05/2025 at 12:37 PM, Staff A, Administrator, stated they expected staff to submit MDS's per the required RAI timelines. Reference WAC 388-97-1000 (4)(b), (5)(b) Refer to F641 for additional information.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to routinely timely and accurately complete Minimum Data Sets (MDS - an assessment tool) for 9 of 11 sampled residents (Residents 3, 12, 14, 39, 82, 83, 90, 109, and 510), reviewed for timely MDS assessment completion. This failure affected federal health information data gathering and placed residents at risk for inaccurate monitoring of the residents' progress over time, untimely comprehensive review of residents' health data/information, and a diminished quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.11 revised October 2024, showed the RAI consisted of three basic components: the Minimum Data Set (MDS), the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. The MDS contained data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. A RAI (MDS, CAA process, and utilization guidelines) assessment must be completed initially and periodically for any resident residing in the facility. The assessment reference date (ARD) was the end of the resident observation period and served as the reference point for determining the care and services captured on the MDS assessment. <Resident 3> According to the 09/28/2024 quarterly assessment, Resident 3 required supervision up to partial assistance to complete most activities of daily living (ADL). Review of Resident 3's 12/29/2024 quarterly assessment showed the assessment observation end date was 12/29/2024. The assessment further showed it was not signed as completed as of 02/05/2025. <Resident 12> According to the 12/19/2024 quarterly assessment, Resident 12 was able to perform most ADLs independently. The assessment further showed the observation end date was 12/19/2024 and was signed as completed on 02/04/2025. Review of the 12/20/2024 discharge assessment showed Resident 12's discharge date was 12/20/2024. The assessment further showed it was signed as completed on 02/04/2025. <Resident 39> According to the 10/13/2024 quarterly assessment, Resident 39 required substantial up to dependent staff assistance to perform most ADLs. The assessment further showed the observation end date was 10/13/2024 and was signed as completed on 10/25/2024. (continued on next page)

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 02/07/2025

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 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident 39's 01/01/2025 annual assessment showed the observation end date was 01/01/2025 and the assessment was not signed as completed as of 02/06/2025.

<Resident 82>

According to the 09/26/2024 quarterly assessment, Resident 82 required supervision up to partial assistance to complete most ADLs. The assessment further showed the observation end date was 09/26/2024 and was signed as completed on 10/14/2024.

Review of Resident 82's 12/27/2024 quarterly assessment showed the observation end date was 12/27/2024 and the assessment was signed as completed on 02/05/2025.

Review of Resident 82's discharge assessment showed Resident 82 discharged from the facility on 01/24/2025 with a return not anticipated. The assessment further showed it was signed as completed on 02/05/2025.

<Resident 83>

According to the 09/26/2024 quarterly assessment, Resident 83 was dependent on staff assistance to perform most ADLs. The assessment further showed the observation end date was 09/26/2024 and was signed as completed on 10/14/2024.

Review of Resident 83's 12/27/2024 quarterly assessment showed the observation end date was 12/27/2024 and was signed as completed on 02/05/2025.

<Resident 510>

According to the 01/09/2025 admission assessment, Resident 510 admitted to the facility on [DATE] and discharged on [DATE] with a return not anticipated. The assessment further showed it was not signed as completed as of 02/06/2025.

Review of an against medical advice (AMA) release form showed Resident 510 discharged from the facility AMA on 01/09/2025.

During an interview and record review on 02/05/2025 at 12:09 PM, Staff E, MDS Director, explained the process for completing MDS assessments included reviewing data in resident records to complete the MDS by the ARD. Staff E acknowledged the facility was behind on completing MDS assessments, as required. Staff E provided a list of MDS assessments that were currently late. Review of the MDS in progress list from 11/01/2024 through 02/04/2025 showed 76 MDS's were still in progress beyond the ARD.

37544

<Resident 14>

(continued on next page)

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 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641	

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

According to the 12/03/2024 admission MDS assessment, section B showed Resident 14 was able to make themselves understood and understood others, however this conflicted with the information under section C which documented Resident 14 was not interviewed due to being severely cognitively impaired and rarely or never understood. The assessment further documented Resident 14 had diagnoses which included non-Alzheimer's dementia.

Review of the nursing progress notes from 11/27/2024 through 02/04/2025 showed Resident 14 was cognitively impaired, had dementia, was alert to self only, but able to make needs known at times.

<Resident 109>

According to the 12/26/2024 admission MDS assessment, section B showed Resident 109 was sometimes able to make themselves understood and usually understood others, however this conflicted with the information under section C which documented Resident 109 was not interviewed due to being severely cognitively impaired and rarely or never understood.

<Resident 90>

According to the 11/26/2024 admission assessment, Resident 90 had diagnoses including dementia. Section B of the assessment documented Resident 90 was able to make themselves understood and understood others, however this conflicted with the information under section C which documented Resident 90 was not interviewed due to being severely cognitively impaired and rarely or never understood. The assessment further showed the observation end date was 11/26/2024 and was signed as completed on 12/04/2024.

Review of Resident 90's quarterly assessment showed the observation end date was 01/14/2025 and was signed as completed on 02/01/2025.

Review of Resident 90's 01/24/2025 discharge assessment showed Resident 90 discharged from the facility on 01/24/2025 with a return not anticipated. The assessment further showed it was not signed as completed as of 02/03/2025.

In an interview on 02/04/2025 at 3:18 PM, Staff B, Director of Nursing, was asked about the conflicting information in sections B and C of Resident 14, 109, and 90's MDS assessments. Staff B stated a resident was marked as being able to make themselves understood and understanding others when they have the ability to make their needs known whether in a verbal or non-verbal manner and staff understood them. Staff B explained to be marked rarely or never understood meant the resident could not respond verbally, in writing or by using any other method. Staff B acknowledged Resident 14, 109 and 90's assessments did not accurately reflect the resident's status as of the ARD and should have.

In a follow-up interview on 02/05/2025 at 12:29 PM, Staff B acknowledged the facility was behind on completing MDS assessments, as required.

In an interview on 02/05/2025 at 12:37 PM, Staff A, Administrator, acknowledged the facility was behind on completing MDS assessments, as required. Staff A stated they expected staff to complete MDS assessments per the required time frames.

Reference (WAC) 388-97-1000(b)(d)

(continued on next page)

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	02/07/2025

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F640 for additional information.

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NAME OF PROVIDER OR SUPPLIER Avalon Care Center at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) [an assessment used to identify people referred to nursing facilities with mental illness, intellectual disabilities, or related conditions], was completed after an exempted hospital stay for 1 of 5 sampled residents (Resident 46), reviewed for PASARR services. This failure placed the resident at risk for inappropriate placement, and/or not receiving timely and necessary services to meet mental health care needs. Findings included . Per the [DATE] quarterly assessment, Resident 64 admitted to the facility in [DATE] from the hospital and had diagnoses which included depression and anxiety. Review of Resident 46's record showed a level I PASARR was completed prior to admission on [DATE] by the hospital, which showed a level II PASARR (a more in-depth screening, to identify whether nursing home services were needed, and if specialized mental health services were required), was needed, due to meeting the guidelines for an exempted hospital stay (meaning the resident was admitted to the facility directly from a hospital after receiving acute inpatient care, and the expected stay at the facility was 30 days or less). Further record review showed Resident 46 did not discharge from the facility within 30 days or less as expected and was currently still a resident at the facility. A new PASARR was not completed until [DATE], 40 days after the exempted 30-day stay had expired. In an interview on [DATE] at 1:11 PM, Staff L, Social Service Director, stated the PASARR should have been completed timely and this was important so recommendations could be implemented to care for the resident's mental health. Reference: WAC [DATE] (1)(2)(a-c)

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to prepare a discharge summary that included all the required components, complete a final summary of the resident's status upon discharge, complete a discharge plan of care with all the required components, and convey discharge information to the provider continuing care for 2 of 6 sampled residents (Residents 90 and 110), reviewed for discharge. This failure placed residents at risk of unsafe discharges, unmet care needs and diminished quality of life. Findings included . <Resident 90> According to the 01/14/2025 quarterly assessment, Resident 90 required moderate staff assistance to complete most activities of daily living including transfers and ambulation. Resident 90 had severe cognitive impairment. Review of the 01/24/2025 discharge summary showed Resident 90 discharged from the facility to the community. Review of the January 2025 nursing progress notes showed Resident 90 was scheduled to discharge on 01/28/2025. The last progress note in Resident 90's record was on 01/23/2025 at 11:34 PM and showed Resident 90 was in bed with their eyes closed with staff at their bedside. No documentation was found to show when Resident 90 discharged the facility, what condition they were in upon discharge, who Resident 90 left the facility with or what documentation was reviewed or whom it was reviewed with. Review of discharges from 11/05/2024 through 02/05/2025 showed Resident 90 discharged from the facility on 01/24/2025. In an interview on 02/05/2025 at 2:28 PM, Resident 90's power of attorney (POA- person who can make healthcare decisions when a person was unable to) stated the facility informed them Resident 90 was being administered medication to help with behavioral outbursts. Resident 90's POA further stated they felt Resident 90 was overmedicated. The POA explained Resident 90 admitted to the facility requiring one person transfer assist using a walker but upon discharge Resident 90 could barely hold their head up and it took three persons to stand pivot transfer Resident 90 out of the wheelchair. <Resident 110> According to the 01/26/2025 discharge assessment, Resident 110 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including psychoactive (drug or substance that affected how the brain worked and caused changes in mood, awareness, thoughts, feelings, and behaviors) substance abuse, anxiety, and schizophrenia (mental illness that affected a person's thoughts, feelings, and actions). The assessment further showed Resident 110 was independent with making decisions regarding daily life, had fluctuating inattention and disorganized thinking. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avalon Care Center at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/24/2025 hospital transition of care orders showed Resident 110 used amphetamines (methamphetamine or meth, powerful addictive central nervous system stimulant) and discontinuation of use was recommended. Hospital progress notes were included that showed Resident 110 was recently hospitalized with osteomyelitis (bone infection) in both feet but left the hospital AGAINST MEDICAL ADVICE. The notes further showed concerns of underlying psychotic (mental health condition where a person loses touch with reality) illness contributed to Resident 110's recent AGAINST MEDICAL ADVICE discharge and possibly interfering with their medical decision-making capacity. Review of the January 2025 nursing progress notes showed Resident 110 admitted to the facility on [DATE] at approximately 3:30 PM. On 01/26/2025 at 8:00 PM, staff were unable to locate Resident 110 to administer their bedtime medication. At 8:15 PM, an elopement was called. At 8:20 PM, the building was searched inside and out, staff were unable to locate Resident 110. At 8:30 PM, law enforcement was notified of the missing resident. At 9:08 PM, a nursing assistant reported Resident 110 was upset about not having enough snacks earlier in the day and ate their lunch in their room. On 01/27/2025 at 7:11 AM, Resident 110 was located at a local hospital, the resident left the facility and was drinking alcohol and did not know how to get back to the facility. No documentation was found to show what occurred with Resident 110 after the facility located them at the local hospital. Review of discharges from 11/05/2024 through 02/05/2025 showed Resident 110 discharged from the facility on 01/26/2025. In an interview on 02/05/2025 at 4:03 PM, Staff Q, Licensed Practical Nurse, explained social services was responsible for discharge planning but the cart nurse reviewed the discharg packet with a resident. Staff Q further stated a progress note should be written that included the resident's status at time of discharge, who they discharged with, medications sent, what documentation was reviewed and sent upon discharge. In an interview on 02/06/2025 at 9:48 AM, Staff C, Resident Care Manager, explained when a resident discharged the nurse reviewed any discharge paperwork with the resident, gathered medications to send upon discharge, and documented a detailed progress note that included what time a resident discharged , who they left with, any education provided, medications/belongings taken, what condition the resident discharged in, and any concerns voiced, if any. Staff C reviewed Resident 110's medical record. Staff C acknowledged there was no facility follow up documented after Resident 110 was located at a local hospital the day after they eloped from the facility. In an interview on 02/06/2025 at 12:06 PM, Staff L, Social Service Director, explained the discharge process. Staff L stated a discharge summary needed to be completed when a resident discharged with copies of the care plan, medication list, consults, testing performed, therapy notes, and any other pertinent information sent to the receiving provider. Staff L stated they were unsure what discharge documentation was required by nursing upon discharge. (continued on next page)

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/06/2025 at 1:31 PM, Staff A, Administrator, stated Resident 110 was part of the facility's new bridge bed program. Staff A explained the bridge bed program were facility beds paid by a local hospital for persons with placement issues and part of the bridge bed program requirement was that the resident only visited the hospital who paid for the bed, or the resident would be disqualified from the bridge bed program. Staff A further stated after Resident 110 eloped from the facility they were located at the incorrect hospital, so they were disqualified from the bridge bed program. Staff A explained Resident 110's discharge was considered discontinuation of care which they have not had to deal with before. Staff A was informed no discharge documentation was found in Resident 110's medical record. Staff A reviewed Resident 110's medical record. Staff A acknowledged the bridge bed program was new and the program needed tweaking to work out the kinks. Reference WAC 388-97-0080 (7)(a)(b) Refer to F689 and F758 for additional information.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37544 Based on interview and record review, the facility failed to ensure a staff member was available to provide assistance to a resident while they were at an appointment with a provider outside the facility and failed to provide bathing as care planned for 2 of 4 sampled residents (Resident 109 and 54) reviewed for activities of daily living. Findings included . <Resident 109> The 12/26/2024 admission assessment documented Resident 109 was severely cognitively impaired, was dependent on nursing staff for activities of daily living (ADLS) such as toileting and had diagnoses which included medically complex conditions. Review of the State Agency's reporting database showed a concern had been reported which documented Resident 109 was wheelchair bound and had conditions that required a caregiver to be with them while attending appointments with providers outside the facility. The report further documented on 01/06/2025, Resident 109 had been dropped off at an appointment without a caregiver and while at the appointment, the resident needed assistance to the bathroom. Review of the ADL care plan documented Resident 109 required two nursing staff to assist with using the bathroom, and the resident required the use of a mechanical lift for transferring (such as from the wheelchair to the toilet). A progress note on 01/06/2025 at 4:37 PM documented the facility's transportation driver had been sent to pick up Resident 109 from the appointment with the outside provider due to the resident exhibiting behaviors and screaming. In an interview on 02/03/2025 at 12:15 PM, Staff O, Nursing Assistant, stated the facility sometimes scheduled a nursing assistant to go to appointments with a resident and reached out to family also to see if they could attend with the resident. In an interview on 02/05/2025 at 1:37 PM, Staff B, Director of Nursing, confirmed Resident 109 should have had a staff member and/or family member with them at the appointment due to needing assistance for ADLS. <Resident 54> In an interview on 01/28/2025 at 10:53 AM, Resident 54's representative stated the resident was not getting bathed as care planned and was told they had no one to bathe them or the facility had not hired anyone to do bathing. According to the 10/22/2024 quarterly assessment, Resident 54 was cognitively intact and needed assistance from staff for activities of daily living, such as bathing. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the 03/23/2022 care plan, Resident 54 was to be showered/bathed one to two times per week. The resident was to be offered a bed bath if they refused to be showered. Review of the task report bathing documentation from 09/2024 to 01/29/2025 showed the following: September 2024: September 25th was marked non applicable; no other bathing was documented. October 2024: October 8th and 18th documented activity did not occur, October 10th and 23rd documented resident refused, and October 30th was marked non applicable. November 2024: November 7th resident received a bed bath, November 14th and 19th documented resident refused, no other bathing was documented. December 2024: December 11th resident received a bed bath, November 18th documented resident refused, no other bathing was documented. January 2025: January 22nd and 29th resident received a bed bath, January 8th documented resident refused, no other bathing was documented. In an interview on 02/06/2025 at 1:49 PM, Staff N, Registered Nurse, stated showers were given twice weekly unless the resident had another preference. Staff N stated if residents continued to refuse their showers management would be notified to see what interventions could be implemented for the resident to receive bathing. During an interview on 02/06/2025 at 2:57 PM, Staff B, Director of Nursing, stated bathing was provided one to two times per week per the resident's preference. Staff B stated they were aware that Resident 54 had refused bathing and stated they preferred bed baths in the evening. Review of the care plan showed no preference for Resident 54's desire to have been given bed baths in the evening. Reference: WAC 388-97-1060 (2)(c) 46115

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

37544

Based on observation, interview and record review, the facility failed to consistently monitor and provide bowel care timely for 7 of 7 sampled residents (Residents 23, 36, 54, 62, 4, 39, and 46) reviewed for constipation. This failure placed the residents at risk for medical complications and unmet care needs.

Findings included .

<Resident 23>

The 11/21/2024 quarterly assessment documented Resident 23 was cognitively intact to make decisions regarding their care and was dependent on nursing staff for activities of daily living (ADLS) such as toileting.

On 01/28/2025 at 3:51 PM, Resident 23 was observed lying in bed watching television. During the conversation with the resident, they stated they took pain medications and had trouble with constipation at times.

Review of the Order Summary Report from 11/15/2024 through 02/04/2025 documented on 11/15/2024, the physician had ordered a laxative (Senna tablets) to be given on an as needed basis if the resident had not had a bowel movement (BM) in 48 hours, and if the resident still had not had a BM 24 hours after receiving the Senna, an additional laxative (Miralax) was to be given.

Review of the bowel records from 01/04/2025 through 02/01/2025 documented Resident 23 had not had a BM on the following dates as follows:

- 01/06/2026 through 01/12/2025, a period of seven days

- 01/16/2025 through 01/20/2025, a period of five days, and

- 01/28/2025 through 01/31/2025, a period of four days.

Review of the January 2025 Medication Administration Record (MAR) showed the Senna and Miralax had not been administered as ordered during the above time frames, and no documentation was found in Resident 23's record that stated the reason for the omissions.

In an interview on 02/03/2025 at 9:33 AM, Staff R, Licensed Practical Nurse, stated bowel medication was usually given if a resident had not had a BM in 72 hours, unless the physician had ordered something different. After discussion and review of Resident 23's record, Staff R confirmed that bowel medication should have been administered on the dates identified, and if the medication had been offered and refused it should have been documented.

<Resident 36>

(continued on next page)

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 02/07/2025
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/16/2024 quarterly assessment documented Resident 36 was cognitively intact to make decisions regarding their care and was dependent on nursing staff for ADLS such as toileting Review of the Order Summary Report from 01/01/2025 through 02/06/2025 documented on 11/06/2023, the physician had prescribed both Senna tablets and Miralax to be administered on an as needed basis for constipation (no time frame was specified). Review of the bowel records from 01/05/2025 through 02/03/2025 documented Resident 36 had not had a BM from 01/18/2025 through 01/22/2025, a period of five days. Review of the January 2025 MAR showed neither the as needed Senna or Miralax had been administered or offered to Resident 36 during the above time frame, and no documentation was found in the resident's record that stated the reason for the omission. In an interview on 02/04/2025 at 11:03 AM, Staff N, Registered Nurse, stated the facility process was to give bowel medication after 72 hours unless the physician had ordered something different for the resident. In an interview on 02/05/2025 at 1:10 PM, Staff B, Director of Nursing (DNS), stated the expectation was residents would be offered bowel care medication after 48 hours of not having a BM unless the resident's provider had ordered differently. After review of Resident 23 and Resident 36's records, Staff B confirmed bowel care medication should have been offered. <Resident 4> The 12/05/2024 quarterly assessment documented Resident 4 was cognitively intact to make decisions regarding their care and was dependent on nursing staff for ADLS such as toileting. Review of the 10/11/2022 care plan documented the resident was at risk for constipation and had interventions which instructed nursing to monitor BMs and implement interventions as ordered. Review of the January 2025 MAR documented on 12/02/2024, the physician had ordered laxatives (Miralax and Senna) to be given as needed. Review of the bowel records from 01/05/2025 through 02/02/2025, documented Resident 4 had not had a BM on the following dates: - 01/22/2025 through 01/26/2025, except for a small BM on 01/26/2025, a period of five days - 01/28/2025 through 01/30/2025, a period of three days Additional review of the MARS for January 2025 and February 2025, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 48's record that stated the reason for the omissions. <Resident 54> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the 10/22/2024 quarterly assessment, Resident 54 was cognitively intact, able to make decisions regarding their cares, and needed assistance from staff for ADLS, such as toileting. Review of the 03/23/2022 care plan documented the resident was at risk for constipation secondary to reduced mobility and use of pain medication and had interventions which instructed nursing staff to monitor BMs and implement interventions as ordered. Review of the January 2025 MAR documented on 11/06/2023 the physician had ordered laxatives Miralax and Senna to be given as needed. On 01/18/2024, the physician had ordered the following laxatives: Lactulose every two hours as needed times three and if no BM give Milk of Magnesia daily as needed and if no BM give a Bisacodyl suppository. Review of the bowel records from 01/01/2025 through 01/31/2025 documented Resident 54 had not had a BM on the following dates: -01/01/2025 through 01/08/2025, a period of eight days -01/20/2025 through 01/24/2025, except a small BM on 01/21/2025 a period of five days -01/25/2025 through 01/28/2025, except for a small BM on 01/27/2025 and 01/28/2025, a period of four days Additional review of the MARS for January 2025 documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 54's record that stated the reason for the omissions. <Resident 39> Per the 10/13/2024 quarterly assessment, Resident 39 was cognitively impaired, unable to make decisions regarding their cares, and needed assistance from staff for ADLS, such as toileting. Review of the 10/12/2018 care plan documented the resident was at risk for constipation and had interventions which instructed nursing staff to monitor BMs and implement interventions as ordered. Review of the January 2025 MAR documented on 09/29/2023 the physician had ordered the following laxatives: Lactulose every two hours times three doses and if no BM give Milk of Magnesia as needed and if no BM after six hours, give a Bisacodyl suppository. On 11/06/2023 the physician had ordered Miralax and Senna as needed. Review of the bowel records from 12/29/2024 through 01/29/2025 documented Resident 39 had not had a BM on the following dates: -12/31/2024 through 01/05/2025, except for a small BM on 01/01/2025 and 01/03/2025, a period of six days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/08/2025 through 01/11/2025, except a small BM on 01/08/2025 and 01/09/2025, a period of three days -01/27/2025 through 01/29/2025, a period of three days Additional review of the MARS for January 2025 documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 54's record that stated the reason for the omissions. <Resident 46> Per the 12/04/2024 quarterly assessment, Resident 46 was cognitively impaired, able to make decisions regarding their cares, and needed assistance from staff for ADLS, such as toileting. Review of Resident 46's record showed no care plan for constipation. Review of the January 2025 MAR documented on 11/17/2024 the physician had ordered the following laxatives: Senna as needed for no BM after 48 hours and Miralax for no BM after the Senna was administered. Review of the bowel records from 01/01/2025 through 01/30/2025 documented Resident 46 had not had a BM on the following dates: -01/04/2025 through 01/08/2025, a period of five days -01/11/2025 through 01/13/2025, a period of three days -01/15/2025 through 01/17/2025, a period of three days -01/22/2025 through 01/24/2025, a period of three days Additional review of the MARS for January 2025 documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 54's record that stated the reason for the omissions. In an interview on 02/06/2025 at 10:16 AM, Staff N, Registered Nurse, stated the bowel protocol was initiated on day three of no BM. Staff N stated the bowel protocol should have been initiated for the above time frames. At 1:49 PM that same day, Staff N stated a small bowel movement did not count. During an interview on 02/07/2025 at 9:36 AM, Staff B, DNS, stated bowel medications should have been administered as ordered and this was important to prevent a bowel obstruction. <Resident 62> Per the 12/15/2024 quarterly assessment, Resident 62 had diagnoses including kidney disease (damage to the kidneys in which they lose function) and diabetes. The resident was cognitively intact to make decisions regarding their care. The resident was always incontinent of bowels and had an indwelling catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the December 2024 MAR documented on 12/09/2024, the physician ordered a laxative, Senna, to be offered as needed for constipation and given for no BM after 48 hours. An additional laxative, Miralax, was to be offered as needed for constipation and given for no BM 24 hours after Senna. In an observation and interview on 01/28/2025 at 3:18 PM, Resident 62 was laying in bed, eating snacks, and watching television. The resident stated that they have had issues with constipation and the medications were variable in relief. Review of the bowel records from 01/01/2025 through 01/30/2025, showed Resident 62 had no BM's from 01/01/2025 through 01/05/2025 (5 days), 01/08/2025 through 01/10/2025 (3 days) and 01/26/2025 through 01/28/2025 (3 days). Additional review of the MARS for January 2025 documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 62's record that stated the reason for the omissions. In an interview on 02/06/2025 at 3:06 PM, Staff T, Licensed Practical Nurse, confirmed Resident 62 did not have a BM on the above dates and the bowel protocol should have been followed. Reference (WAC): 388-97-1060(1) 46115 50027

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46115 Based on observation, interview, and record review, the facility failed to identify a pressure ulcer and implement treatement timely for the development of a wound for 1 of 2 sampled residents (Resident 54), reviewed for pressure ulcers. This placed the resident at risk for unidentified wounds, worsening pressure ulcers and delayed wound healing. Findings included . Review of the facility policy titled, Quality of Care Skin Integrity dated 08/2018, showed the facility staff would monitor residents skin conditions and be alert to potential changes in the residents' skin condition and identified changes would be reported. The website nih.gov - in which nih refers to national institute of health- with regard to the revised National Pressure Ulcer Advisory Panel pressure injury staging system showed a pressure injury is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion [flow of fluid or blood to cells and tissues], comorbid condition [medical conditions that coexist and affect health and treatment], and condition of the soft tissue Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema [redness that does not disappear when pressure is applied to the area] . Stage 2 pressure injury: partial thickness [involving epidermis and/or dermis] loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister Stage 3 pressure injury: full thickness [wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper] skin loss, in which adipose (fat) or granulation [new connective tissue] tissue is visible in the ulcer Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue], muscle, tendon [strong cords of tissue that connect muscle to bones], ligament [bands that connect bones and joints], cartilage [tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears], or bone in the ulcer . unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead skin or tissue that can appear in a wound] or eschar [dead tissue that forms over healthy skin and eventually falls off] . Deep Tissue Pressure Injury [DTPI]: intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood filled blister It is essential that the intended staging or classification system be used for each type of injury to ensure appropriate treatment. In an interview on 01/28/2025 at 10:53 AM, Resident 54 stated they had a sore on their left heel and had acquired it at the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/2025 at 11:42 AM, Resident 54's representative stated the resident had a huge, rotting sore on their heel that appeared two weeks ago. The representative stated the resident had been dealing with the wound off and on for a year. The representative stated the area on the heel was black and the staff had been circling the area with a marker. The representative stated a wound consultation was requested and nobody followed up on it. Per the 10/22/2024 quarterly assessment, Resident 54 was admitted with diagnoses which included diabetes, Multiple Sclerosis (a disease in which the immune system breaks down the protective covering of the nerves, the resulting nerve damage disrupts communication between the brain and body) and depression. The resident was cognitively intact, able to make their needs known and was dependent for bed mobility. The assessment showed the resident was at risk for pressure ulcers and did not currently have a pressure ulcer. Review of the 03/23/2022 care plan showed Resident 54 had potential for skin impairment related to immobility. On 04/01/2022 the care plan was revised and showed Resident 54 had a pressure ulcer to their left heel related to immobility. The care plan was revised on 09/22/2023 to state the resident had a potential for pressure ulcer development/pressure ulcer to left heel related to immobility. The care plan was again revised on 01/28/2025 to state the resident had a pressure ulcer to their left heel related to immobility. The facility placed interventions which included: 03/23/2022 encourage good nutrition and hydration to promote healthier skin and keep skin clean and dry 02/06/2023 air mattress 04/01/2022 administer medications and treatments as ordered 09/22/2023 keep heels floated while in bed and staff to encourage resident to comply with repositioning 09/29/2023 left foot boot to keep the heel offloading 01/28/2025 betadine to left heel twice daily, United Wound Healing referral 02/03/2025 avoid exposure to temperature extremes: heating pads, hot water bottles, heat lamps, hot/cold solutions and soaks, sunburn, ice packs, avoid mechanical trauma, carefully dry between toes but do not apply lotion between toes, determine and treat cause: poor fitting shoes, poor blood sugar control, pressure area, infection, ensure appropriate protective devices are applied to affected areas, monitor blood sugar levels, monitor pressure areas for color, sensation, temperature, monitor/document wound size, document progress in wound healing on an ongoing basis, notify MD as indicated, monitor and report signs of infection, position resident off the affected area, change position every two hours and as needed, refer to foot care nurse/podiatrist, weekly treatment documentation to include measurements. A 07/19/2024 Skin and Nutrition Review documented the left heel wound was healed. A 10/09/2024 Skin and Nutrition Review stated to discontinue the nutritional drink as the heel wound was resolved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 01/21/2025 Weekly Skin check documented there were no skin concerns. A 01/27/2025 Weekly Skin check documented Resident 54 had an unstageable pressure ulcer that measured five centimeters by three centimeters (cm) to their left heel. A 01/30/2025 Skin and Wound evaluation documented Resident 54 had a stage four pressure ulcer to their left heel that had been present for one to three months and was facility acquired. The wound measured 7.9 cm by 5 cm and had a depth of 2.1 cm. A 02/04/2025 progress note by United Wound Healing, stated the wound was a stage four pressure ulcer. In an interview on 02/06/2025 at 1:43 PM, Staff GG, Nursing Assistant, stated new skin issues were reported to the nurse. When asked if the resident had any wounds, Staff GG stated they had not been at the facility for two days but when last there the resident did not have any wounds. During an interview on 02/06/2025 at 1:49 PM, Staff N, Registered Nurse, stated skin checks were completed weekly by the nurse. Staff N stated when a wound was identified, the provider and resident representative were notified, a treatment order was obtained, alert charting, and measurements of the wound were taken. Staff N stated Resident 54 had a wound on their heel, and was unsure when it developed, they added they started working at the facility in September and thought it was acting up again but would have to check. In an interview on 02/06/2025 at 2:05 PM, Staff C, Resident Care Manager, stated Resident 54's representative brought the pressure ulcer to their attention on 01/27/2025 and they placed a referral that day to United Wound Healing. Staff C stated a treatment for the pressure ulcer was implemented on 01/28/2024. Reference: WAC 388-97-1060 (3)(b)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 46115 Based on interview and record review, the facility failed to ensure a physician ordered foot care referral for a podiatrist was followed for 1 of 2 sampled residents (Resident 54), reviewed for wound care. This failure placed the resident at risk for skin impairment, discomfort, and a diminished quality of life. Findings included . Per the 10/22/2024 quarterly assessment, Resident 54 had diagnoses which included diabetes, Multiple Sclerosis (a disease in which the immune system breaks down the protective covering of the nerves and the resulting nerve damage disrupts communication between the brain and the body), and depression. The resident was cognitively intact and able to make their needs known. In an interview on 01/28/2025 at 10:53 AM, Resident 54's representative stated the resident's toenails were extremely bad and had curled over their toes. The representative stated they were told the facility could not get a podiatrist to come into the facility. The representative stated the nurse practitioner did the resident's toenails on 01/27/2025. Review of a 09/30/2024 provider progress note showed Resident 54 had long/thick toenails and needed a podiatry referral to evaluate and treat the resident for hypertrophic toenails (thickened, overgrown toenails that can cause pain, discomfort, and difficulty with footwear). In an interview on 02/06/2025 at 1:49 PM, Staff N, Registered Nurse, stated nursing staff processed provider orders. Staff N stated if a resident had a podiatry referral, depending on their insurance, the resident would have an appointment arranged with an outside provider. During an interview on 02/07/2025 at 7:46 AM, Staff C, Resident Care Manager, was asked why the order in September for podiatry was not followed and they stated the facility was trying to get a podiatrist to come into the facility to see the residents and was unsure if residents could be sent out to see the podiatrist. In an interview on 02/07/2025 at 7:48 AM, Staff L, Social Service Director, stated the facility was getting a list of residents who needed podiatry because they were trying to get a podiatrist to come into the facility. Staff L stated they could send the residents out to see the podiatrist. During an interview on 02/07/2025 at 7:53 AM, Resident 54 stated they did not leave the facility for appointments because it was too hard for them to do so. In an interview on 02/07/2025 at 11:05 AM, Staff B, Director of Nursing, was asked if the resident's nail care could have occurred earlier than January and they stated staff could have asked the provider sooner to assist with nail care and nursing could have attempted nail care as well. Staff B stated nail care was important to prevent infections. At the time of the survey exit Resident 54 had still not been seen by a podiatrist. Reference WAC 388-97 -1060 (3)(j)(viii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46115 Based on interview and record review the facility failed to ensure falls were investigated, safety interventions implemented, and residents monitored after falls were sustained for 4 of 6 sampled residents (Residents 4, 14, 30,and 90), reviewed for falls. In addition, the facility failed to assess residents for risks associated with a substance use disorder (SUD) and their ability to safely smoke for 2 of 3 sampled resident (Resident 46 and 110), reviewed. This failure placed residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Fall Prevention Program dated February 2020, showed residents would be evaluated for fall risk upon admission, quarterly, and as needed. The policy showed all residents would be considered at risk for falls upon admission and general precautions implemented. A fall risk decision tree would be utilized to identify potential interventions specific for each resident with identified interventions implemented and added to the resident's person-centered care plan. The policy further showed each fall would be thoroughly investigated and implementation of interventions monitored by nursing staff on a routine basis. Review of the facility policy titled, Behavioral Health Services revised September 2018, showed the facility provided necessary behavioral health care and services to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being. The facility utilized assessment, care planning, implementation and plan revision to meet the individual resident's behavioral health needs. The policy further showed non-pharmacological interventions were to be used as clinically indicated and if a resident required more intensive behavioral health services, the facility would document reasonable attempts to provide for and/or arrange for such services. Review of the facility policy titled, Physical Environment Smoke Free Facility revised March 2019, showed the facility was designated smoke free within the building with the smoke-free area extending outward from the building the distance designated by State and local laws. The policy included the utilization of electronic cigarettes, pipes, cigars, tobacco products and/or vaping equipment as smoking materials. Residents, visitors, contractors, and staff were not permitted to smoke on the property at any time. <SUBSTANCE USE DISORDER> <Resident 110> According to the 01/26/2025 discharge assessment, Resident 110 admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including psychoactive (drug or substance that affected how the brain worked and caused changes in mood, awareness, thoughts, feelings, and behaviors) substance abuse, anxiety, and schizophrenia (mental illness that affects a person's thoughts, feelings, and actions). The assessment further showed Resident 110 was independent with making decisions regarding daily life, had fluctuating inattention and disorganized thinking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 01/20/2025 hospital social worker mental health assessment showed Resident 110 previously eloped from the hospital and returned with progression of their bone infection. Resident 110 reported methamphetamine (meth/amphetamine, powerful addictive central nervous system stimulant) and alcohol usage, for over [AGE] years. Resident 110 disclosed their substances of choice were meth and beer, consuming 1 ball and two cans of beer per day. Resident 110 explained they used drugs and/or alcohol to calm down when they were mad or angry. Review of the 01/24/2025 hospital transition of care orders showed Resident 110 used amphetamines and discontinuation of use was recommended. Hospital progress notes were included that showed Resident 110 was recently hospitalized with osteomyelitis (bone infection) in both feet but left the hospital AGAINST MEDICAL ADVICE. The notes further showed concerns of underlying psychotic illness contributed to Resident 110's recent AGAINST MEDICAL ADVICE discharge and possibly interfering with their medical decision-making capacity. Review of the 01/25/2025 nursing admission assessment showed Resident 110 drank one beer per day and smoked meth, 1 ball per day sometimes. Review of the 01/25/2025 wander risk assessment showed Resident 110 could move without assistance, did not have a history of wandering, had no diagnoses of cognitive impairment, and had no reported episodes of wandering in the past six months. The assessment identified Resident 110 as low risk for wandering or elopement, contrary to the hospital information. Review of the 01/26/2025 care plan showed Resident 110 required partial assistance to complete most of their activities of daily living and used a wheelchair for mobility. The care plan showed no documentation Resident 110 had a substance use disorder, no interventions were found to address potential risks associated with a SUD. Review of January 2025 nursing progress notes showed Resident 110 admitted to the facility on [DATE] at approximately 3:30 PM. On 01/26/2025 at 8:00 PM, staff were unable to locate Resident 110 to administer their bedtime medication. At 8:15 PM, an elopement was called. At 8:20 PM, the building was searched inside and out, staff were unable to locate Resident 110. At 8:30 PM, law enforcement was notified of the missing resident. On 01/27/2025 at 7:11 AM, Resident 110 was located at a local hospital, the resident left the facility and was drinking alcohol and did not know how to get back to the facility. No documentation was found to show what occurred with Resident 110 after the facility located them at the local hospital. In an interview on 02/05/2025 at 3:30 PM, Staff P, Nursing Assistant, was unsure what staff were trained to recognize signs and/or symptoms of substance use, how the facility dealt with potential emergencies related to substance use or how the facility assessed for potential risks associated with substance use such as a resident leaving the facility without staff knowledge. Staff P further stated the facility cared for residents with SUDs but had not seen it care planned. In an interview on 02/05/2025 at 3:44 PM, Staff Q, Licensed Practical Nurse (LPN), stated the facility used a wander risk assessment to assess for elopement risk. Staff Q further stated the facility monitored resident behaviors for potential signs and/or symptoms of substance use. Staff Q reviewed Resident 110's medical record. Staff Q acknowledged Resident 110 had a SUD with a history of smoking a ball of meth a day but no care plan was implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/2025 at 4:08 PM, Staff C, Resident Care Manager (RCM), stated the facility determined if a resident had a SUD history by reviewing the medical records. Staff C was unsure how residents with SUD were assessed for potential risks associated with substance use. Staff C acknowledged the facility cared for residents with history of SUDs. Staff C reviewed Resident 110's medical record. Staff C acknowledged Resident 110 had psychoactive substance abuse listed as a diagnoses but did not have a care plan or interventions implemented. Staff C further stated Resident 110 eloped from the facility, drank alcohol, was unable to get back to the facility, and ended up in the hospital. In an interview on 02/06/2025 at 11:29 AM, Staff L, Social Service Director (SSD), explained a SUD disorder could be use of alcohol, marijuana, or an illicit substance that alters a person's life. Staff L explained resident records were reviewed to attempt to determine if a resident had a history of SUD and a social service psychosocial evaluation with questions on SUD was to be completed. Staff L reviewed Resident 110's medical record. Staff L acknowledged Resident 110 had a SUD diagnoses but a social service psychosocial evaluation with questions on SUD was not completed and Resident 110 did not have a SUD care plan with interventions implemented. In an interview on 02/26/2025 at 1:17 PM, Staff B, Director of Nursing, was unsure if the facility had an assessment to assess for risks associated with SUD. Staff B further stated the facility maintained resident safety by monitoring resident behaviors and implementing care plan interventions. Staff B reviewed Resident 110's medical record. Staff B stated Resident 110 admitted on the weekend and social services did not have time to complete their assessment because Resident 110 eloped prior. In an interview on 02/06/2025 at 1:31 PM, Staff A, Administrator, stated a SUD would fall under the facility's behavioral health program policy, the facility did not have a policy specifically for dealing or managing SUDs. <Resident 46> The 12/04/2024 quarterly assessment showed Resident 46 had diagnoses including anxiety and depression, was cognitively intact and able to make their needs known. Review of the 08/20/2024 hospital history and physical showed the resident had an alcohol level of less than ten and a urine toxicology which was positive for cannabinoids. The intake stated the resident used marijuana seven days per week. Review of the 08/25/2024 nursing admission assessment showed Resident 46 used marijuana. Review of the 08/28/2024 care plan showed showed no documentation Resident 46 had a SUD, no interventions were found to address potential risks associated with a SUD. In an interview on 02/05/2025 at 3:44 PM, Staff Q reviewed Resident 46's medical record. Staff Q acknowledged Resident 46 had a history of SUD, but no care plan was implemented. In an interview on 02/05/2025 at 4:08 PM, Staff C reviewed Resident 46's medical record. Staff C stated Resident 46 did not have a SUD listed as a diagnosis. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/06/2025 at 10:32 AM, Staff C stated Resident 46 was asked on 01/18/2025 if they had smoked marijuana and they stated yes. Staff C stated when asked on 01/19/2025 if they had smoked marijuana because they had glossed eyes and slurred speech, the resident stated they were not going to smoke it earlier but was shaking their head yes and that they would hide it outside. Staff C stated there was no assessment to assess for marijuana use, the nurses used their clinical judgment, notified providers and placed the resident on alert charting for continued monitoring. When asked if counseling was offered for drug use, Staff C stated they were unsure, but they had meetings for those dealing with alcohol abuse. In an interview on 02/06/2025 at 11:29 AM, Staff L acknowledged Resident 46 voiced marijuana use but when asked Resident 46 would deny a SUD. Staff L reviewed Resident 46's medical record. Staff L acknowledged Resident 46 did not have a SUD care plan or interventions implemented. <SMOKING> During the entrance conference meeting on 01/28/2025 at 8:42 AM, with Staff A, when asked if the facility had residents who smoked, Staff A stated the facility was a non-smoking facility but they had smokers and residents who smoked and they had to be 25 feet away from the building and there were no designated smoking times, since residents had to be independent to smoke. The 12/04/2024 quarterly assessment showed Resident 46 had diagnoses including stroke, respiratory failure and high blood pressure, was cognitively intact and able to make their needs known. They required assistance for transfers and wheelchair mobility. An 08/28/2024 care plan documented Resident 46 was a smoker or used an electronic cigarette/vape device and would not smoke without supervision. An 08/28/2024 smoking screen documented the resident smoked one to two times per day, had visual deficits, was unable to demonstrate a safe technique for extinguishing matches/lighter and dispose of ashes safely, unable to retrieve a cigarette if it were dropped, unable to use a fire extinguisher to extinguish a fire as a result of smoking and used medications that could cause drowsiness. The resident stated they stopped smoking one month prior. A 11/23/2024 hospital note documented the resident had reported smoking cigarettes and that they had never used smokeless tobacco. A 01/22/2025 provider note documented the resident was seen related to their falls and their smoking regimen was discussed as they were going outside to smoke. The resident informed the provider they had vaped. The provider advised cessation; however, the resident was not going to quit smoking. Resident 46 was not observed smoking during the survey. In an interview on 02/06/2025 at 10:16 AM, Staff N, Registered Nurse, stated smoking supplies were kept in the nurse's carts and they thought smoking assessments were completed quarterly and with a significant change in condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/06/2025 at 10:32 AM, Staff C when asked who smoked on the unit, stated Resident 46 did, but had not seen them go outside to smoke since they had moved to the unit. Staff C stated the resident smoked on 01/28/2025 when they were on the east side of the facility. Staff C stated the resident should have had another smoking assessment when they found out they were smoking again. Staff C stated it was brought up in a progress note on 01/18/2025 that the resident had smoked. Staff C added the smoking assessment was important to ensure the resident was capable of smoking without injuring themselves, capable of disposing the cigarette in a safe area and that they could hold the cigarette safely. Staff C stated the facility was non-smoking, but the residents had a right to smoke. Staff C stated the smoking area was on the facility grounds, in the corner to the right of the parking lot when you exited the front door. Staff C stated they should have a fire blanket and there were fire extinguishers on all hallways. Staff C stated they have not provided supervision for any of the smokers because they have never had anyone that needed it. When Staff C was asked to look at Resident 46's smoking assessment from 08/28/2024, they stated the resident needed supervision and was unsafe to smoke independently. In an interview on 02/06/2025 at 11:09 AM, Staff A stated the facility did not have a fire blanket because they were a non-smoking facility and to get a blanket would say they were a smoking facility. Staff A stated they did not have a designated smoking area, and the residents went 25 feet away from the front entrance of the building. Staff A stated when Resident 46 arrived at the facility they smoked cigarettes, and they educated them on doing so. Staff A stated the resident was unsafe to smoke independently. Staff A stated the facility did not provide supervision for smokers and they could not stop them from going outside to smoke. Staff A stated they offered cessation and needed to make sure the residents were safe. Staff A stated if the resident could not get themselves outside to smoke, they were not allowed to smoke. Staff A stated Resident 46 should have had a new smoking assessment after they returned from the hospital in November. During an interview on 02/06/2025 at 12:36 AM, the Fire Marshall stated the facility needed to define their policy that they were a non-smoking facility and that smoking was not allowed on the property or if they allowed smoking on the property the area that the residents were allowed to smoke had to be defined and must be 25 feet away from entrances, exits, windows, and ventilation intakes. The facility also needed to have things ready such as a fire blanket, fire extinguisher and a place to dispose of cigarettes. <FALLS> <Resident 4> According to the 12/05/2024 quarterly assessment, Resident 4 had diagnoses including a right hip fracture, dementia and high blood pressure. The assessment further showed Resident 4 had not sustained a fall since the most recent admission but had undergone a surgery to repair the fracture. Resident 4 was cognitively intact and able to make their needs known. The 11/23/2024 discharge assessment showed Resident 4 had two or more non injury falls, two or more falls with minor injury and one fall with major injury. Review of the 12/02/2024 fall risk evaluation showed Resident 4 had a history of falls and was at risk for additional falls. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 12/02/2024 risk for falls care plan showed Resident 4 slid from their wheelchair on 05/07/2024, slid in the bathroom on 05/28/2024, rolled out of bed on 06/28/2024, slid from edge of bed onto floor on 09/09/2024, found on floor on 10/23/2024, had an unwitnessed fall on 11/07/2024, res found on floor on 11/08/2024 and had three unwitnessed falls on 11/23/2024. The care plan had multiple fall interventions in place to include placing a fall mat on the floor which was initiated on 10/10/2022. Per the 10/23/2024 incident investigation, Resident 4 had a fall when they had attempted to transfer from their bed to their wheelchair without assistance. The intervention was to place an impact mat at bedside to reduce injury with falls. Resident 4 hit their head and received a hematoma (a localized collection of blood that pools in an area). The resident was supposed to have a fall mat in place as care planned on 10/10/2022, but that had not occurred. In an interview on 02/07/2025 at 9:36 AM, Staff B stated the impact mat was probably the same as the floor mat, same concept. Staff B stated Resident 4 should have had a fall mat in place prior to the fall on 10/23/2024 to help prevent injury. <Resident 14> According to the 12/03/2024 admission assessment, Resident 14 had diagnoses including atrial fibrillation (irregular heartbeat), dementia and repeated falls. The assessment further showed Resident 46 had a fall prior to admission. Resident 14 was cognitively impaired and was able to make their needs known. Review of the 11/27/2024 fall risk evaluation showed Resident 14 had a history of falls and was at risk for additional falls. Review of the 11/27/2024 risk for falls care plan, last updated 01/30/2025, showed Resident 14 had unwitnessed falls on 12/08/2024, 12/09/2024, 12/10/2024, 01/04/2025 and 01/07/2025. The care plan had multiple fall interventions in place which included the bed against the wall, a floor mat in front of the bed, and for the resident not to be left alone in their room in their wheelchair. In an observation on 01/30/2025 at 1:53 PM, Resident 14 was lying in bed asleep. There was a fall mat on the resident's right side of the bed. The bed was not up against the wall and there was no fall mat on the left side of the bed. During an observation on 02/03/2025 at 09:43 AM, Resident 14 was sitting in their wheelchair in their room alone. In an observation at 11:29 AM, that same day, the resident was brought to their room by a nursing assistant and was alone in their wheelchair in their room. At 11:49 AM, the resident was lying in bed with a fall mat on their right side, the bed was not up against the wall and there was no fall mat on the left side of the bed. In an observation on 02/03/2025 at 2:05 PM, the resident was lying in bed and there was no fall mat on the floor. At 2:11 PM, Resident 14 was sitting on the side of the bed yelling they needed to go to the bathroom. At 2:14 PM, the resident attempted to stand and sat back down on the bed. At 2:17 PM, the resident sat up and then laid back down. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/04/2025 at 8:57 AM, Resident 14 was lying in bed and had no fall mat on the floor. At 1:26 PM, the resident was sitting in their wheelchair in their room alone. In an observation on 02/07/2025 at 8:08 AM, the resident was sitting in their wheelchair in their room alone. During an interview on 02/07/2025 at 12:09 PM, Staff GG, Nursing Assistant, stated fall risk interventions were found on the care plan. Staff GG stated Resident 14 was a fall risk and had fall mats and interventions needed to be implemented to minimize the risk of injury. In an interview on 02/07/2025 at 12:12 PM, Staff B stated the expectation was for nursing staff to follow the care planned interventions and it was important to prevent future falls and to keep the resident safe. 47328 <Resident 90> According to the 01/14/2025 quarterly assessment, Resident 90 had severe cognitive impairment and sustained two or more falls while in the facility. The assessment further showed Resident 90 required moderate staff assistance to complete most activities of daily living including transfers and ambulation. Review of 11/15/2024 hospital notes showed Resident 90 had progressive dementia with frequent falls including a recent ground level fall that resulted in a neck fracture. Review of the 11/20/2024 fall risk evaluation showed Resident 90 had a history of multiple falls in the past 3 months. Review of the 11/20/2024 care plan showed Resident 90 was at risk for falls and instructed staff to anticipate resident needs, ensure the call light was within reach, maintain a safe environment, ensure proper footwear was worn, and keep commonly used items within reach. The care plan further showed Resident 90 sustained 9 falls, two falls on 11/22/2024, and additional falls on 11/23/2024, 11/25/2024, 12/26/2024, 01/07/2025, 01/11/2025, 01/15/2025, and on 01/22/2025. Review of November 2024 nursing progress notes showed on 11/18/2024 the facility transported Resident 90 from the hospital to the facility for admission. During transport Resident 90 repeatedly attempted to get out of their wheelchair (WC) while the vehicle was in motion requiring the driver to pull over three times. Once at the facility, staff attempted to admit Resident 90, but the resident was too impulsive to participate in the admission process with several attempts to self-transfer out of the WC, bed, and off the toilet with redirection only successful for a short time. Resident 90 was unaware of their safety needs and required constant supervision as they would transfer in less than a minute and seemingly required one on one supervision as Resident 90's safety would be compromised if left alone at any time. Resident 90 was transported back to the hospital for more adequate and safer placement at a later time. Resident 90 returned to the facility for admission on 11/20/2024. The notes further showed Resident 90 sustained three falls prior to having one-on-one supervision initiated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident 90's fall incident reports showed the following: -11/22/2025 unwitnessed fall near the nurses' station. A 12/15/2024 summary showed a new intervention to provide activities that promote exercise and strength building when possible. Review of the care plan showed this intervention was initiated on 11/20/2024, four days prior to the fall. -11/23/2024 unwitnessed fall self-transferring out of bed. A 12/15/2025 summary showed a new intervention of physical therapy consult for strengthening was added. Review of provider orders showed physical therapy was ordered on 11/20/2024, three days prior to the fall. -11/23/2024 (second fall that day) staff overheard resident having an unwitnessed fall. A 12/15/2024 summary showed a new intervention of 1:1 care. -11/24/2024 fall during staff assist. A 12/15/2024 summary showed a new intervention of safety reminders to resident. Review of the care plan showed this intervention was initated 01/31/2025, seven days after Resident 90 discharged the facility. -11/25/2025 fall while working with therapy. A 12/15/2024 summary showed a new intervention of medication review. Review of the record showed no documentation Resident 90's record was reviewed for high-risk medications. -12/07/2024 no incident report provided. Nursing progress notes showed Resident 90 had a near miss fall in the bathroom. -12/26/2024 fall during staff assisted toileting. A 01/26/2025 summary showed a new intervention of using a mechanical lift for transfers as needed was initiated. -01/07/2025 witnessed fall near bed. A 01/30/2025 summary showed a new intervention of activities that minimize falls while providing diversion and distraction was implemented. -01/11/2025 fall during staff assist. A 01/31/2025 summary showed an intervention of reviewing past falls to determine root cause and removing potential fall causes was implemented. No specific intervention was identified. -01/15/2025 fall during staff assist. A 01/31/2025 summary showed a new intervention of right side of bed placed against the wall with fall mat on floor in front of bed. -01/22/2025 witnessed fall during resident transport to the bathroom. A 01/31/2025 summary showed an intervention of reminding resident to lock wheelchair brakes was implemented. In an interview on 02/05/2025 at 2:28 PM, Resident 90's power of attorney (POA, person who can make healthcare decisions) stated Resident 90 had numerous falls at home, including a fall that resulted in a neck fracture prior to facility placement. The POA further stated Resident 90 sustained a few falls prior to the facility implementing 1:1 monitoring. The POA was concerned Resident 90 continued to fall even after 1:1 monitoring was implemented and wondered how that was possible. <Resident 30> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/21/2025 admission assessment, Resident 30 admitted to the facility on [DATE] with diagnoses including stroke with weakness and/or paralysis affecting one side of the body. The assessment further showed Resident 30 sustained a fall in the month prior to admission and a fracture related to a fall in the past six months. Resident 30 was cognitively intact and able to clearly verbalize their needs. Review of the 01/06/2025 history and physical showed Resident 30 had an unwitnessed fall on 12/22/2024 with head injury and loss of consciousness. On 12/23/2024 Resident 30 had a craniotomy (surgical procedure where part of the skull was removed to access the brain) performed to remove a hematoma (collection of blood that pools outside of a blood vessel). Review of the 01/15/2025 fall risk evaluation showed Resident 30 had a history of falls and was at risk for additional falls. Review of the 01/15/2024 risk for falls care plan showed Resident 30 had an unwitnessed fall on 01/18/2025 and instructed staff to anticipate resident needs, clip the call light to the bed within reach, ensure commonly used items were within reach and resident wore appropriate footwear. Review of the 01/18/2025 facility fall incident report showed Resident 30 had an unwitnessed fall reaching for their call light at 1:15 AM. Upon assessment a bump was noted to the back of Resident 30's head and neurological (neuro, series of simple tests done to assess how the brain and nervous system was functioning) assessment was initiated. Review of the attached neurological flow sheet instructed staff to obtain vital signs and complete neuro checks every 15 minutes x one hour, then every 30 minutes x one hour, then every hour x four hours, then every four hours x 24 hours. The form documented vital signs, and neuro checks every 15 min x the first hour through 2:15 AM, then starting again at 6:00 AM, nearly four hours later, not as instructed on the form. Review of the January 2025 nursing progress notes showed Resident 30 had an unwitnessed fall on 01/18/2025 at 1:15 AM. No documentation of vital signs or neuro assessment was found between 2:15 AM and 6:00 AM. At 7:04 AM, Resident 30 was medicated for a headache. At 1:44 PM, Resident 30's family member visited and was unhappy with cares. The provider was notified of Resident 30's fall that morning, the provider assessed Resident 30, and Resident 30 was transported to the hospital for further evaluation related to hitting their head after having a recent craniotomy. Review of 01/18/2025 provider progress note showed Resident 30 sustained a fall around 1:00 AM with redness and swelling noted to the right side of the head. Resident 30 reported 5 out of 10 pain (on a scale of 0-10, 0 being no pain and 10 being worst pain experienced). Resident 30 explained they hit the same location on their head as the previous fall that occurred on 12/23/2024 (prior to admission) that resulted in a craniotomy. Resident 30 was transferred to the hospital for additional testing. In an interview on 01/31/2025 at 4:06 PM, Resident 30's family member explained Resident 30 had a recent fall out of bed and hit their head. Resident 30 was on blood thinners and experienced a brain bleed before. Resident 30's family member had to insist Resident 30 be sent to the hospital for further evaluation because the facility was not monitoring them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/06/2025 at 3:54 AM, Staff N, Registered Nurse, explained residents were assessed for fall risk upon admission, quarterly, and when a fall occurred. Staff N further stated when a fall was unwitnessed neuro checks were to be performed, a fall incident report was to be completed, and care plan updated with a new intervention. Staff N acknowledged if a new fall intervention was not implemented timely it could lead to further falls. In an interview on 02/07/2025 at 8:58 AM, Staff C, Resident Care Manager, explained neuro checks were performed for unwitnessed falls, if the resident was a poor historian and when a resident hit their head during a fall. Staff C further stated a resident was to be placed on alert charting to monitor for latent injuries and care plan updated with a new fall intervention to prevent reoccurrence. Staff C stated they expected staff to monitor residents and implement interventions when falls occurred. In an interview on 02/07/2025 at 9:18 AM, Staff B, Director of Nursing, defined a fall as any unplanned change in plane and explained a new intervention should be implemented each time a fall occurred to prevent further falls. Staff B stated staff were expected to complete fall incident reports, implement new interventions, and follow the facility fall policies when falls occurred. Reference WAC 388-97-1060 (3)(g)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

46115

Based on observation, interview, and record review, the facility failed to ensure acceptable parameters of nutrition were maintained for 2 of 2 sampled residents (Residents 4 and 14) reviewed for nutrition. Resident 4 experienced harm when they had a significant weight loss of 7.9% in approximately three months and 14. 29% in six months. Resident 14 experienced harm when they had a significant weight loss of 8.51% in one month and their weight loss was not reported to the dietician. This failure placed the residents at risk for further decline in their weight, unintended consequences of poor nutrition, and decreased quality of life.

Findings included .

Review of the facility policy titled, Nutrition and Hydration dated 01/22/2021, showed residents would be provided with the nutrition and hydration needed to attain or maintain a healthy nutritional status, to the extent possible, and to identify residents with special needs or at risk for nutritional deficiencies. Residents whose nutritional screen indicated a risk for nutritional deficiencies, or current nutritional deficiencies, will be further evaluated by the Registered Dietician (RD) to identify nutritional needs and potential interventions. Meal intake will be documented following each meal to assist in early identification of reduced intake. A resident who takes less than 50% of a meal will be offered an alternate meal. A resident with consistently low intake of meals may be referred to the RD for evaluation and recommendation.

A significant weight loss is defined as a 5% loss in one month, a 7.5% loss in three months and a 10% loss in six months.

<Resident 4>

Per the 12/05/2024 quarterly assessment, Resident 4 had diagnoses which included malnutrition (reduced availability of nutrients that leads to changes in the body composition and function), depression and dementia. The resident was cognitively intact, did not reject cares, and was able to eat with set up assistance and had no weight loss.

Resident 4's 10/04/2022 comprehensive care plan had the following care areas implemented:

-Activities of daily living (ADL) self-care performance deficit, the resident is independent for eating with set-up assistance.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Risk for alteration in nutritional status related to increased nutritional needs secondary to healing needs as evidenced by bone fracture and surgical incision, altered metabolism (glucose) as evidenced by diabetes, irritable bowel syndrome, gastroesophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining), chronic obstructive pulmonary disease (a group of lung diseases that makes it difficult to breathe), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone which disrupts your metabolism), increased risk for disordered eating patterns secondary to anxiety and depression; interventions included to give diet as ordered-regular textures, regular/thin consistency of fluids, provide and serve supplements as ordered, updated 12/08/2024 to give a nutritional shake three times per day, weights per protocol, encourage fluids, Registered Dietician to evaluate and make diet change recommendations as needed. A 03/07/2024 Nutritional Screen assessment by the Registered Dietitian (RD) documented Resident 4 was 59.7 inches tall and weighed 146.6 lbs.; was eating 75-100% of their meals and there was no usual body weight listed. Resident 4 had no edema, and their weight was relatively stable with minimal fluctuations over the past quarter to year. A 11/09/2024 Nutritional Evaluation assessment by the RD documented Resident 4's weight was 138.6 lbs., and the resident was consuming 50-74.9% of their meals and 25-49.9% of their snacks. The RD stated weight was relatively stable with minimal fluctuations past quarter to year, down 9.8% this past year, beneficially, ongoing weight monitoring in place. A 12/08/2024 Nutritional Evaluation assessment completed by the RD documented Resident 4 weighed 138 lbs. and their weight had been stable over the past quarter to year with a gradual downward trend considered beneficial. The resident was eating 25-49.9% of their meals. The weight loss was attributed to fluid loss post-surgery for hip fracture. The weight was relatively stable with minimal fluctuation over the past quarter to year, down 9.8% this past year. Resident's intake poor to fair since readmission. A review of the record showed Resident 4 had lost 14.29% in 6 months and 7.9% in approximately 3 months. The resident had the following weights listed: 1/29/25 123.6 lbs. 12/27/24 123.4 lbs. 11/5/24 134.2 lbs. 7/26/24 144.2 lbs. Per the medication administration record, a nutritional shake was ordered on 12/13/2024 to be given three times a day. The record showed there had been no evaluation to determine whether other interventions would be beneficial for Resident 4's weight loss although they had continued weight loss from July 2024-December 2024. (continued on next page)

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 02/07/2025
NAME OF PROVIDER OR SUPPLIER Avalon Care Center at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Actual harm Residents Affected - Few	In an observation on 01/31/2025 at 12:03 PM, Resident 4 was sitting in their wheelchair with their lunch in front of them. Resident 4 was eating a roll and had not touched anything else on their tray. At 12:20 PM, Resident 4 was eating the roll and had a bite of fish. At 12:38 PM, the resident stated the fish and vegetables were not good and was eating a few bites of cake. The resident did not consume anything else on their tray and was not given an alternate meal or a nutritional shake by staff. In an observation on 02/03/2025 at 12:05 PM, Resident 4 was asleep in bed and had no meal tray in their room. At 12:32 PM, 1:35 PM, 2:03 PM and 2:55 PM, the resident remained asleep, and no lunch or nutritional shake was offered to the resident. At 2:03 PM, 2 nursing assistants entered the resident's room and stated Resident 4 was not feeling good. In an interview on 02/07/2025 at 9:04 AM, Staff C, Resident Care Manager, stated weight loss interventions should have been implemented prior to 12/12/2024. Staff C stated they could have added a nutritional supplement and monitored Resident 4 to ensure they were getting adequate nutrition. Staff C added this could have prevented some of Resident 4's weight loss. During an interview on 02/07/2025 at 10:13 AM, Staff B, Director of Nursing, stated when a resident had experienced weight loss, nutritional supplements and snacks would be encouraged, weight loss would be monitored, weight loss triggers assessed, and the RD would make a recommendation. Staff B stated nursing can also put interventions in place for weight loss. Staff B stated Resident 4 took snacks, not routinely, had no edema (swelling), and had no orders in place for weight loss and was unsure why they did not. Staff B added putting an intervention in place prior could have prevented some of Resident 4's weight loss. <Resident 14> Per the 12/03/2024 quarterly assessment, Resident 14 had diagnoses which included malnutrition (reduced availability of nutrients that leads to changes in the body composition and function), depression and anxiety. The resident was severely cognitively impaired and needed set up to touching assistance with meals and had no weight loss. Resident 14's 11/27/2024 comprehensive care plan had the following care areas implemented: -Resident has a nutritional problem or potential nutritional problem, and will maintain adequate nutritional status as evidenced by maintaining weight and no signs and symptoms of malnutrition through the review date, this was updated on 12/10/2024; interventions included to give diet as ordered-regular textures soft and bite sized, regular/thin consistency of fluids, provide and serve diet as ordered, monitor intake and record every meal, weigh and record per provider order and facility protocol, and RD to evaluate and make diet change recommendations as needed. A 12/02/2024 Nutritional Screen assessment by the RD documented Resident 14 was 65 inches tall and weighed 116.4 lbs.; was eating 50-74.9% of their meals and there was no usual body weight listed. Resident 14 had no edema, and their weight might fluctuate status post hospitalization for a fracture. (continued on next page)

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Avalon Care Center at Northpointe	9827 North Nevada Spokane, WA 99218

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

A 12/02/2024 Nutritional Evaluation assessment by the RD documented Resident 14's weight was 116.4 lbs. , and the resident was consuming 50-74.9% of their meals and 25-49.9% of their snacks. The RD stated weight was relatively stable with minimal fluctuations past quarter to year, down 9.8% this past year, beneficially, ongoing weight monitoring in place. The resident might benefit from gradual weight gain or stability of weight given current body mass index and ideal body weight.

A review of the record showed Resident 14 had lost 8.51% in 1 month. The resident had the following weights listed:

12/26/24 106.5

11/27/24 116.4

A 12/11/2024 provider note stated Resident 14 was at risk for malnutrition due to dementia, poor intake, altered texture, was malnourished, and had end stage dementia and hospice was to see the patient on 12/12/2024.

Review of the record showed no evaluation was completed to determine the need for further interventions for Resident 14's significant weight loss.

In an observation on 01/31/2025 at 11:17 AM, Resident 14 was sitting in the dining room and was taking bites of their dessert. The resident had not consumed any other food on their tray. The nursing assistant explained to the resident what was on their tray, and they declined to eat. The licensed nurse in the dining room stated the resident liked Boost (a nutritional supplement). At 11:29 AM, Resident 4 was not given a nutritional supplement or alternate meal. Resident 14 was asked if they wanted to go back to their room and they stated yes. At 11:32 AM, the nursing assistant brought the resident to the nurse and reported that they did not eat their lunch.

On 1/31/2024 at 11:36 AM, the doctor assisted Resident 14 to their room for an assessment. At 12:09 PM, the resident was given a shower. At 12:41 PM the resident was assisted to sit in the hall and no nutritional supplement or alternate meal had been given to the resident. At 2:06 PM, the resident was asleep in their wheelchair.

During an observation on 02/03/2025 at 11:06 AM, Resident 14 was sitting in the dining room and taking bites of their food independently. At 11:11 AM a nursing assistant asked if the resident needed help to eat and moved their dessert closer to them. At 11:16 AM, the resident had consumed three quarters of a glass of milk and approximately five percent of their food. At 11:26 AM, the resident had stopped eating and had not consumed any further food. At 11:29 AM, the nursing assistant brought Resident 14 back to their hall, placed them in their room and got a stand aid to assist them to the restroom. At 11:36 AM, the nursing assistant left the hall and did not report poor meal intake to the licensed nurse.

On 02/03/2025 at 11:49 AM, Resident 14 was assisted to bed and was not offered an alternate meal or nutritional shake.

On 02/06/2025 at 4:21 PM, Staff G, Nursing Assistant, stated when a resident had poor intake they were offered an alternate meal, the nurse was notified and would decide if a nutritional shake was needed.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/06/2025 at 4:24 AM, Staff H, Registered Dietician, stated Resident 14 had lost 10 lbs. in one and a half weeks, had a low body mass index and probably needed weight gain. Staff H stated the resident was evaluated by the other dietician before they started working at the facility, so it was hard to catch everything when you're stepping in, so the resident slipped through the cracks. Staff H stated it would have been good for the nursing assistants and unit manager to bring the weight loss to their attention. Staff H added Resident 14 should have had interventions such as a nutritional supplement and nutritionally enhanced meals added. Staff H stated they should have been notified since they were new to the building. In an interview on 02/07/2025 at 8:15 AM, Staff C stated the dietician was new and believed they checked the weights and if not, they were discussed in their weekly nutrition at risk meeting. Staff C added interventions should have been added for Resident 14's weight loss and nursing could have obtained orders for a supplement from the provider. Staff C was unsure why Resident 14 was never seen by hospice. Reference: WAC 388-97-1060(3)(h)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review the facility failed to ensure respiratory treatments had provider orders, that provider orders were carried out, and care plan goals and interventions were developed for 3 of 3 sampled residents (Residents 71, 358 and 359), reviewed for respiratory care. These failures placed residents at risk for respiratory complications and a diminished quality of life. Findings included . Review of the facility policy titled, Quality of Care Respiratory Care dated July 2018, showed the facility would provide residents with necessary respiratory care and services in accordance with professional standards of practice, the resident's care plan and choices. The policy included a list of respiratory therapy modalities that could be provided at the facility which included breathing techniques, CPAP (continuous positive air pressure, a treatment that used pressure to keep the airway open by way of a mask) use, and oxygenation support. Staff were to assess and monitor a resident's respiratory condition, including their response to therapy provided and any changes in respiratory conditions. The policy further showed residents who required respiratory services would have physician orders and a resident-centered respiratory care plan implemented. Oxygen therapy could be provided through various delivery systems, and the provider order was to include an indication for use, equipment to be used, oxygen levels to initiate and/or discontinue oxygen therapy. <Resident 359> Per the 01/29/2025 admission assessment, Resident 359 had diagnoses including chronic obstructive pulmonary disease (COPD, lung disease that made it hard to breathe) and cardiomyopathy (heart muscles too weak to pump blood). The assessment further showed Resident 359 did not receive oxygen therapy. Resident 359 was cognitively intact and able to clearly verbalize their needs. Review of provider orders as of 02/06/2025 showed Resident 359 had no orders for oxygen therapy administration, care and/or maintenance of oxygen equipment and tubing. Review of the January 2025 through February 2025 nursing progress notes showed Resident 359's oxygen level was 96% on 01/24/2025 and 92% on 01/30/2025, with use of oxygen via nasal cannula (tubing used for oxygen flow). Review of the 01/28/2025 COPD care plan instructed staff to administer medications as ordered, include resident in care planning, and identify ways to reduce sources of respiratory irritations. Review of the 01/30/2025 altered respiratory status care plan instructed staff to elevate the head of the bed, monitor for signs and/or symptoms of respiratory infection, respiratory distress, and abnormal breathing patterns. No documentation was found to show Resident 359 received oxygen therapy or how to maintain oxygen equipment or tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 01/28/2025 at 1:04 PM, there was an oxygen concentrator (a medical device that supplies oxygen for breathing) plugged in with an attached nasal cannula at Resident 359's bedside. There was an Oxygen in Use sign posted on the door. Similar observations were made on 01/29/2025 at 11:49 AM and 01/31/2025 at 9:23 AM. In an observation and interview on 01/28/2025 at 3:46 PM, Resident 359 was in bed and the oxygen concentrator was at their bedside. Resident 359 stated they used 2 liters (L) of oxygen nightly. In a follow-up observation and interview on 02/03/2025 at 10:43 AM, Resident 359 was in bed and had an oxygen nasal canula in their nose. Resident 359 stated they recently completed a physical therapy session and applied the oxygen afterwards. A similar observation was made on 02/05/2025 at 4:25 PM. In an interview on 02/06/2025 at 12:35 PM, Staff T, Licensed Practical Nurse (LPN), stated residents who had lung disease would generally have orders for oxygen therapy in place to enable their breathing to perform daily activities. Staff T reviewed Resident 359's medical record. Staff T acknowledged Resident 359 had no orders for oxygen therapy. In an interview on 02/06/2025 at 1:26 PM, Staff U, Resident Care Manager (RCM), stated Resident 359 should have had oxygen therapy orders in place along with a care plan. <Resident 358> Per the 01/30/2025 admission assessment, Resident 358 had diagnoses including heart failure (heart cannot pump enough blood) and sleep apnea (a sleep disorder in which breathing stopped and started repeatedly during sleep). The assessment further showed Resident 358 used oxygen therapy and did not use a CPAP. Resident 358 was cognitively intact to verbalize their needs. In an observation and interview on 01/28/2025, Resident 358 was sitting in their wheelchair, and a CPAP machine was on their nightstand. Resident 358 stated they were admitted to the facility on [DATE] with their personal CPAP machine. Resident 358 explained during the admission process, an unknown staff told them not to be concerned about wearing their CPAP because it would be set up that night. Resident 358 stated their CPAP machine was assembled three days later on 01/27/2025 and they wore it for three hours. Per review of the provider orders as of 02/07/2025 showed Resident 358 had no order for routine CPAP use, CPAP settings, cleaning and/or changing the filter. Review of the 01/24/2025 self-care deficit care plan showed Resident 358 was dependent on staff assist to perform most activities of daily living. The 01/24/2025 altered respiratory status care plan instructed staff to elevate the head of the bed, administer oxygen therapy via nasal cannula, monitor for signs and/or symptoms of respiratory distress and changes in breathing pattern. No documentation was found for Resident 358 to wear a CPAP routinely, CPAP settings, cleaning and/or changing the machine filter. Review of the January 2025 nursing progress notes showed no documentation Resident 358 used or had a CPAP machine. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 01/28/2025 at 3:46 PM, Resident 358 was asleep in bed and their CPAP machine sitting on the nightstand. During an interview and observation on 01/29/2025 at 11:12 AM, Resident 358 stated they forgot to use their CPAP machine last night. Resident 358 stated staff assisted them by putting on the CPAP mask and filling the reservoir with distilled water. The CPAP machine remained on the nightstand with a jug of distilled water. Similar observations were made on 02/03/2025 at 10:17 AM and 02/05/2025 at 4:26 PM. In an interview on 02/06/2025 at 12:14 PM, Staff V, Nursing Assistant, stated they had not observed Resident 358 with their CPAP mask in place the mornings they worked. Staff V acknowledged Resident 358 has had the CPAP machine in their room since they were admitted to the facility. In an interview on 02/06/2025 at 12:20 PM, Staff T, LPN, stated Resident 358 utilized their CPAP machine at night since their admission and were monitored every hour when they went to bed. Staff T reviewed Resident 358's medical record. Staff T acknowledged Resident 358 had no provider orders for use of their CPAP machine, CPAP settings, cleaning and/or changing the machine filter. Staff T further stated Resident 358 should have CPAP orders implemented so staff were informed of the respiratory care needs. In an interview on 02/06/2025 at 1:24 PM, Staff U, RCM, stated that when a resident was admitted with their own CPAP machine, staff acknowledged their settings used at home. Staff U further stated it was important to have physician orders for CPAP use so staff were able to appropriately care for the resident. <Resident 71> Per the 01/02/2025 quarterly assessment, Resident 71 had diagnoses including respiratory failure (serious condition where the lungs cannot get enough oxygen), COPD and sleep apnea. Resident 71 was cognitively intact and able to make decisions regarding their care. In an observation and interview on 01/29/2025 at 9:50 AM, Resident 71 was lying in their bed and had their personal CPAP machine on their nightstand. Resident 71 stated they had not worn their CPAP machine for the last two nights because they fell asleep before they could apply it. In an observation and interview on 01/31/2025 at 08:49 AM, Resident 71 was laying in their bed. Resident 71 again stated they did not wear their CPAP machine last night because they were tired and fell asleep before they could apply it. In an observation and interview on 02/03/2025 at 10:20 AM, Resident 71 stated if they were asleep, staff did not wake them up to apply their CPAP. In an observation and interview on 02/05/2025 at 9:50 AM, Resident 71 was laying in their bed and was hardly able to keep their eyes open. Resident 71 again stated they did not use the CPAP machine last night and were tired. In an observation and interview on 02/6/2025 at 3:35 PM, Resident 71 was lying in their bed and more alert than previous days. Resident 71 stated they used their CPAP machine last night. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 12/05/2024 self-care deficit care plan showed Resident 71 was dependent on staff assist to perform most activities of daily living. The 12/05/2024 altered respiratory status care plan instructed staff to elevate the head of the bed, monitor for respiratory distress, administer medications as ordered, and use a CPAP per home settings. No documentation was found for CPAP cleaning and/or changing the machine filter. Per review of the provider orders showed an active 12/21/2024 order for Resident 71 to wear a CPAP nightly, refill the distilled water chamber at bedtime, remove the CPAP mask in the morning and cleanse with hot water and dish soap. Record review of the medication administration record from 01/26/2025 to 02/03/2025, documented Resident 71 wore their CPAP at bedtime daily, when Resident 71 voiced it had not been worn. During an interview on 02/06/2025 at 12:35 PM, Staff T, LPN, stated the night shift nurse monitored Resident 71 when they used the CPAP machine. Staff T reviewed Resident 71's medical records. Staff T stated documentation showed Resident 71 wore the CPAP machine nightly and they were unaware Resident 71 had not been wearing it. In an interview on 02/06/2025 at 1:41 PM, Staff U, RCM, acknowledged Resident 71 had been sick recently and had not used their CPAP machine. Reference WAC 388-97-1060 (3)(j)(ii)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37544 Based on observation, interview, and record review, the facility failed to ensure consistent, ongoing communication and collaboration with the dialysis facility for 1 of 2 sampled residents (Resident 23) reviewed for dialysis, a treatment that removed waste products and excess fluid from the bloodstream when the kidneys no longer functioned properly. In addition, the facility failed to ensure Resident 23's care plan included accurate goals and interventions related to the care and maintenance of the central venous catheter (CVC: a flexible tube that was inserted into a vein to provide an access site for dialysis). Findings included . The 11/21/2024 admission assessment documented Resident 23 was cognitively intact to make decisions regarding their care and had diagnoses which included diabetes and end stage kidney disease. In addition, the assessment documented the resident received dialysis via an intravenous access site. In an interview on 01/28/2025 at 3:27 PM, Resident 23 was observed lying in bed watching television. During the conversation, the resident stated they received dialysis treatments and had a CVC that was used as the access site. Resident 23 had the following active provider orders: - monitor the dialysis fistula (an access site for dialysis that was created by connecting an artery to a vein) every shift for potential complications and signs of infection - monitor the fistula for thrill (a vibration felt by feeling the fistula) and bruit (listening to the fistula for a swishing sound), and to notify the kidney physician if absent. - complete and print the Pre-Dialysis Assessment and Communication form, ensure the form was sent with the resident on Mondays and Fridays to their dialysis appointments, review and follow up as indicated upon return from the appointment, and to call the dialysis center if the form was not sent back with the resident. Review of Resident 23's record found Pre-Dialysis assessment and Communication forms for the dates of 12/30/2024, 01/03/2025, 01/13/2025, 01/24/2025, and 02/03/2025, which showed out of 19 appointments, the form had been returned five times. All of the returned forms documented Resident 23 had a CVC for the dialysis access site, and did not have a fistula. Review of the Dialysis care plan documented interventions were implemented on 11/18/2024 which instructed licensed nursing staff to monitor, document, and report any signs or symptoms of infection to the dialysis access site. On 11/27/2024, interventions were added that instructed the licensed nursing staff to monitor the dialysis fistula every shift for a thrill, and bruit, and to notify the kidney physician if absent. No goals or interventions were found regarding a CVC. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 Medication and Treatment Administration Records showed the licensed staff had documented every shift that they had checked the dialysis fistula for a thrill and bruit and signs of infection every shift as ordered. Additional review of the Medication and Treatment Records from November 2024 through February 2025 found the licensed staff were documenting they had checked Resident 23's dialysis fistula for a thrill and bruit each shift. In a follow up interview on 01/31/2025 at 9:20 AM, Resident 23 was observed lying in bed watching television. When asked for clarification regarding the dialysis access site, Resident 23 stated they had never had a fistula, had a CVC, and pulled the collar of their shirt down to show the CVC on their right upper chest. Resident 23 stated they were avoiding getting a fistula as long as possible, they were ugly, had seen them burst open, they didn't last forever, had to be redone, and there was a man at dialysis whose arms looked like a snake was crawling down it because of the multiple fistula revisions they have had to had done. In an interview on 02/03/2025 at 9:42 AM, Staff R, Licensed Practical Nurse, stated the Pre-Dialysis Assessment and Communication forms were filled out and sent with the resident, the nurses made sure it was returned with the resident, and a call was placed to the dialysis center if it wasn't. Staff R stated Resident 23 had a fistula when asked what type of access site the resident had, then immediately corrected and stated, no, the resident had a CVC. When asked about the documentation of the thrill and bruit, Staff R stated it had to be an error. In an interview on 02/05/2025 at 1:29 PM, Staff B, Director of Nursing, stated the expectation was the Pre-Dialysis Assessment and Communication form was completed, returned with the resident and a call made if it was not. Staff B stated Resident 23 had a CVC for dialysis and stated the dialysis orders and care plan interventions should reflect that and acknowledged they did not. Reference (WAC) 388-97-1900 (1), (6)(a-c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47328

Based on interview and record review the facility failed to ensure the facility had enough staff to provide care according to facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 3 of 8 sampled residents (Resident 83, 90 and 110), reviewed for sufficient staffing. This failure placed all residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life.

Findings included .

Review of the facility assessment updated December 2024, showed the facility was licensed for 119 beds with an average daily census of 88. The assessment further showed the facility provided care related to fall prevention, behavioral health needs, substance use disorders (SUD), nutrition services, pressure injury prevention and care, and infection prevention practices. The facility employed a staffing coordinator to assist with facility staffing needs. The assessment further showed the facility leadership utilized the facility assessment as a framework to ensure sufficient staff with the appropriate competencies and skill sets were available to care for residents' needs on each unit and shift (day, evening, night). The facility's budget was used as a staffing guide, but leadership may choose to adjust staffing based on resident needs. If the facility census increased or decreased the facility might add or reduce the number of staff on each shift. If the resident's acuity increased or decreased the facility might add or reduce additional staff on each unit. The facility's staffing contingency plan included use of on-call nurse managers and facility leadership to provide immediate coverage, overtime hours, incentives for staff to work, or use of agency staffing to maintain adequate staffing coverage.

<Resident 90>

According to the 01/14/2025 quarterly assessment, Resident 90 had severe cognitive impairment and sustained two or more falls while in the facility. The assessment further showed Resident 90 required moderate staff assistance to complete most activities of daily living including transfers and ambulation.

The 11/18/2024 provider order summary indicated Resident 90 did not receive antipsychotic medications (medication that affect the mind, emotions, and behaviors).

The 11/18/2024 nursing progress note documented Resident 90 was transported to the facility for admission.

(continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During transport Resident 90 repeatedly attempted to get out of their wheelchair (WC) while the vehicle was in motion requiring the driver to pull over three times. Once at the facility, staff attempted to admit Resident 90, but the resident was too impulsive to participate in the admission process with several attempts to self-transfer out of the WC, bed, and off the toilet with redirection only successful for a short time. Resident 90 was unaware of their safety needs and required constant supervision as they would transfer in less than a minute and seemingly required one on one supervision as Resident 90's safety would be compromised if left alone at any time. Resident 90 was transported back to the hospital for more adequate and safer placement at a later time. Resident 90 returned to the facility for admission on 11/20/2024. The notes further showed Resident 90 sustained three falls prior to having one-on-one supervision initiated. The 11/18/2024 hospital progress notes showed Resident 90 was very pleasant, made eye contact, and did not show agitation. The hospital received report from the facility Resident 90 was agitated, impulsive, lacked judgement and behaved agressively. The resident had been sent to the care facility earlier in the day, but challenges had arisen due to the facility report of understaffing and inablity to provide Resident 90 with 1:1 supervision. The resident was started on a low dose antipsychotic medication, Seroquel. Review of the 11/20/2024 hospital discharge medication list showed Resident 90 was to be administered Seroquel 25 milligrams (mg) twice daily after discharge. Review of the 11/20/2024 care plan showed Resident 90 was at risk for falls and instructed staff to anticipate resident needs, ensure the call light was within reach, maintain a safe environment, ensure proper footwear was worn, and keep commonly used items within reach. The care plan further showed Resident 90 sustained 9 falls from 11/22/2024 through 01/22/2025. The 01/08/2025 provider progress note documented Resident 90 had increased behaviors, made inappropriate sexual gestures and was impulsive which caused an additional fall. The plan was to increase Seroquel to 100 mg three times daily. The provider also ordered for Resident 90 to receive Ativan (antianxiety medication) twice daily to reduce impulsiveness. In an interview on 02/05/2025 at 2:28 PM, Resident 90's power of attorney (POA, person who can make healthcare decisions on ones behalf if unable to do so) stated Resident 90 had numerous falls at home, including a fall that resulted in a neck fracture prior to facility placement. The POA stated Resident 90 sustained falls at the facility, 1:1 monitoring was implemented, yet the resident continued to fall. The POA stated they were informed Resident 90 was administered medications to help reduce behavioral outbursts. The POA stated it was their opinion the resident was overmedicated. The POA explained Resident 90 required one person for transfers using a walker on admission to the facility but could barely hold their head up and required three people to transfer out of their WC at discharge. <Resident 110> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 01/26/2025 discharge assessment documented Resident 110 was admitted on [DATE], discharged on [DATE], and had diagnoses which included psychoactive substance abuse (drug or substance that affected how the brain worked and caused changes in mood, awareness, thoughts, feelings, and behaviors), and schizophrenia (mental illness that affected a person's thoughts, feelings, and actions). Resident 110 was independent with making decisions regarding daily life, had fluctuating inattention and disorganized thinking. The 01/24/2025 hospital transition of care orders documented Resident 110 used amphetamines (powerful addictive central nervous system stimulant) and discontinuation of its use was recommended. The resident had been hospitalized with a bone infection in both feet but left the hospital against medical advice. The note documented underlying psychotic illness (mental health condition where a person loses touch with reality) contributed to the resident leaving against medical advice and interfered with their medical decision-making capacity. The 01/25/2025 wander risk assessment showed Resident 110 could move without assistance, did not have a history of wandering, had no diagnosis of cognitive impairment, and had no reported episodes of wandering in the past six months. The assessment identified Resident 110 as low risk for wandering or elopement. The 01/26/2025 care plan documented Resident 110 required partial assistance to complete most of their activities of daily living and used a wheelchair for mobility. There was no documenation that Resident 110 had a substance use disorder (SUD), and no goals or interventions were developed regarding potential risks associated with a SUD such as leaving the facility without staff knowledge. The January 2025 nursing progress notes documented Resident 110 arrived at the facility on Saturday 01/25/2025 at approximately 3:30 PM. On 01/26/2025 at 8:00 PM, staff were unable to locate Resident 110 to administer their bedtime medication. At 8:15 PM, an elopement was called. At 8:20 PM, the building was searched inside and out, staff were unable to locate Resident 110. At 8:30 PM, law enforcement was notified of the missing resident. On 01/27/2025 at 7:11 AM, Resident 110 was located at a local hospital, had been drinking and was unable to find their way back to the facility. No documentation was found that showed what occurred with Resident 110 after the facility located them at the local hospital. In an interview on 02/05/2025 at 4:08 PM, Staff C, Resident Care Manager, acknowledged Resident 110 had psychoactive substance abuse listed as a diagnoses but did not have a care plan or interventions implemented. Staff C further stated Resident 110 eloped from the facility, drank alcohol, was unable to get back to the facility, and ended up in the hospital. In an interview on 02/06/2025 at 1:17 PM, Staff B, Director of Nursing, stated the facility maintained resident safety by monitoring resident behaviors and implementing care plan interventions. Staff B reviewed Resident 110's medical record. Staff B stated Resident 110 admitted on the weekend and eloped prior to assessments being completed. In an interview on 02/06/2025 at 1:31 PM, Staff A, Administrator, was asked if the facility had guidelines such as not admitting after a certain time of day or on the weekends because the facility team was not available to complete needed assessments to ensure adequate resident safety. Staff A acknowledged the process was being reviewed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 83> According to the 12/27/2024 quarterly assessment, Resident 83 was dependent on staff assistance to perform most activities of daily living. Resident 83 was cognitively intact and able to clearly verbalize their needs. In an interview on 01/28/2025 at 2:49 PM, Resident 83 stated they had excessively long call light wait times. Resident 83 explained they had a clock on their bedside table and had waited up to one hour and 40 minutes to have their call light answered. During an interview on 02/04/2025 at 2:32 PM, the Ombudsman (a person who acted as an advocate for residents living in long-term care) stated residents expressed concerns about the facility's lack of staff. In an interview on 02/05/2025 at 9:37 AM, Staff EE, Nursing Assistant, stated the facility did not have enough staff on the [NAME] unit because every resident required two staff assistance for cares. In a confidential interview on 02/05/2025 at 10:07 AM, Confidential Staff 1, feared retaliation and wanted to remain anonymous. Confidential Staff 1 acknowledged the facility did not have enough staff, especially in the evenings and on weekends. In a confidential interview on 02/06/2025 at 11:35 AM, Confidential Staff 2, feared retaliation and wanted to remain anonymous. Confidential Staff 2 acknowledged the facility did not have enough staff and some nights only one nurse worked. In a confidential interview on 02/06/2025 at 2:07 PM, Confidential Staff 3, feared retaliation and wanted to remain anonymous. Confidential Staff 3 explained the nursing assistant section assignments were set and did not change based on resident acuity. Confidential Staff 3 was asked what occurred if staff did not have good teamwork. Confidential Staff 3 stated the section assignments were not adjusted. In an interview on 02/06/2025 at 2:27 PM, Staff Y, Staffing Coordinator, explained the [NAME] unit residents required more staff assistance and the nursing assistant to resident ratio was about 1:10 on that hall. In an interview on 02/07/2025 at 9:03 AM, Staff A, Administrator, stated Staff Y wore 4 different hats and explained Staff Y was the staffing coordinator, health unit coordinator, driver, and appointment scheduler. Staff A further stated some staff worked multiple double shifts and/or extra shifts. Staffing was reviewed with Staff A. Staff A acknowledged the facility utilized fewer nursing assistants when the facility census was decreased. In an interview on 02/07/2025 at 9:06 AM, Staff B, Director of Nursing, stated staff had voiced the need for more staff but the staff scheduled was adequate and enough to meet resident needs. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F552, F689, F692 and F758 for additional information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 37544 Based on interview and record review the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 2 of 5 sampled staff (Staff P and Y), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and diminished quality of life. Findings included . Review of the following Nursing Assistant (NA) personnel files found no documentation that showed a yearly performance evaluation had been completed following: - Staff Y, Nursing Assistant - Staff P, Nursing Assistant In an interview on 02/03/2025 at 1:36 PM, Staff A, Administrator, stated they had not been aware there was not a process in place for completing yearly performance evaluations, and the facility was in the process of getting evaluations started. Reference (WAC): 388-97-1680 (1), (2)(a-c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 46115 Based on interview and record review, the facility failed to ensure monitoring of potential adverse effects from a blood thinning medication was done consistently for 1 of 5 sampled residents (Resident 22) reviewed for unnecessary medications. This failure placed the resident at risk for medical complications, unmet care needs and adverse side effects. Findings included . <Resident 22> The 01/06/2025 quarterly assessment documented Resident 22 was able to make decisions regarding their care and had diagnoses which included heart failure and high blood pressure. In addition, the assessment documented the resident was taking a blood thinning medication. The provider orders documented Resident 22 was prescribed a blood thinning medication (Xarelto). Additional orders included instruction to the licensed staff to monitor for adverse reactions such as bleeding, severe bruising, difficulty breathing or chest pain. Review of the January 2025 Medication Treatment Record on 01/31/2025 found on the following dates and shifts, the monitoring documentation for adverse side effects of the blood thinning medication were blank and had not been completed: - day shift from 01/02/2025 through 02/05/2025, and 02/08/2025 through 02/11/2025 - evening shift on 01/11/2025, - night shift on 01/03/2025, 01/05/2025, 01/09/2025, 01/17/2025, 01/24/2025, and 01/25/2025. In an interview on 02/05/2025 at 11:03 AM, Staff N, Registered Nurse, stated the expectation was that all charting/documentation was completed each shift as ordered and a progress note made if there were any issues or concerns. After review of the resident record, Staff N confirmed the documentation was blank as stated above. In an interview on 02/05/2025 at 1:21 PM, Staff B, Director of Nursing, stated the expectation was that medication monitoring and any documentation was completed before the end of the shift. After review of Resident 22's record, Staff B confirmed the blood thinning medication had not been consistently monitored. Reference: WAC 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to ensure residents were not given psychotropic medications (medication that affected the mind, emotions, and behaviors) unless the medication was necessary to treat specific conditions documented in the clinical record, residents received non-medication behavioral interventions, and behavior and adverse side effect monitoring was consistently done for 3 of 6 sampled residents (Residents 22, 23 and 90), reviewed for unnecessary medications. This failure placed residents at risk of being chemically restrained, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Chemical Restraint dated November 2017, showed the facility would provide a safe environment that was free from abuse including the use of chemical restraints not required to treat the resident's medical symptoms. The policy defined a chemical restraint as any drug that was used for discipline or staff convenience and not required to treat medical symptoms. The policy further showed if it was determined administration of a medication was being used to treat a medical symptom, the facility would review the use of the medication and ensure it was supported by adequate indication and rationale for use, was used at the correct dose and duration with adequate monitoring. Documentation would include behavioral interventions unless contraindicated, monitoring for medication effectiveness and potential adverse consequences. The policy included examples of chemical restraint as administering medication to prevent wandering and to quiet a resident who continually called out, without attempting alternative interventions. <Resident 90> According to the 11/26/2024 admission assessment, Resident 90 admitted to the facility on [DATE] with diagnoses including dementia, traumatic brain injury (TBI- brain damage caused by an external force), anxiety, and depression. Resident 90 had severe cognitive impairment with fluctuating inattention, disorganized thinking and no altered level of consciousness. Review of November 2024 nursing progress notes showed on 11/18/2024 the facility transported Resident 90 from the hospital to the facility for admission. During transport Resident 90 repeatedly attempted to get out of their wheelchair (WC) while the vehicle was in motion requiring the driver to pull over three times. Once at the facility, staff attempted to admit Resident 90, but the resident was too impulsive to participate in the admission process with several attempts to self-transfer out of the WC, bed, and off the toilet with redirection only successful for a short time. Resident 90 was unaware of their safety needs and required constant supervision as they would transfer in less than a minute and seemingly required one on one supervision as Resident 90's safety would be compromised if left alone at any time. Resident 90 was transported back to the hospital for more adequate and safer placement at a later time. Resident 90 returned to the facility for admission on 11/20/2024. The notes further showed Resident 90 sustained three falls prior to having one-on-one supervision initiated. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/18/2024 facility order summary documented Resident 90 had no active orders for antipsychotic medications. The 11/18/2024 hospital progress notes showed Resident 90 was very pleasant, made eye contact, and did not show agitation. The hospital received report from the facility Resident 90 was agitated, impulsive, lacked judgement and behaved agressively. The resident had been sent to the care facility earlier in the day, but challenges had arisen due to the facility report of understaffing and inablity to provide Resident 90 with 1:1 supervision. The resident was started on a low dose antipsychotic medication, Seroquel. Review of the 11/20/2024 hospital discharge medication list showed Resident 90 was to be administered Seroquel 25 milligrams (mg) twice daily after discharge. Review of the 11/21/2024 facility order summary showed Resident 90 was to be administered Seroquel 25 mg twice daily for psychophysical visual disturbances, violent behavior, restlessness and agitation. Review of the 11/21/2024 provider progress note showed Resident 90 was started on low dose Seroquel due to dementia with behavioral disturbances. The provider's treatment plan included continued use of Seroquel at 25 mg twice daily. The provider's note also included the following general recommendations for environmental treatment of agitation: frequent orientation with cues, staffing consistency, communicate with short clear statements and requests, maintain day/night structure especially with lighting, minimize noise/stimuli especially at night, ensure the resident had freedom of mobility within confines of medical treatment and plan, ensure pain was addressed related to resident may not be able to vocalize which may lead to agitation, and correct any sensory deficits by ensuring the resident wore hearing aides and/or glasses as needed. Review of the 11/20/2024 self-care performance deficit care plan showed Resident 90 required partial staff assistance to perform most activities of daily living including bed mobility and transfers. The 11/21/2024 psychotropic medication use care plan instructed staff to administer medications as ordered, monitor for adverse side effects, orient to reality and clarify mistaken beliefs. The 11/27/2024 delirium (sudden and severe state of confusion) care plan instructed staff to call Resident 90 by their preferred name, encourage resident family, friends, and care givers to be at bedside during episodes of confusion. The 11/30/2024 impaired cognitive function care plan instructed staff to administer medications as ordered, monitor for potential side effects and medication effectiveness. No documentation was found to show the provider's 11/21/2024 recommendations for evironmental treatment of agitation were care planned or implemented. Review of the 11/23/2024 provider progress note showed Resident 90 had moments of agitation with garbled speech. The provider's plan showed Resident 90 was responding well to Seroquel therapy and the provider continued Seroquel 25 mg twice daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 11/25/2024 provider progress note showed Resident 90 sustained a fall, was transferred to the hospital for evaluation and returned with multiple recommendations for behaviors. The provider's note further showed the hospital increased Resident 90's Seroquel from 25mg to 50mg twice daily and advised continued increase by 25 mg twice daily to reduce hyperactivity and agitation until symptoms were controlled or max dose of 750 mg/ 24 hours was reached. The provider noted Resident 90 was currently on Seroquel 75mg daily with reported increased fatigue and Resident 90 was more sedated today. The hospital also recommended starting use of Ativan (antianxiety medication) orally for anxiety and in an injectable form for severe agitation and combativeness. Review of the 11/26/2024 provider note showed Resident 90 had frequent falls associated with behaviors including violent aggression. Resident 90 was now being administered Seroquel 75 mg twice daily with some improvement in behaviors and anxiety. Review of the 12/03/2024 provider progress note showed Resident 90's behaviors were controlled with the recent Seroquel dose increase to 75 mg twice daily. Review of the 12/06/2024 provider progress note showed Resident 90 was administered the as needed antianxiety medication five times in the last two weeks. Resident 90 was to continue receiving Seroquel 75 mg twice daily and use the as needed Ativan. Review of the 12/10/2024 provider progress note showed Resident 90 reported intermittent sleep issues. The provider's plan was to increase Seroquel to 100mg twice daily and continue the as needed Ativan. The provider note did not document any behaviors Resident 90 experienced, if any. Review of the 12/10/2024 psychotropic medication review showed Resident 90 was taking Seroquel 100 mg twice daily, which was an increased dose, with behaviors documented as agitation and acting out. The notes did not include details or specific examples of what acting out meant. Review of December 2024 point of care behavior task documentation showed Resident 90 only experienced behaviors on 12/15/2024, 12/16/2024, 12/18/2024, 12/21/2024, 12/22/2024, 12/23/2024, and 12/26/2024. Review of the December 2024 through January 2025 medication administration record (MAR) behavior monitoring showed inconsistent behavior monitoring with omissions in documentation on the following dates: December- Dayshift 12/05/2024, 12/13/2024, 12/17/2024, 12/19/2024, 12/21/2024 through 12/23/2024, 12/26/2024 through 12/28/2024. Night shifts 12/08/2024, 12/14/2024, 12/16/2024, 12/17/2024, 12/20/2024 through 12/23/2024 and 12/26/2024. January- Dayshift 01/06/2025, 01/08/2025, 01/10/2025 through 01/13/2025, 01/20/2025, and 01/21/2025. Night shifts 01/02/2025, 01/03/2025, 01/05/2025, 01/09/2025, 01/10/2025, 01/13/2025, 01/14/2025, 01/16/2025, 01/20/2025, and 01/21/2025. (continued on next page)

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the 01/08/2025 provider progress note showed Resident 90 had increased behaviors and impulsiveness. Resident 90 had been making more sexual inappropriate gestures, comments and just inappropriateness. Resident 90 had another fall due to impulsiveness. The provider's plan was to increase the Seroquel to 100 mg three times daily due to impulsiveness which leads to falls, inappropriate behaviors, and sexual inappropriateness. The note further showed the as needed Ativan was not effective at managing impulsiveness, Resident 90 continued to be a fall risk, and the provider scheduled Ativan 1 mg twice daily routinely.

Review of the 01/09/2025 psychotropic medication review showed Resident 90 was taking Seroquel 50 mg twice daily, not 100mg three times daily as ordered by the provider, with behaviors listed as impulsive, jumps out of bed, and agitation.

Review of November 2024 through January 2025 nursing progress notes showed Resident 90 was alert to self only, not redirectable, was short with staff, cursed at times, self-transferred often, had unsteady gait, experienced frequent falls, was confused, and anxious at times. The notes further showed Resident 90 was administered as needed Ativan for restlessness and anxiousness, minimal vague documentation was found to show what non-medication interventions were attempted prior to medicating, intervention effectiveness and/or specific details of the behaviors Resident 90 experienced. No documentation of violent, aggressive or combative behavior was found.

According to the 01/14/2025 quarterly assessment, Resident 90 had diagnoses including violent behavior, restlessness and agitation. Resident 90 had severe cognitive impairment, continuous nonfluctuating inattention, disorganized thinking, and an altered level of consciousness.

Review of the 01/22/2025 provider discharge summary showed Resident 90 sustained repeat falls secondary to impulsiveness. Resident 90 discharged the facility with provider orders to administer Seroquel 100 mg three times daily, Ativan 1 mg routinely twice daily and Ativan 1 mg every four hours as needed for agitation.

In an interview on 02/05/2025 at 2:28 PM, Resident 90's power of attorney (POA- person who could make healthcare decisions when someone was unable to do so for themselves) stated the facility informed them Resident 90 was being administered medication to help with behavioral outbursts. Resident 90's POA further stated they felt Resident 90 was overmedicated. The POA explained Resident 90 admitted to the facility requiring one person transfer assist using a walker but upon discharge Resident 90 could barely hold their head up and it took three persons to stand pivot transfer Resident 90 out of the WC.

In an interview on 02/06/2025 at 12:38 PM, Staff L, Social Service Director, explained nurses monitored resident behaviors through the MAR and nursing assistants via point of care behavior task documentation. Staff L reviewed Resident 90's medical record. Staff L acknowledged there were significant omissions in the MAR behavior monitoring documentation and nursing progress notes with behavior details was lacking. Staff L further stated behavior documentation was critical because it was reviewed and used to determine potential medication adjustments, either decreases or increases.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/07/2025 at 8:47 AM, Staff C, Resident Care Manager, explained resident behaviors were monitored through progress notes, behavior monitors in the MAR and task documentation. Staff C explained Resident 90 had behaviors which included anxiousness and agitation related to waking up from sleeping demanding to see their spouse, jumping out of bed, walking into the hall and difficult with redirection. Staff C reviewed Resident 90's medical record. Staff C acknowledged Resident 90's behavior documentation was lacking. In an interview on 02/07/2025 at 9:11 AM, Staff B, Director of Nursing, explained behaviors were monitored various ways including behavior monitoring in the MAR and nursing progress notes. Staff B stated Resident 90's behaviors included being impulsive, yelling out, and sexually inappropriate behaviors. Staff B stated they expected staff to document behaviors with sufficient detail to justify medication adjustments. 37544 <Resident 22> According to the 01/06/2025 quarterly assessment, Resident 22 had diagnoses including depression and bipolar disorder (a mental illness that caused extreme mood swings that affected thinking, behaviors, and sleep). Ressident 22 was able to make decisions regarding their care. Review of the Order Summary Report from 05/22/2024 through 01/31/2025 showed when Resident 22 had been admitted to the facility on [DATE], the physician had prescribed psychotropic medications (Abilify and Celexa) to treat the symptoms of the bipolar disorder and depression. Admission orders included instruction to the licensed staff to monitor for behaviors which may indicate a change in the resident's mental health, and to monitor for any potential adverse side effects of the psychotropic medications. Review of the care plan showed interventions which instructed the nursing staff to monitor for behavior changes and possible adverse side effects related to the use of the psychotropic medications had been implemented on 05/20/2020. Review of the January 2025 Medication Treatment Record on 01/31/2025 found on the following dates and shifts, the documentation for the behavior and adverse side effect monitors were blank and had not been completed: - day shift from 01/02/2025 through 02/05/2025, and 02/08/2025 through 02/11/2025 - evening shift on 01/11/2025, - night shift on 01/03/2025, 01/05/2025, 01/09/2025, 01/17/2025, 01/24/2025, and 01/25/2025. In an interview on 02/05/2025 at 11:03 AM, Staff N, Registered Nurse, stated the expectation was that all charting/documentation was completed each shift as ordered and a progress note made if there were any issues or concerns. Staff N reviewed Resident 22's medical record. Staff N acknowledged documentation was blank as stated above. <Resident 23> (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avalon Care Center at Northpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 11/21/2024 admission assessment, Resident 23 had diagnoses which included anxiety and depression. Resident 23 was cognitively intact and able to make decisions regarding their care. Review of the Order Summary Report from 11/15/2024 through 02/04/2025 showed when Resident 23 admitted to the facility on [DATE], the physician had prescribed psychotropic medications (Elavil and Ambien) to treat the symptoms of depression and anxiety. Additional orders included instruction to the licensed staff to monitor for any potential adverse side effects of the psychotropic medications. Review of the care plan showed interventions had been implemented on the day of admission and instructed the nursing staff to monitor for adverse side effects and behaviors that were unusual for the resident. Review of the January 2025 Medication Treatment Record on 01/31/2025 found the documentation for the adverse side effect monitors were blank and had not been completed on the following dates and shifts: - day shift on 01/05/2025 - evening shift on 01/09/2025, 01/14/2025, and 01/26/2025. In an interview on 02/05/2025 at 10:14 AM, Staff R, Licensed Practical Nurse, stated all documentation needed to be completed each shift as ordered and confirmed some of the documentation had not been done. In an interview on 02/05/2025 at 1:21 PM, Staff B, Director of Nursing, stated documentation for the behavior and adverse side effects monitors was completed before the end of each shift. Staff B reviewed Resident 22 and 23's records. Staff B acknowledged documentation had not been completed consistently. Reference (WAC): 388-97--1060 (3)(k)(i) Refer to F552 and F661 for additonal information.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 37544 Based on interview and record review, the facility failed to ensure 3 of 5 sampled residents (Residents 22, 46 and 71), reviewed for medication administration, received medication as ordered by the physician. Failure to administer insulin, a medication used to treat diabetes, and consistently monitor blood sugar levels, a test done that checked the level of sugar in the blood stream, and failure to follow the parameters for holding a blood pressure medication created significant medication errors, and placed the residents at risk for medical complications, unintended health consequences and diminished quality of life. Findings included . INSULIN AND BLOOD SUGAR MONITORING <Resident 22> The 01/06/2025 quarterly assessment documented Resident 22 was able to make decisions regarding their care and had diagnoses which included high blood pressure and Diabetes, a medical condition caused when the body was unable to breakdown sugar. In addition, the assessment documented the resident received insulin, a medication used in the treatment of diabetes to keep blood sugar levels in the blood stream at normal ranges. The provider ordered the following medications: - On 01/23/2023, Humalog, a fast-acting insulin that started to work within 15 minutes, was to be administered three times a day, - On 01/24/2023 blood sugar checks were to be done before meals, and - On 11/07/2024, Lantus, a long-acting insulin, was to be administered twice a day Review of the January 2025 Medication Administration Records (MARS) on 01/31/2025 found the following: - On 01/02/2025, the Lantus was not given during the evening shift - On 1/11/2025, the blood sugar checks had not been done before any of the meals, and neither the Humalog nor the Lantus had been given. - On 01/24/2025, the blood sugar checks had not been done before breakfast or lunch nor had the Humalog been given, and the Lantus was not given during the dayshift. There was no documentation that explained the reason for the omission of the blood sugars and administrations of the Humalog and Lantus on the dates above. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/04/2025 at 11:01 AM, Staff N, Registered Nurse, (RN), stated medications needed to be administered as ordered by the physician and documented in the MAR and/or the progress notes if not given or there were concerns. After review of Resident 22's record, Staff N confirmed no documentation was made that showed why the insulin and blood sugar orders had not been administered as ordered. <Resident 71> The 01/02/2025 quarterly assessment documented Resident 71 had diagnoses that included end-stage renal (kidney) disease dependent on dialysis (a mechanical way of removing waste from the body when the kidneys no longer functioned), diabetes and ketoacidosis (lack of insulin that causes the breakdown of fat for energy, which caused acid to build up in the blood). Resident 71 was cognitively intact and received insulin injections. A review of Resident 71's active orders documented the resident was to have their blood sugar level obtained before meals and at bedtime. The resident was also to receive an injection of 13 units of Humalog insulin three times daily. On 01/15/2025, an order was given for resident 71 to receive additional insulin coverage after their meals and at bedtime. The amount of insulin to be received was based on the result of their blood sugar check. Additional orders were given for Resident 71 to take sevelamer (lowered the amount of phosphorous in the blood) 2400 milligrams three times a day with meals, and to have dialysis sessions every Monday, Wednesday and Friday from 1:20 PM to 5:20 PM. A review of the medication/treatment administration records (MAR/TAR) for January 2025 through February 05, 2025 documented Humalog insulin13 units injections were scheduled to be given each day at 7:30 AM, 11:30 AM, and 4:30 PM. On Mondays, Wednesdays and Fridays during the resident's dialysis treatments when Resident 71 was out of the facility, they missed their insulin on the following dates and times: 11:30 AM- 01/06/2025, 01/10/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025, 01/31/2025 and 02/05/2025. 4:30 PM-01/01/2025, 01/03/2025, 01/06/2025, 01/08/2025, 01/10/2025, 01/15/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025, 01/31/2025 and 02/05/2025. Blood sugar checks with insulin coverages beginning 01/15/2025 were scheduled on the MARs to be checked and administered at mealtimes daily during the following timeframes of 6:00 AM to 10:00 AM, 10:00 AM to 2:00 PM, and 2:00 PM to 6:00 PM. Resident 71's blood sugar checks and insulin coverage were omitted on the following dates and times: 10:00 AM to 2:00 PM-01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025 and 01/31/2025. 2:00 PM to 6:00 PM-01/15/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025 and 01/31/2025. Resident 71 also had doses of sevelamer omitted on the following dates in January 2025: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/03/2025, 01/06/2025, 01/10/2025, 01/15/2025, 01/20/2025, 01/22/2025, 01/24/2025, 01/27/2025, 01/29/2025 and 01/31/2025. In the areas on the MARS where the staff were to enter that the medications listed above had been administered, there was a code 1 entered. The key on the MAR documented that a code 1 indicated the resident was out of the facility without their medications. During an interview on 02/07/2025 at 9:03 AM, Resident 71 stated they brought a lunch with them to their dialysis sessions, but they did not receive any medications during their sessions. During an interview on 02/07/2025 at 9:04 AM, Staff CC, Licensed Practical Nurse, stated they gave Resident 71 their medications and on the days the resident had dialysis sessions, the resident left the facility at around 10:20 AM and did not return until after 6:00 PM. Staff CC did not send any medications to dialysis with Resident 71 and entered the code 1 on the MAR. Staff CC stated they were unsure if the providers were aware the resident was not receiving their medications on dialysis days. During an interview on 02/07/2025 at 9:50 AM, Staff DD, Physician Assistant, reviewed Resident 71's MARs with the surveyor. Staff DD stated there had been no communication from staff regarding the timing of the resident's insulins and sevelamer. Staff DD stated they would have expected staff to communicate with them regarding this so that medication doses could be adjusted or dosed differently if able so that doses were not omitted. Staff DD stated staff could assess Resident 71 to see if they were able to self-administer their medication at dialysis. If so, this also prevented doses from being omitted depending on the assessment. BLOOD PRESSURE PARAMETERS <Resident 22> During review of Resident 22's January 2025 MARS on 01/31/2025, an order was found that documented on 11/23/2024, the physician had prescribed a medication (Metoprolol) to manage Resident 22's high blood pressure. The instructions directed the nursing staff to assess Resident 22's heart rate prior to administering the medication. If the heart rate was below 50 beats per minute (bpm) the Metoprolol was to be held. On 01/26/2025 and 01/27/2025, Resident 22's heart rate was documented to be below the parameter of 50 bpm, but the documentation indicated the Metoprolol was still given, and not held as directed in the order. No documentation was found that showed why the medication had not been held. In an interview on 02/04/2025 at 10:57 AM, Staff N, Registered Nurse, reviewed Resident 22's record and confirmed no documentation was found that explained the reason for giving the Metoprolol when the heart rate was below the ordered parameters. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/2025 at 1:21 PM, Staff B, Director of Nursing, stated the expectation was medications, insulin and blood sugar monitoring were to be done as ordered by the physician. After review of Resident 22's record, Staff B confirmed the blood sugars and insulins had not been administered as ordered. With regards to Resident 22's Metoprolol, Staff B was able to locate progress notes on the dates in question, that documented the physician was notified of the low heart rate values, but no order was given to administer the medication with the low heart rate. Staff B stated the Metoprolol should have been held. <Resident 46> The 12/04/2024 quarterly assessment documented Resident 46 was able to make decisions regarding their care and had diagnoses which included high blood pressure. A review of the resident's January MARS showed the physician had prescribed a medication (Metoprolol) on 11/27/2024 to manage Resident 46's high blood pressure. The instructions directed the nursing staff to assess the resident's blood pressure and heart rate and if the systolic blood pressure (SBP, the top number of the blood pressure reading) was less than 120 and the heart rate was less than 60 bpm the Metoprolol was to be held. On 01/02/2025, 01/06/2025, 01/08/2025, 01/11/2025, 01/12/2025, and 01/27/2025, Resident 46's SBP was documented to be below the parameter of 120, but the documentation indicated the Metoprolol was still given and not held as directed in the order. No documentation was found that showed why the medication had not been held. In an interview on 02/06/2025 at 10:16 AM, Staff N, Registered Nurse, stated blood pressure medications needed to be held per the parameters and this was important because the resident could have a bad outcome. During an interview on 02/06/2025 at 10:32 AM, Staff C, Resident Care Manager, stated the blood pressure medications should have been held and the provider should have been notified. Reference: WAC 388-97-1060 (3)(k)(iii) 46033 46115

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

47328

Based on observation, interview, and record review the facility failed to ensure medications were stored under proper temperature controls in 2 of 3 sampled medication rooms (East and West) and in 1 of 3 medication storage refrigerators (East), reviewed for medication storage. This failure placed residents at risk of receiving less than the optimum dose of their medications, adverse side effects, and diminished quality of life.

Findings included .

<West Medication Room>

During observation on 02/05/2024 at 1:16 PM, the [NAME] medication room was observed with Staff F, Licensed Practical Nurse. No thermometer was observed in the medication room where various medications were stored at room temperature.

<East Medication Room>

During observation, interview, and record review on 02/07/2025 at 7:42 AM, the East medication room was observed with Staff B, Director of Nursing. No thermometer was observed in the medication room where various medications were stored at room temperature. Staff B acknowledged the East medication room did not have a thermometer to monitor the temperature of the room where various medications were stored. The refrigerator contained various insulins, intravenous medications and concentrated oral antianxiety medications. Staff B stated staff checked the medication room refrigerator temperatures every night shift. Review of the February 2025 temperature log showed only one entry of 32 degrees on 02/06/2025. Review of the January 2025 temperature log showed temperature entries for 13 out of 31 days. Staff B acknowledged the medication room refrigerator temperature log had numerous omissions. Staff B stated they expected staff to check the temperatures in the medication refrigerator because storing medications at inappropriate temperatures could potentially affect the quality of medications.

During an interview on 02/07/2025 at 10:35 AM, Staff A, Administrator, stated they expected staff to check the medication room refrigerator temperatures because storing medications at incorrect temperatures could potentially affect medication quality. A policy on medication storage was requested at that time and again at 3:30 PM. No documentation was provided.

Reference WAC 388-97-1300 (2), -2340

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

37544

Based on observation, interview and record review, the facility failed to provide appetizing and palatable food for 5 of 9 sampled residents (Residents 18, 23, 36, 48 and 54) reviewed for food. This failure placed the residents at risk for decreased nutritional intake, and a diminished quality of life.

Findings included .

<Resident 18>

The 01/13/2025 quarterly assessment documented Resident 18 was cognitively intact and able to make decisions regarding their care.

On 01/29/2025 at 9:05 AM, Resident 18 was observed in their room seated in their recliner. Resident 18 stated the food was not good, that the vegetables were mushy and any chicken they got was a processed patty. The resident stated they had been at the facility for years and could not remember when they had last seen a real chicken breast or real drumstick. Resident 18 stated the food was just thrown on the plate so that it did not look appetizing. They stated they had talked about their concerns with the dietary staff but there had been no results.

<Resident 23>

The 11/21/2024 quarterly assessment documented Resident 23 was cognitively intact to make decisions regarding their care.

On 01/28/2025 at 3:27 PM, Resident 23 was observed lying in bed watching television. When asked about the food, Resident 23 stated, they sent it back often, it was not good, they sent it back a lot, the eggs at breakfast were not edible, I have no idea what they do to them, but it smells and tastes terrible.

On 01/31/2025 at 9:20 AM, Resident 23 was observed lying in bed watching television. When asked how breakfast was, Resident 23 stated it was good, had sausage, but one time the meal looked like scraps, like someone had eaten and they were served the left-over plate.

<Resident 36>

The 12/16/2024 quarterly assessment documented Resident 36 was cognitively intact to make decisions regarding their care.

During an interview on 01/28/2025 at 10:26 AM, Resident 36 stated they were a lousy cook and the facility cook was even worse. The resident stated the food was inedible, too salty, and most of the time they usually did not eat the food, just had a sandwich.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/2025 at 11:56 AM, Resident 36 stated they wanted a sandwich, the lunch did not taste like it should and they did not like it. At 12:18 PM, the resident received a sandwich and stated it was good. <Resident 48> The 01/09/2025 comprehensive assessment documented Resident 48 had diagnoses which included gastroesophageal reflux disease (GERD) (a chronic digestive disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining) and esophageal ulcer (a sore that develops in the lining of the esophagus) with bleeding. The resident was cognitively intact to make decisions regarding their care. In an observation and interview on 02/03/2025 at 12:48 PM, Resident 48 was lying in bed, eating their lunch meal (pork roast with gravy, spinach, rice, coffee, milk, and lemonade). The resident stated that the food was sometimes too salty and did not have enough flavor or seasoning. <Resident 54> The 10/22/2024 quarterly assessment documented Resident 54 was cognitively intact to make decisions regarding their care. During an interview on 01/28/2025 at 10:40 AM, Resident 54 stated the food was not good and they used too much salt. Resident 54 stated they requested sandwiches, soup and fruit. In an interview on 01/28/2025 at 11:42 AM, Resident 54's representative stated the food was extremely bad and the meat was too tough. In an observation on 01/31/2025 at 11:59 AM, Resident 54 was served fish, vegetables and cake. Resident 54 stated they did not like the food and had requested a sandwich. During an observation on 02/03/2025 at 11:53 AM, Resident 54 stated they did not like the meat and had requested a sandwich. <Test Tray> On 02/04/2025 at 12:49 PM, a test tray of the lunch meal was sampled by the survey team. The meal consisted of a chicken taco, baked apples, rice, and beans. The alternative entree was bar-be-que pork. The chicken in the taco tasted like it was canned and the rice and beans were bland without taste or flavor. The appearance of the meal was unappetizing, brown in appearance and without color. The bar-be-que pork was the only item that tasted good and had flavor. A subsequent test tray was obtained from the last cart being served during the breakfast meal and sampled by the survey team on 02/07/2025 at 8:36 AM. The temperature of the food was lukewarm. The meal consisted of hashbrowns, scrambled eggs, oatmeal with brown sugar and diced mangos. The hashbrowns tasted like they were seasoned with a salt substitute that was not appetizing. The scrambled eggs tasted flavorless and had large mushy curds. The oatmeal with brown sugar tasted bland and was soupy. The diced mangos were hard, unripe and had no fruit flavor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/04/2025 at 11:34 AM, Staff W, Dietary Manager, stated they tasted the food while cooking or before tray line to assure that the food was palatable. Staff W stated that this was important for adequate meal consumption and maintaining nutrition for the healing of residents. During an interview on 02/04/2025 at 2:32 PM, a representative from the State Ombudsman office reported to the survey team residents had expressed to their office multiple concerns related to the food and had requested Staff W to attend the Resident Council meetings so the concerns related to the temperature and taste of the food could be discussed, and it took six months before Staff W attended. Reference WAC 388-97-1100 (1), (2) 46033 46115 50027

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review the facility failed to store, discard and distribute food, and monitor temperatures of foods being served in accordance with professional standards for food safety for 1 of 1 facility kitchens, reviewed. This failure placed residents at risk for food borne illness and diminished quality of life. Findings included . Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed that food must be labeled with the date the food was prepared, the package opened, and the date the food must be discarded as directed by the food manufacturer's use-by-date. The U.S. FDA Food Code 2022 also showed that there was an increased risk of contamination when food was held, cooled and reheated at improper temperatures. Thus, temperatures of food must be taken and monitored. Records must be maintained to verify food temperatures are within the parameters required for food safety. <Food Storage> During a kitchen observation and interview on [DATE] at 9:07 AM, the walk-in refrigerator contained a crate of approximately 36 pasteurized eggs with an expiration date of [DATE]. Staff W, Dietary Manager, acknowledged that the eggs were expired and quickly disposed of the crate of eggs. In an interview on [DATE] at 12:00 PM, Staff W stated the eggs should have been discarded. Staff W stated that it was important for the prevention of bacterial growth and resident illness. <Food Preparation and Service> During an observation of a tray line service held in the dining room on [DATE] at 10:54 AM, Staff FF, Assistant Dietary Manager, began using a digital thermometer to check the temperatures of the food items resting in the steam table. Staff FF checked the food temperatures for the food items being served from the steam table. In an observation and interview on [DATE] at 11:10 AM, a resident was observed eating a chef's salad in the dining room. Staff FF did not check the temperature for the chef's salad. Staff W stated the salad was brought out of the refrigerator in the kitchen. During an observation of a tray line service held in the kitchen on [DATE] at 11:18 AM, Staff FF unloaded the food items that were served in the dining room off a cart and onto the steam table in the kitchen. No staff checked the temperatures of the food from the steam table before the start of tray line. When prompted by the surveyor, Staff W stated the facility did not check temperatures at the steam table in the kitchen. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 11:45 AM, Staff W stated the facility did not check temperatures of foods after the first tray line was completed in the dining room. They stated the second tray line completed in the kitchen consisted of randomly checking temperatures of various foods and those temperatures were not documented. Staff W stated that it was important to monitor temperatures for prevention of food contamination and bacterial growth. Record review on [DATE] of the temperature logs from [DATE] through [DATE] for both serving locations (dining room and kitchen) showed no documentation of temperatures for the kitchen tray line. Reference: WAC [DATE](3), -2980

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

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review the facility failed to ensure arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreement was reviewed and explained in a form, manner, and/or language understood by the resident and/or their legal representative for 3 of 3 sampled residents (Residents 14, 60, 90), reviewed for arbitration. This failure placed residents at risk of being uninformed of their rights, loss of legal protection, loss of right to pursue legal action and a diminished quality of life. Findings included . The Avalon Healthcare Management Patient and Facility Arbitration Agreement stated the parties understood that any dispute would be resolved by arbitration, and not by a lawsuit or court process. The policy further stated that the parties understood and agreed that by entering the arbitration agreement, they waived their constitutional right to a jury trial, and that by signing the agreement, they acknowledge they have read, and understood that the arbitrator's decision was binding, could not be appealed, and could be enforced by a court. <Resident 14> The 12/03/2024 admission agreement documented Resident 14 admitted to the facility on [DATE], was severely cognitively impaired and had diagnoses which included non-Alzheimer's dementia. Review of Resident 14's record showed the facility's arbitration agreement was e-signed on 12/04/2024 by Resident 14, and not their legal representative. Review of the progress notes from 11/27/2024 through 02/04/2025 showed Resident 14 was cognitively impaired, had dementia, was alert to self only, but able to make needs known at times. On 02/05/2025 at 9:47 AM, Resident 14 was observed sitting in their wheelchair in the hallway. When asked how long they had lived at the facility, the resident stated they had lived there since the facility opened. When asked what the date was today, the resident stated they didn't know. <Resident 60> The 06/06/2025 admission assessment documented Resident 60 admitted to the facility 05/31/2024, was severely cognitively impaired and had diagnoses which included Alzheimer's dementia. Review of Resident 60's record showed the facility's arbitration agreement was electronically signed on 06/03/2024 by the severely cognitively impaired Resident 60, and not their legal representative. Review of the progress notes from 05/31/2025 through 02/05/2025 showed Resident 60 was cognitively impaired, oriented to self only, but able to make needs known at times to staff. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/2025 at 11:53 AM, Resident 60 was observed sitting in their wheelchair in their room. When asked if the facility's arbitration agreement had been explained to them, and if they had signed the agreement, Resident 60 stated when they were in the Air Force, they were going to make decisions about the airplane. I am not the pilot, just a person on the plane. Resident 60 pointed to their amputated left knee and stated that was all they had left, there was no fuel. Resident 60 then made a gesture with their hands and then stated I had a tube this size, I can't find it. <Resident 90> The 11/26/2024 admission assessment documented Resident 90 admitted to the facility 11/20/2025, was severely cognitively impaired and had diagnoses which included non-Alzheimer's dementia. Review of Resident 90's record showed on 11/21/2025 the facility's arbitration agreement was e-signed by the resident and not their legal representative. A progress note on 11/21/2024, the day Resident 90 signed the arbitration agreement, Staff AA, Physician Assistant, documented Resident 90 had dementia and believed they were in Hood River, Oregon. In an interview on 02/05/2025 at 2:28 PM, the arbitration agreement was explained to Resident 90's power of attorney (POA, person who can make healthcare decisions when a person is unable to do so). The POA stated Resident 90 was confused and could not sign an arbitration agreement. The POA acknowledged the facility did not review the arbitration agreement with them, Resident 90's legal representative. In an interview on 02/05/2025 at 12:07 PM, Staff Z, Admission Director stated the arbitration agreement was offered when residents admitted to the facility. When asked if the facility had a process in place or if an assessment was done prior to the agreement being offered to determine if a resident was cognitively able and/or had the mental capacity to enter into and sign an arbitration agreement, Staff Z stated they reviewed the residents records that were received when they admitted to determine if the resident was able to understand and sign the agreement, and if they were not, then the agreement would be offered to the resident's representative and/or Power of Attorney (POA). When asked if the resident and/or representative gave up the right to go to court if they entered into an agreement, Staff Z stated they did not believe they gave up the right, but they would ask Staff A, Administrator. In an interview on 02/05/2025 at 12:17 PM, Staff A, Administrator, confirmed arbitration was used to settle disputes and the resident and/or representative gave up the right to go to court if entered into an agreement, and it remained in effect if the resident discharged and admitted at a later date. Staff Z stated they did not know that the agreement would be valid after the resident discharged . When informed Residents 14, 60 and 90 all had severe cognitive impairments and had signed the arbitration agreements, Staff A stated the agreement should have been offered to the resident's representatives and/or POA. No Associated WAC

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37544

Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions were implemented when indicated for 2 of 4 sampled residents (Residents 46 and 54) reviewed that had draining wounds and that hand hygiene was completed when indicated during 1 of 2 dining observations and 1 of 2 wound treatments observed. Additionally, N95 respirator-style masks were not donned correctly in accordance with the Centers for Disease Control (CDC) guidelines by 7 Staff (R, HH, II, JJ, X, T, and KK) when reviewing infection control practices, infection prevention and control policies were not reviewed yearly as required and a water management plan was not fully developed. These failures put residents and staff at risk of becoming ill with contagious viral and bacterial infections and spreading those illnesses to others.

Findings included .

The 04/02/2024 Centers for Disease Control (CDC) publication Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant organisms (MDROs) described Enhanced Barrier Precautions as the use of gown and gloves during high-contact resident care activities to prevent the transfer of MDROs from resident to resident through contact with staff hands and clothing. High contact resident care activities included dressing, bathing, showering, changing linens, providing hygiene, changing briefs, wound care, or care for devices such as catheters or feeding tubes. Enhanced barrier precautions were intended to remain in place for the duration of the resident's stay, or until the resolution of the wound or medical device that placed them at risk.

The 05/16/2023 CDC publication, How to use Your N95 Respirator, stated N95 respirators (a special type of tight-fitting mask that filters particles) must form a seal to the face to work properly. The document showed the mask was to be placed under the chin, with the nose piece bar at the top, the top strap pulled over the head and placed near the crown, and the bottom strap placed at the back of the neck, below the ears. The straps were to lay flat, be untwisted, and not be crisscrossed.

At the time of the survey, the facility had an outbreak of COVID-19, a highly contagious viral illness that caused difficult breathing, fever, body aches, lethargy and serious health consequences in vulnerable populations.

<N95 Respirator Use>

On 01/28/2025 at 9:49 AM, Staff R, Licensed Practical Nurse (LPN), was observed wearing an N95 mask with both mask straps placed above the ears towards the top of the head.

On 01/28/2025 at 10:00 AM, Staff HH, LPN, was observed wearing an N95 mask with both straps positioned above the ears around the back of the head.

On 01/28/2025 at 11:04 AM, Staff R, LPN, was again observed wearing an N95 mask with both straps positioned above the ears towards the top of the head.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/28/2025 at 11:42 AM , Staff II, Nursing Assistant (NA), was observed wearing a stocking hat and a neck scarf. Staff II wore an N95 mask with the top strap of the mask positioned on top of the head, over the stocking hat, the bottom strap of the mask was positioned over the back of the scarf. On 01/28/2025 at 12:01 PM, Staff II's N95 mask straps continued to be positioned incorrectly, with the top strap over the stocking hat and the bottom strap lying over the back of the scarf. Several other staff members were present in the hallway and nobody corrected or redirected Staff II about the positioning of the straps. On 01/28/2025 at 12:03 PM Staff JJ, Occupational Therapist, was observed wearing an N95 mask with the top strap positioned correctly, but the bottom strap was positioned over their long hair, and not around the back of the neck. On 01/28/2025 at 12:16 PM, Staff X, NA, was observed wearing an N95 mask with both straps positioned above the ears on the back of their head. When asked about the positioning of the straps, Staff X stated they had received training on PPE, and knew one strap was supposed to be on the top of the head, and the bottom one behind the neck, but it was inconvenient to place the straps like that because of their hair clip. On 01/28/2025 at 12:27 PM, Staff II donned a gown and gloves prior to entering room [ROOM NUMBER] to deliver lunch trays. Staff II removed the stocking hat and positioned the top strap correctly prior to entering the room, but the bottom strap was still lying over the back of the neck scarf. At 12:32 PM, Staff II exited the room, doffed the gown/gloves and N95, put the stocking hat back on, donned a new N95 and positioned the top strap of the mask over the stocking hat on the top of head. Staff II stated they had received training regarding PPE and the wearing of N95 masks. When informed about the proper placement of the N95 straps, Staff II stated they were not aware that the top strap needed to be directly on the head and wearing over a hat or other items could interfere with the mask creating a seal. Staff II then positioned the straps correctly. On 01/31/2025 at 9:32 AM, Staff X, NA, was observed walking down the hall wearing an N95 mask with both straps positioned on the top of the head. When Staff X saw the surveyor, they adjusted the bottom strap behind the neck. On 02/03/2025 at 10:01 AM, Staff T, LPN, was observed wearing an N95 with the straps placed behind their neck. Staff T stated the straps slid down, so they wore them behind the neck to get a tight seal. On 02/05/2025 at 11:55 AM, Staff KK, NA, was observed wearing both straps of their N95 around the top of the head, above the ears. Staff KK stated one strap was supposed to be behind the neck, but it bothered their skin to wear it like that and started to cause a rash. Staff KK expressed understanding about the importance of wearing the straps correctly to get a better seal. On 02/05/2025 at 2:21 PM, Staff KK was observed with their N95 mask below their chin. In an interview on 02/05/2025 at 10:20 AM, Staff R, LPN, was again observed with both N95 straps positioned above the ears. When asked about the placement of the straps, Staff R felt the straps and stated it was incorrect and positioned them properly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/07/2025 at 9:10 AM, observations and concerns related to the improper wearing of N95 masks and not following CDC guidelines during an active COVID-19 outbreak was discussed with Staff A, Administrator, Staff B, Director of Nursing (DNS), and Staff LL, Corporate Registered Nurse (RN). Staff A acknowledged the concerns. <Enhanced Barrier Precautions> In an observation on 01/31/2025 at 8:54 PM, Resident 54 was lying in bed watching television. The resident was not wearing their foam boot to their left heel and there was yellow drainage from their heel wound on the pillowcase. There was no enhanced barrier sign on the resident's door and no PPE nearby. Similar observations of Resident 54 without an enhanced barrier sign on the door were made on 02/03/2025 at 9:50 AM, 02/05/2025 at 11:28 AM and 02/06/2025 at 1:30 PM. In an interview on 02/06/2025 at 2:57 PM, Staff B, DNS, stated residents with wounds needed to be on enhanced barrier precautions and this was important to stop the spread of germs. In an observation and interview on 02/05/2025 at 11:54 AM, Resident 46 was lying in bed. The resident had bloody drainage on their shirt under their right armpit. The resident stated they had a sore under their armpit. Resident 46 did not have an enhanced barrier sign on their door and there was no PPE nearby. Review of the January 2025 medication administration record showed a 01/17/2025 provider order to cleanse the right armpit with wound cleanser and to apply a dressing every day and as needed. In an interview on 02/06/2025 at 2:22 PM, Staff C, Resident Care Manager, stated Resident 54 should have been on enhanced barrier precautions. <Wound Care> In an observation on 02/06/2025 at 1:30 PM, Staff BB, RN, put on a pair of gloves, touched Resident 54's foam boot, adjusted the resident's bed with their bed controls, obtained a pad out of the resident's bag, touched items in a bin that was filled with treatment supplies, cut the resident's pad in half, lifted the resident's left heel, opened betadine swabs and applied it to their heel while wearing the same pair of gloves. Staff BB, wearing the same pair of gloves, placed the resident's foot back into the foam boot, placed pillows under their leg, then removed their gloves, turned the light off in the room and then performed hand hygiene. During an interview on 02/06/2025 at 1:42 PM, Staff BB stated they should have changed their gloves and performed hand hygiene before the wound care, and this was important to prevent the spread of germs. <Dining Service> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 01/28/2025 at 11:03 AM, Staff W, Dietary Manager, passed a tray to a resident, then touched another resident's glass of juice to move it, without performing hand hygiene, passed another tray, then touched the glass on the serving cart, touched another resident's plate, opened the resident's ketchup, picked up the salt and pepper holder and moved it to another location, then sanitized their hands. In an interview on 01/28/2025 at 11:27 AM, Staff W stated hand hygiene should have been completed after every tray was passed, and after touching things such as cups, clothing, and the glass on the serving cart. During an interview on 02/07/2025 at 1:17 PM, Staff D, Infection Preventionist, stated all nurses should be able to determine who needed enhanced barrier precautions. The expectation would be for staff to follow the guidance on the enhanced barrier sign, and this was important because it breaks the chain of infection and stops the spread of germs. Staff D stated staff needed to clean their hands between every person and when they removed their gloves. <Infection Prevention Program policies and procedures> A review of the Infection Prevention policies documented the policies were created or revised on the following dates and were not current: -Antibiotic Stewardship (11/2017, revised 03/2019) -Antibiotic Stewardship Program (05/2019, revised 11/2020, 04/2022) -Infection Prevention and Control Program (11/2017, revised 06/2022) -Infection Preventionist (09/2018) -Influenza and Pneumococcal Immunizations (11/2017, revised 06/08/2022) -Standard Precautions, Enhanced Barrier Precautions and Transmission-based Precautions (07/26/2022) -Vaccination Requirement for SARS-Cov-2 (COVID-19) (01/27/2022, revised 03/21/2022, 06/29/2022) During an interview on 02/07/2025 at 11:13 AM, Staff A, Administrator acknowledged the policies were not current. <Water Management Plan> On 02/05/2025, documents for the facility water management plan were requested. A document titled, Risk Management Plan for Legionella Control in the Operation and Management of the Water Systems of 'Facility Name' was provided. The document was a template and had not been completed with facility specific information. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/2025 at 11:13 AM, Staff A, Administrator, stated they would check to see if the completed document was in the maintenance department. Staff A returned with a binder that included hot water temperature checks that had been done weekly and a sample of the water chlorine test kit that the facility used to test chlorine levels in their water system. After review with the surveyor, Staff A acknowledged that the water management plan needed to be further developed so that all the elements that were required were included. There had been no cases of Legionnaires disease since the prior survey. Reference: WAC 388-97-1320 (2)(b), 1320 (1)(c) 46033 46115

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure resident beds were in safe operating condition for 4 of 26 beds in use on the [NAME] nursing unit observed. Specifically, bed controls had wires exposed and old electrical tape that had peeled off for 4 resident beds. This failure put residents at risk of injury and of being deprived of a home-like environment. Findings included . On 01/29/2025 at 9:35 AM, Resident 74 was observed in room [ROOM NUMBER]-1 seated on their bed. The bed control was observed to have wiring exposed where the wiring entered the portion that had buttons for adjusting the position of the head or foot of the bed. The resident stated they were unsure when the wiring became exposed. There were no frayed wires present. On 01/29/2025 at 10:18 AM, Staff K, Maintenance Director had replaced the bed in room [ROOM NUMBER]-1 and was observed pushing the bed with the exposed wiring down the hall. On 01/29/2025 at 10:25 AM, further resident bed observations identified the following: -The bed in room [ROOM NUMBER]-2 had two areas on the cord of the bed control that had old peeled electrical tape that had begun to come off. Under, there were exposed bed control wires. -The bed in room [ROOM NUMBER]-1 had electrical tape that had begun to peel off near the portion that was connected to the controller and wires were exposed. -The bed in room [ROOM NUMBER]-2 had old electrical tape that had begun to peel off and wiring was exposed. The same beds were observed in the same condition on 01/30/2025 at 2:09 PM and 02/03/2025 at 9:28 AM. During an interview on 02/06/2025 at 12:57 PM, Staff K stated if they did not receive a work order, they did not know if beds were in disrepair. Staff K stated they did not do regular walk around preventive inspections or audits of the equipment on the nursing units. They stated if they received a work order for a bed it was fixed. See also citation K0921. Reference: WAC 388-97-2100

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure the call bells were in working condition for 2 of 50 residents observed (Residents 4 and 74) housed on the [NAME] nursing unit. This failure placed residents at a safety risk of having their urgent needs unanswered and unintended health consequences. Findings included . <Resident 74, room [ROOM NUMBER]-1> On 01/29/2025 at 9:35 AM, Resident 74 was observed in their room seated on their bed. The call light cord was observed pulled out of the wall, coiled up in a cardboard toilet paper roll and was placed on top of the chest of drawers. The call light system at the wall over the resident's head of their bed had green painter's-type tape over the button that turned off the light if it had been activated. Resident 74 stated their call light had not functioned for a couple of weeks. Resident 74 stated previously the light did not shut off and they had removed the cord the previous day. Resident 74 stated they had notified Staff S, Recreation Therapy at that time. Resident 74 stated if they needed staff they went in the hall to get someone. They were unsure how they would get help if, for example, they had fallen in their room. During an interview on 01/29/2025 at 9:41 AM, Staff F, Licensed Practical Nurse (LPN), stated they were not aware that Resident 74's call bell did not work. They stated they had not noticed the cord was pulled out when they had given Resident 74 their medications earlier. Staff F observed the call light and after they attempted to reinsert the cord into the wall identified that the cord did not work. On 01/29/2025 at 10:01 AM, Staff K, Maintenance Director, replaced the call light cord and the call system again functioned. Staff K confirmed they had received a work order from Staff S on 01/28/2025 at 1:28 PM but they had not seen the work order until 01/29/2025, that morning. Staff K stated they were the only maintenance worker for the entire building and attempted to address work orders timely. <Resident 4, room [ROOM NUMBER]> On 02/04/2025 at 4:20 PM, Resident 4 was observed lying in their bed and stated they did not feel well. Resident 4 stated they had not eaten and stated they were hungry. When Resident 4 attempted to activate their call light to request food, it was observed that it did not work. On 02/04/2025 at 4:24 PM, Staff Q, LPN, was notified the call light in room [ROOM NUMBER] did not work. Staff Q stated Resident 4 had problems with their call light in the past and used to pull the cord out of the wall and the cord had been replaced several times. Staff Q retrieved a desk-style manual call bell for Resident 4 and notified Staff K. On 02/04/2025 at 4:48 PM, Staff K had repaired the call light in room [ROOM NUMBER] and the call bell functioned. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 02/06/2025 at 12:57 PM, Staff K stated they did not do routine regular observations or audits of the equipment on the nursing units. They stated if they did not get a work order, they did not know if call bells did not function. Reference: WAC 388-97-2280(1)(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure resident personal refrigerators were maintained in a clean manner, without expired foods and at the appropriate temperatures for 2 of 5 sampled residents (Residents 74 and 51) reviewed for a homelike environment. This failure placed the residents at risk of eating spoiled foods and having an unclean environment. Findings included . <Resident 74> During an interview on [DATE] at 9:35 AM, Resident 74 was observed seated on the edge of their bed. A small dormitory-style refrigerator was on the floor next to the head of the bed. Inside the refrigerator, a brown liquid had been spilled on the bottom. A can of soft drink rested in the liquid, and a supplement drink was on the shelf. Resident 74 stated they were given the refrigerator when another resident got a new one. They stated they kept drinks and snacks in it, but were unsure who kept track of refrigerator temperatures.They stated there was no temperature log in their room. On [DATE] at 9:40 AM, Resident 74's refrigerator no longer had a brown liquid in the bottom. There were empty coffee mugs and half full fruit cups on top of the refrigerator. There was no temperature log. <Resident 51> During an observation on [DATE] at 2:31 PM, Resident 51 was lying in bed. They had a personal refrigerator that contained vanilla yogurt that had expired on [DATE] and butterscotch pudding that had expired on [DATE]. The refrigerator was unclean with spilled brown liquid on the bottom shelf and there was no temperature log. Subsequent observations of the refrigerator being unclean with expired yogurt and butterscotch pudding were made on [DATE] at 1:25 PM, [DATE] at 9:02 AM, [DATE] at 9:20 AM, and [DATE] at 8:54 AM. In an interview on [DATE] at 9:24 AM, Staff X, Nursing Assistant, stated they were unsure of who was responsible for monitoring the resident's personal refrigerator. During an interview on [DATE] at 9:26 AM, Staff C, Resident Care Manager, stated temperature logs were kept in the resident rooms and the expired food should have been discarded. Staff C stated the temperature of the refrigerator should have been monitored to prevent illness. In an interview on [DATE] at 9:28 AM, Staff B, Director of Nursing, stated the nurses were responsible for monitoring the personal refrigerators. Staff B stated they should have monitored the temperatures, discarded expired food and kept the refrigerators clean to prevent illness. Reference: WAC [DATE] (1) (continued on next page)

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 02/07/2025
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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46115