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	05/28/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment for 1 of 3 units (Unit 1 - North Unit), observed for environment. This failure resulted in residents being unable to have a clear view to the outside through several windows. Findings included.During an interview on 05/19/2026 at 1:05 PM, the resident council stated the facility did not clean the windows, they were too dirty and unable to see outside.During observation on 05/21/2026 at 9:12 AM, on Unit 1 - North Unit, both windows in room [ROOM NUMBER] had a white film, similar to hard water residue (chalk, white mineral spots), on the outside of the windows which made the whole window blurry to look out of. During observation and interview with Resident 78 on 05/21/2026 at 11:16 AM, the windows in their room (310) were observed. Resident 78 stated the windows had been blurry with a white film on the outside since they admitted in mid-April 2026 and they were unsure if housekeeping cleaned them. Similar observations were made on 05/21/2026 at 2:04 PM, and 3:23 PM, on 05/22/2026 at 9:10 AM and 11:42 AM, on 05/26/2026 at 5:17 AM, and on 05/27/2026 at 9:50 AM. During observations on 05/21/2026 at 10:13 AM, five out of eight windows on the Unit 1 - North Unit, the common television room had a white film on the outside which made the windows blurry to look out of. Similar observations were made on 05/21/2026 at 2:06 PM and 3:24 PM, on 05/22/2026 at 11:43 AM, on 05/26/2026 at 4:53 AM and 6:36 AM, and on 05/27/2026 at 9:51 AM.During observation on 05/21/2026 at 10:15 AM, the windows in room [ROOM NUMBER] had a white film on them, which made the whole window blurry to look out of. Similar observations were made at 2:04 PM and 3:24 PM, on 05/22/2026 at 9:11 AM and 11:44 AM, on 05/26/2026 at 4:51 AM, and on 05/27/2026 at 9:50 AM. During observation and interview on 05/27/2026 at 9:54 AM, Staff J, Nursing Assistant, stated the housekeepers cleaned residents' room daily, including the windows in the rooms. Staff J observed the windows in room [ROOM NUMBER]. Staff J acknowledged the windows had a white film on them that made it difficult to look out of. Staff J was unsure how long the windows were in that condition.During observation and interview on 05/27/2026 at 10:06 AM, Staff K, Housekeeper, stated the facility was full service and cleaned whatever needed to be cleaned, including the inside windows. Staff K observed the windows in room [ROOM NUMBER]. Staff K acknowledged many windows along the Unit 1 - North Unit of the 300 unit had a hard water film on them from the sprinkler water hitting the windows. Staff K further stated they attempted to clean the outside windows once, but it was difficult and were only able to clean a small corner of one window. Staff K was unsure if professional cleaning had been scheduled.During observation and interview on 05/27/2026 at 10:17 AM, with Staff L, Maintenance Director, the windows in rooms [ROOM NUMBERS] were observed. Staff L acknowledged the windows had a hard water film on them that made them blurry to look out of caused by the sprinkler water hitting the windows along the North side of the building.During an interview on 05/28/2026 at 12:23 PM, Staff A, Administrator, acknowledged windows on the Unit 1 - North Unit side of the facility had a hard water film on them that made them blurry to look out of. Staff A stated they expected staff to maintain a clean, comfortable, and home-like environment.Reference WAC 388-97-1060 (1)-(3)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that lorazepam liquid (a controlled anti-anxiety medication with potential for abuse) was monitored adequately to minimize risk of loss or diversion, in 2 of 3 medication rooms inspected (Med room [ROOM NUMBER] - East and Med room [ROOM NUMBER] - West). Additionally, the facility failed to discard 2 vials of an expired Tuberculin PPD (a solution injected under the skin to test for exposure to tuberculosis, a contagious respiratory disease) in 1 of 3 medication rooms inspected (Med room [ROOM NUMBER] - West). These failures placed the facility at risk of diversion of controlled medications and residents at risk of receiving expired test solution, inaccurate test results and possible adverse health consequences. Findings included. <Lorazepam> During an inspection of the Med room [ROOM NUMBER] -West on 05/28/2026 at 11:47 AM, Staff D, Registered Nurse (RN) opened the locked box in the medication refrigerator, which contained the following two medications:A bottle of lorazepam liquid (controlled substance used for anxiety) for Resident 8. There were markings on the side of the bottle, that showed the approximate amount remaining in the bottle. The level of liquid showed 28 milliliters (ml, a unit of measurement) remaining in the bottle. Another bottle of lorazepam liquid for Resident 35, with approximately 8 ml remaining in the bottle. During a concurrent interview, Staff D stated that two nurses counted the controlled medications at every change of shift. The nurse coming on-shift would look at the medications in the locked drawer of the medication cart, then tell the nurse going off-shift the page number that the medication was in the narcotic book. Together they would verify the amount of medication remaining and matched the count in the book. When the narcotic book was reviewed, the lorazepam remaining for Resident 8 was documented as 29.5 ml (Staff D and this surveyor observed 28 ml.) The lorazepam remaining for Resident 35 was documented as 13.2 ml (Staff D and this surveyor observed 8 ml). Staff D stated, that is a problem. They stated they were unaware the lorazepam was in the refrigerator, had never included them in the count, nor had any nurse they counted with mentioned checking the refrigerator. Staff D stated, I will be doing that from now on. During an interview on 05/28/2026 at 12:20 PM, Staff V, RN, stated that during the medication count at shift change, they also had to count the refrigerated medications and wished there was a better way to remember that. During an inspection of Med room [ROOM NUMBER] -East on 05/28/2026 at 12:39 PM, Staff Y, RN, opened the locked box in the medication refrigerator, which contained four bottles of lorazepam liquid. Two of the bottles were labeled for a current resident and were counted every shift. The amount remaining for these bottles matched the narcotic book. The other 2 bottles were both unopened with an intact seal, and the labels read Omnicell (an automated, secure medication dispensing machine, that staff accessed medications with a secure code.) During a concurrent interview, Staff Y stated when the nurses count the controlled medications at shift change, they should go page by page through the narcotic book, so nothing was missed (like medications locked in the refrigerator). Staff Y stated that since the 2 bottles of lorazepam labeled Omnicell were not assigned to any resident, they were not included in the change of shift count, instead they were counted monthly with the pharmacy staff. When asked if a staff took the Omnicell lorazepam when accessing the same lockbox as resident medications, how would anyone know, if it was only counted once a month? Staff Y responded that is a good question. I understand why it is a concern. During an interview on 05/28/2026 at 2:08 PM, Staff I, Unit Manager, stated they had been informed by Staff D of the discrepancy of the amounts remaining of the lorazepam and that it had not been included in the change of shift count. Staff I stated they had informed Staff B, Director of Nursing (DON), and they were following up on it. Staff I was informed of the inspection of the Med room [ROOM NUMBER] - East findings with the Omnicell lorazepam and interview with Staff Y. Staff (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I acknowledged that all controlled substances needed to be counted during shift change to avoid diversion. During an interview on 05/28/2026 at 3:11 PM, Staff A, Administrator, and Staff B, DON, acknowledged that the lorazepam liquid should have been counted every shifty to minimize the risk of diversion and identify any discrepancies quickly. <Tuberculin PPD>During an inspection of the Med room [ROOM NUMBER] -West on 05/28/2026 at 11:27 AM with Staff Z, Unit Manager, two Tuberculin Purified Protein Derivative (PPD a medication used to detect a tuberculosis infection) vials were observed in the medication refrigerator. One vial was opened on 03/11/2026 (over two months ago) and the other was opened on 02/08/2026 (over three months ago). According to the 11/09/2020 Food and Drug Administration Tuberculin PPD package insert, https://www.fda.gov/media/74866/download, opened multi-dose PPD vials must be discarded 30 days after the initial puncture or after their expiration date. During an interview on 05/28/2026 at 3:39 PM, Staff B stated the Tuberculin PPD testing solution should be discarded 30 days after it is opened and it should have been discarded. Reference: WAC 388-97- 1300(2)

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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. Based on observation, interview and record review, the facility failed to ensure staff implemented Enhanced Barrier Precautions (EBP, use of gowns and gloves during high contact resident care activities) during 3 of 5 resident care observations (Resident 112, 144, 15) and failed to ensure gloves were worn during an insulin injection for 1 of 3 medication administration observations. These failures placed residents and staff at risk of spreading infectious bacteria, and exposure to blood or body fluids.Findings included. The Centers for Disease Control (CDC) 04/02/2024 Implementation of Personal Protective Equipment (PPE, gloves, disposable gowns, eye protection or masks, for example) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html recommended the use of EBP as an infection control intervention. EBP recommended the use of gowns and gloves during high contact resident care activities when other types of precautions did not apply for residents with wounds and/or indwelling medical devices. High contact care activities included dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care, assisting with toileting and device care that included central intravenous (IV) lines, urinary catheters, and feeding tubes. <Tube Feeding Flush> Review of the 04/14/2026 admission comprehensive assessment documented Resident 112 had diagnoses that included stroke from a bleed into the brain, inability to move the right side of the body and difficulty swallowing. Resident 112 was severely cognitively impaired, had a urinary catheter (a catheter inserted into the bladder that allowed urine to drain) and received greater than 51% of their nutrition via a gastrostomy tube (g-tube, a feeding tube inserted surgically through the abdomen into the stomach that allowed safe delivery of nutrition.) Resident 112 was dependent on staff for most of their activities of daily living. The 04/13/2026 provider order instructed staff to use EBP when caring for Resident 112 related to their urinary catheter and their feeding tube. On 05/20/2026 at 11:32 AM, Resident 112 was observed lying in bed. A urinary catheter collection bag was hung on the bedframe, and a tube-feeding pole was next to the head of the bed. An orange CDC EBP sign hung on the door at the entrance to the resident's room. It had a picture of two red stop signs at the top, and instructed staff to clean their hands before entering and when leaving the room, and instructed staff to wear a gown and gloves (PPE) for high contact resident care activities that included care or use of central lines, urinary catheters, and feeding tubes. A plastic bin that contained gowns and gloves and other PPE was also at the entrance. On 05/21/2026 at 9:02 AM, Resident 112's g-tube was observed being flushed with water with Staff S, Licensed Practical Nurse (LPN). Resident 112 was lying in bed and Staff S put on gloves and exposed Resident 112's g-tube on their abdomen. A large plastic syringe was filled with tap water and injected into a port on the g-tube. After Staff S replaced the residents gown and covers, they removed their gloves, washed their hands, and exited the resident's room. At this time, the signage on the door was reviewed with Staff S. Staff S stated they were not aware they were to wear a gown when flushing the resident's g-tube; they thought the gown was worn for more in-depth care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Antibiotic Administration via a Central IV Line> Review of the 05/18/2026 comprehensive admission assessment documented Resident 144 had diagnoses that included bacteremia (blood infection) and Streptococcal arthritis (inflammation of a joint from a Streptococcus bacterial infection) of the left hip. Resident 144 was mildly cognitively impaired and received antibiotics daily. The 05/15/2026 care plan documented Resident 144 required antibiotics via a peripherally inserted central catheter (PICC, a long flexible tube inserted into a large vein in the neck, chest or arm and advanced until the tip rests near the heart; also known as a central line) for their Streptococcal arthritis. On 05/15/2026, an order was given to administer cefazolin (an antibiotic) via the PICC three times daily. On 05/18/2026 at 3:16 PM, Resident 144 was observed resting on top of his bed. A CDC EBP sign was hung on the door, and a bin of PPE was right inside the door. A central line was observed on Resident 144's chest inserted just under the collar bone and was covered in a transparent dressing. The insertion site was visible and had no visible signs of infection or redness. Resident 144 stated they had the central line for about two months. On 05/26/2026 at 8:36 AM, Staff Q, LPN, was observed administering medications to Resident 144. Staff Q had prepared the medications at the medication cart then entered Resident 144's room. Staff Q put on a pair of gloves. After Resident 144 took their oral medications, Staff Q hung a bag of IV antibiotics on a pole, inserted the tubing in the pump, used an alcohol swab to clean the ends of the central line, and connected the antibiotic tubing to the central line and started the infusion. Staff Q then removed their gloves, washed their hands and exited the room. Staff Q stated they had received education regarding EBP and staff knew who needed EBP by hearing in morning report, or by seeing the signage on the door. Staff Q reviewed the EBP signage outside the residents door and stated they should have put on a gown when administering the antibiotic in the central line. During an interview on 05/28/2026 at 1:20 PM, Staff F, Resident Care Manager, stated staff were expected to wear gowns for those residents requiring EBP. The gowns protected staff from spreading bacteria to other residents and helped prevent infections. <Insulin injection> In an observation on 05/26/2026 at 6:46 AM, Staff X, LPN, entered Resident 7's room to administer an insulin injection. Staff X sanitized their hands, cleansed Resident 7's abdomen with an alcohol wipe and gave the injection. Staff X did not wear gloves as required for the injection. In an interview on 05/26/2026 at 7:59 AM, Staff X stated gloves needed to be worn when having direct contact with bodily fluids and it was important to prevent the spread of infection. <Catheter care> In an observation on 05/22/2026 at 1:16 PM, Staff W, Nursing Assistant (NA), entered Resident 15's room to empty their suprapubic catheter (a flexible tube inserted directly into the bladder used to drain urine). Staff W put on a pair of gloves and emptied Resident 15's catheter, no gown was worn as required. (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 05/22/2026 at 1:20 PM, Staff W pointed to the enhanced barrier sign outside of Resident 15's room and stated they should have worn a gown. Staff W stated it was important to wear a gown for infection control. In an observation on 05/27/2026 at 12:28 PM, Staff T, NA, entered Resident 15's room to cleanse their suprapubic catheter. Staff T put on a pair of gloves and wiped the area surrounding the catheter with a sanitizing wipe. Staff T did not wear a gown as required. In an interview on 05/27/2026 at 12:28 PM, Staff T stated they should have worn a gown and it was important to prevent the spread of germs. In an interview on 05/28/2026 at 2:32 PM, Staff C, Infection Preventionist, stated that staff not wearing gloves during insulin injections put them at risk for blood exposure and the residents at risk for germs. Staff C stated their expectation was for staff to wear gowns when caring for residents with drains and tubes. Reference: WAC 388-97-1320, 1620(2)(b)(i)(ii)

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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. Based on observation, interview and record review, the facility failed to ensure a resident was evaluated to safely self-administer their medication for 1 of 6 sampled residents (Resident 3) reviewed for medication administration. This failure placed the resident at risk for unintended health consequences.Findings included.A quarterly assessment, dated 05/01/2026, documented that Resident 3 had diagnoses of Chronic Obstructive Pulmonary Disease (COPD, a lung condition), chronic pain and constipation. The resident was alert, oriented and made their needs known. During an interview and observation on 05/19/2026 at 1:09 PM, Resident 3 stated they had some problems with constipation, but bought some stool softeners from Amazon and had no further issues since starting them. Resident 3 stated they were not sure if facility staff were aware, but since the medication was over the counter, it should be fine. The resident stated they also took their Lactaid (Lactase, an enzyme that helps to break down lactose in dairy products) from the bedside, because it took a long time to get it from the nurses. The resident stated the stool softeners were kept in their nightstand drawer and their Lactaid packets were observed on their bedside table.During an interview and observation on 05/27/2026 at 8:55 AM, Resident 3 stated that they took Lactase every time they ate dairy, nearly every day, but had not needed the stool softener for a couple of months. The top drawer of their nightstand was partially opened with a bottle of Tums (an antacid) visible. Resident 3 reported that they did not inform staff when they took the Lactaid and staff were aware, but acknowledged staff may not have been aware they took the stool softeners. Review of the Medication Administration Record (MAR) for May 2026 showed Resident 3 had numerous medications that could be given if needed for constipation and none were marked as given. The MAR also showed an order for Lactase, three tablets every eight hours if needed for lactose intolerance. No doses were marked as given. There was no provider order that showed the resident could take their own medications, nor any order for Tums was found.As of the morning of 05/27/2026, there was no evaluation of Resident 3s ability to self administer medication found in their medical record and their care plan did not show they were authorized to administer their own medications. During an interview on 05/27/2026 at 3:03 PM, Staff H, Registered Nurse, stated that the facility would need a provider order for a resident to take their own medications. There were no residents authorized to take on their own medication and facility staff needed to administer them. During an interview on 05/27/2026 at 3:30 PM, Staff I, Unit Manager stated that in order for a resident to self-administer their medications, they required a doctor's order. Next, they needed an evaluation to determine if they were able to safely and responsibly take the medication on their own. When informed about the interview and observations of Resident 3's medication in their room. Staff I stated they would immediately ask the resident about it, talk to the doctor and do an evaluation. Staff I confirmed that Resident 3 should not have medications at the bedside without the evaluation and order from their doctor. During an interview on 05/28/2026 at 3:11 PM, both Staff A, Administrator and Staff B, Director of Nursing acknowledged that Resident 3 should have been evaluated for safety to administer their medications and that a provider order should have been obtained.Reference: WAC 388-97-1060 (3)(l)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) Level II evaluations were completed timely for 1 of 5 sampled residents (Resident 7) reviewed for PASRR. This failure placed the resident at risk for unmet care needs and a decline in condition. Findings included .According to a 04/30/2026 annual assessment, Resident 7 was cognitively intact and had diagnoses that included depression (a mood disorder that caused a persistent feeling of sadness and loss of interest) and bipolar disorder (a mental health condition that caused extreme, unusual shifts in mood, energy, activity levels, and concentration). Review of Resident 7's medical record showed a PASRR Level I (screening tool to determine if a resident required further evaluation for serious mental illness or intellectual disability) was completed prior to admission on [DATE] that indicated no Level II evaluation (evaluation that identified any specialized services the resident required) was needed as Resident 7 did not have a diagnosis of serious mental illness at that time. Further record review indicated that Resident 7 was diagnosed with bipolar disorder on 11/20/2025 and depression on 12/24/2025 which would require a PASRR Level II evaluation to be completed. No documentation of a PASRR Level II was found in the resident's electronic record and no information was provided. In an interview on 05/26/2026 at 11:33 AM, Staff D, Social Services Director, confirmed that no PASRR Level II was completed for Resident 7 as required. Staff D further stated that a PASRR Level II was important to complete so the facility could care plan to address mental health issues for the resident. In an interview on 05/28/2026 at 11:24 AM, Staff A, Administrator, and Staff B, Director of Nursing, stated a PASRR Level II was expected to be completed when a resident had a diagnosis of serious mental illness. Reference: WAC 388-97-1915(4)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, the facility failed to revise comprehensive care plans for 1 of 3 sampled residents (Resident 65) whose care plan was reviewed for accident hazards. This failure placed the resident at risk for burns and a diminished quality of life. Findings included . The 02/27/2026 quarterly assessment documented Resident 65 had diagnoses that included dementia and weakness. The resident had severe cognitive impairments and required set up assistance for meals.The 11/27/2024 care plan documented Resident 65 had an activity of daily living self-care performance deficit related to weakness, loss of balance and deconditioning. The interventions were for Resident 65 to eat in the hallway close to the nurse's station and to provide set up assistance for eating. In an observation on 05/18/2026 at 1:16 PM, Resident 65 was sitting in their wheelchair across from the nurse's station. The resident was holding a mug of coffee in their hand, and their hand was very shaky. Resident 65 stated their pants were soaked and they spilled every cup of coffee they were given. Resident 65's shirt and pants were visibly soiled with coffee. Resident 65 denied burns and discomfort.In an observation on 05/21/2026 at 9:00 AM, Resident 65 was sitting in their wheelchair across from the nurse's station with their breakfast tray in front of them. Resident 65 had a coffee mug in their hand and was having difficulty consuming the coffee due to the shakiness of their hand. In an observation on 05/26/2026 at 12:05 PM, Resident 65 was sitting in their wheelchair. Resident 65 had coffee in a mug and was having difficulty holding it due to their hand being shaky. In an interview on 05/27/2026 at 12:38 PM, Staff T, Nursing Assistant (NA), stated when a resident was having difficulty holding their cups, they notified the nurse and kitchen to get adaptive equipment. Staff T stated Resident 65 had been having difficulty holding their cups and were given spout cups (cups with lids that prevented fluids from spilling) to consume their fluids. Staff T stated the spout cups were not on the Kardex (a part of the residents' care plan that NAs used to provide care). In an interview on 05/27/2026 at 12:45 PM, Staff G, Registered Nurse, stated Resident 65's hands were shaky and they were given a cup with a lid. Staff G stated the cup with the lid needed to be on the care plan so staff were aware, otherwise they would not know if the cup was to be used. In an interview on 05/26/2026 at 11:07 AM, Staff B, Director of Nursing, stated they were unaware Resident 65 was having difficulty holding their cups. Staff B stated there was no adaptive equipment on the resident's care plan. Staff B stated a hot beverage assessment was completed upon admission, quarterly and with changes in condition. Staff B stated Resident 65 should have had an assessment and adaptive equipment added to their care plan. Staff B stated this was important to ensure no injuries occurred. Reference: WAC 388-97-1020(2)(c)(d)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a peripherally inserted central catheter (PICC, a long flexible intravenous [IV] tube inserted into a vein that was advanced to a large vein near the heart, also called a central line) was maintained as ordered for 1 of 1 sampled residents (Resident 144) reviewed for antibiotic use. Additionally, the bowel management protocol was not implemented when indicated for 1 of 5 sampled residents (Resident 11) reviewed for medication regimen reviews. These failures placed the residents at risk of unintended health consequences and decreased quality of life. Findings included. The Omnicare Central Vascular Access Devices pharmacy policy revised 06/01/2024 documented the catheter insertion site was a potential entry site for bacteria that may cause a catheter-related infection. Sterile dressing changes with a transparent dressing (one that allowed the insertion site to be visualized and protected the catheter) were to be completed on admission, at least weekly, or if the dressing had become wet, loose or soiled. If the transparent dressing was clean, dry, intact and dated, the admission dressing change was able to be omitted and scheduled for seven days from the date on the dressing. Chlorhexidine gluconate (CHG, an antiseptic that killed bacteria) saturated antimicrobial discs were to be placed, with a provider order, under the transparent dressing. Needleless connectors (caps attached at the end of the catheter where tubing or needleless syringes screwed on and accessed the central line for administration of flushes and medications) were potential sites for contamination and required careful attention to infection prevention procedures. Needleless connector caps were to be changed upon admission and at least every seven days, before and after blood samples were drawn or any time the connector integrity was in question. <Central Line Care> The 05/18/2026 comprehensive admission Assessment documented Resident 144 was admitted on [DATE] and had diagnoses that included dementia, fracture around the artificial left hip joint and Streptococcal arthritis of the left hip (inflammation and infection of the joint caused by Streptococcus bacteria). Resident 144 was mildly cognitively impaired and received antibiotics daily. The 05/15/2026 care plan documented Resident 144 had Streptococcal Arthritis that required antibiotics via a PICC. On 05/18/2026 at 3:16 PM, Resident 144 was observed resting on their bed. They wore a shirt that was unbuttoned. On their right chest area under the collarbone, a central line (a long, flexible, and durable medical tube inserted into a large vein) was observed. The central line was covered with a transparent dressing that was dated 05/12/2026. The skin at the insertion site was visible and was without redness or drainage. The central line had two tubes; each tube was capped at the end. Resident 144 stated they had the central line for approximately two months and got antibiotics through it. The 05/28/2026 Order Summary Report documented Resident 144's orders included the following: -05/15/2026 Cefazolin (antibiotic) 2 grams via IV (in the vein) three times daily through 05/28/2026. -05/15/2026 Flush each tube of the PICC with 10 Milliliters (ml) of normal saline before and after each medication administration and every shift (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05/15/2026 Monitor PICC site, dressing/date, and injection caps every shift. -05/19/2026 PICC line sterile dressing change every 7 days on dayshift and as needed using an antimicrobial disk and transparent dressing. Document external catheter length (the length of catheter exposed from the point of insertion at the skin to the end of the catheter hub to prevent potential complications). The orders did not include instructions for changing the needleless connector caps. Review of the May 2026 Medication and Treatment Administration Records (MAR/TAR) showed a PICC dressing change was to be completed on 05/19/2026. The area to document the completion of the dressing change had a number 9 entered. The code at the bottom of the MAR showed that an entry of number 9 was defined as see progress note. There was no place on the MAR to document the needleless end cap changes. Review of 05/19/2026 progress notes documented one tube on Resident 144's PICC was clogged and did not flush. Staff F, Resident Care Manager (RCM) and provider were notified. Orders were obtained to inject Alteplase, an enzyme that dissolved clots into the PICC. Approval was given to give the afternoon dose of antibiotic late. The note did not document whether the dressing change due on 05/19/2026 was completed. On 05/21/2026, an entry was documented on the MAR that the PICC dressing change was completed at 8:00 PM, nine days after the dressing change of 05/12/2026. An additional order was entered on the MAR to apply an antimicrobial disk to the PICC site topically every seven days for PICC dressing changes. There was no entry that documented the application of the antimicrobial disk was completed. On 05/26/2026 at 8:38AM, Staff Q, Licensed Practical Nurse, was observed administering the antibiotic through Resident 144's PICC line. Resident 144 was lying on their bed. Their PICC line on their right chest was visible. The dressing was dated 05/21/2026, and there was no antimicrobial disk under the dressing at the catheter insertion site. Staff Q changed the needleless end caps at this time and connected the antibiotic infusion tubing to the central line and started the infusion. Staff Q stated the end caps were changed every four days. During an interview on 05/28/2026 at 1:03 PM, Staff E, Registered Nurse (RN), stated when a resident with a central line had antibiotics ordered, the pharmacy called and discussed this with the nurses. At that time, staff ordered the antimicrobial disk, and the pharmacy sent them with the dressings, replacement end caps and antibiotic doses and these were all kept in the medication room. Staff E stated needleless end cap changes were usually part of the order for the central line dressing changes. Staff E reviewed the resident's orders and acknowledged there was no order to change the end caps and no place to document these changes on the MAR. Staff E stated the dressing and needless end caps were to be changed every seven days and the caps were to also be changed if blood had been drawn through the central line. Staff E observed Resident 144 at this time and confirmed there was no antimicrobial disk present at the catheter insertion site under the dressing. Staff E stated the resident was at risk of infection if dressings and end caps were not changed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2026 at 1:20 PM, Staff F, RCM, stated dressing and end cap changes were part of an order set. They acknowledged the PICC dressing should have been changed on 05/19/2026 and the order to place a antimicrobial disk at the insertion site should have been followed. They expected staff to change the dressing and end caps and document that they were done. Staff F stated failure to maintain the PICC line as ordered placed the resident at risk of infection. <Resident 11> The 03/12/2026 quarterly assessment documented Resident 11 had diagnoses that included Parkinson's disease (a progressive disorder of the central nervous system that affected movement and worsened over time), and kidney failure. The resident had moderate cognitive impairments and was independent with toileting. The 10/06/2025 care plan documented Resident 11 was at risk for constipation related to medication use and had a history of constipation. The care plan instructed nursing staff to follow the facility bowel protocol for bowel management. Review of Resident 11's provider orders showed the following: -Miralax as needed for constipation (no frequency when the medication was to be given) -Senna as needed for constipation (no frequency when the medication was to be given) Review of Resident 11's bowel record from 04/01/2026 through 05/22/2026 showed no bowel movement (BM) from 04/20/2026 to 04/23/2026 (four days), and 04/25/2026 through 04/29/2026 (five days). In an interview on 05/27/2026 at 12:06 PM, Staff U, Nursing Assistant, stated BMs were monitored every shift and documented in the resident's record. In an interview on 05/28/2026 at 8:51 AM, Staff V, RN, stated the bowel protocol was to be initiated for no bowel movement after 48 hours. Staff V stated Resident 11 did not have the bowel protocol orders in place but had as needed bowel medications ordered that should have been offered. In an interview on 05/28/2026 at 10:49 AM, Staff B, Director of Nursing, stated the bowel protocol was initiated when the resident had no BM in 48 hours. Staff B stated small BMs did not count. Staff B stated their expectation was for nursing to give the medications as ordered and to monitor for nausea, vomiting, and distension. Staff B acknowledged Resident 11 did not have bowel protocol orders in place. Reference: WAC 388-97-1060(1)-(3)

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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. Based on observations, interview and record review, the facility failed to maintain a pressure-reducing mattress on the ordered setting, for 1 of 3 residents (Resident 5) reviewed for pressure ulcer/injury (wounds from unrelieved pressure). This failure placed residents at risk of worsening pressure ulcers and possible delayed wound healing. Findings included.A quarterly assessment, dated 03/31/2026, documented Resident 5 had diagnoses of quadriplegia (partial or complete paralysis of both arms and legs) and had significant pressure ulcers on their coccyx (tailbone) and left ankle. The resident was totally dependent on staff to position them in bed. The resident was alert and made their needs known.An order for moon boots (a pressure relief foot covering, worn in bed) and air mattress was written on 04/29/2026.An order for an alternating pressure relieving mattress, with instructions for the licensed nurse to check function and adjust the setting, as needed every shift, was written on 05/07/2026.The 11/14/2025 care plan showed the intervention for the alternating pressure mattress order was added on 05/07/2026.The May 2026 Treatment Administration Record (TAR) showed the order for the alternating pressure mattress and instructions to check the function and adjust the setting. This was initialed as completed by the nurses twice daily since ordered, with no missing entries. On 05/21/2026 at 1:19 PM, Resident 5 was observed on their bed. The control panel for the air mattress showed that the setting was on Static and not on Alternating. The panel lock icon was locked.On 05/22/2026 at 10:24 AM, the control panel showed the air mattress was on the Static setting and the panel was locked. When asked if the air mattress ever inflated and deflated, the resident stated they did not think so. During an observation of Resident 5's wound care on 05/26/2026 at 6:20 AM, Staff O, consultant for an outside wound care company, was asked how the air mattress settings worked. Staff O noted that it was on Static and said it should be on Alternating. Staff O turned the power off and back on again, and pressed the panel lock button, but was unable to adjust the mattress settings.On 05/26/2026 at 11:26 AM, Resident 5's air mattress was observed on Static and the panel was locked. On 05/27/2026 at 9:37 AM, observed Resident 5's air mattress was on Static and the panel was locked. During an interview on 05/26/2026 at 8:29 AM, Staff P, Licensed Practical Nurse (LPN), was asked if they checked the function and adjusted the setting on the air mattress when documenting on the TAR. Staff P stated they made sure it was turned on and filled with air. They further clarified that it would show on the order, if it should be on alternating pressure. During an interview on 05/26/2026 at 8:54 AM, Staff Q, LPN, was asked if they checked the function and adjusted the setting on the air mattress when documenting on the TAR. Staff Q stated that they made sure the air mattress was on and inflated. They further stated that when the air mattress was delivered, the settings were already programmed and was locked, so they could not be changed. They further stated, if they are on an air mattress, it should be alternating pressure. During an interview on 05/27/2026 at 9:50 AM, Staff R, Central Supply Manager stated that they did not mess with the settings on the air mattresses at all. They just brought it to the room, and the nurse or Unit Manager set it up. During an interview on 05/27/2026 at 3:03 PM, Staff H, Registered Nurse, was asked if they checked the function and adjusted the setting on the air mattress when documenting on the TAR. Staff H stated that they just plugged it in, made sure it was on, and had air and stated, the resident would know if it was not working. During an interview on 05/27/2026 at 3:30 PM, Staff I, Unit Manager, stated that the nurse should verify the unit (air mattress) was plugged in, inflated and functioning as it should. When asked about the instruction to check settings on the TAR, what setting was it referring to, Staff I stated it might be about resident's weight, which affected the inflation and comfort. Staff I stated that they had just looked at Resident 5's mattress, stated that it should have been on Alternating, and it did not match the current provider order. During an interview on 05/28/2026 at 3:11 PM, both Staff A, Administrator and Staff B, Director of Nursing acknowledged that the setting on the air mattress for Resident 5 did not match the order. During a telephone interview on 06/01/2026 at 9:23 AM, the service technician for the mattress manufacturer, stated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the Static setting meant that the constant airflow kept the mattress at the same, steady pressure. The Alternating setting meant that every other tube (that made up the mattress) inflated and deflated to alternate the pressure on the body. Reference: WAC 388-97-1060(3)(b)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to implement interventions to prevent weight loss for 2 of 8 sampled residents (Residents 11 and 62) reviewed for nutrition. This failure resulted in the residents being at risk for further weight loss and a decline in their health. Findings included .<Resident 11>The 12/05/2025 revised nutrition care plan stated Resident 11 had the potential for nutritional problems related to their history of malnutrition and dementia. The care plan did not instruct nursing staff on what to do for poor intake at meals.The 03/12/2026 quarterly assessment documented Resident 11 had diagnoses that included dementia and malnutrition. Resident 11 had moderate cognitive impairments and was able to make their needs known. A review of Resident 11's weights showed the following:-11/19/2025: 214.2 Pounds (lbs.)-02/18/2026: 207.1 lbs.-04/04/2026: 205.4 lbs.-05/04/2026: 197.8 lbs. The residents weight records showed a 3.7% loss in one month, a 4.49% loss in three months and a 7.66% loss in six months.Resident 11's meal intake was reviewed from 04/21/2026 through 05/20/2026 and showed the following:-0-25% was consumed for 21 meals-26-50% was consumed for 13 meals-51-75% was consumed for 17 meals-76-100% was consumed for 26 mealsIn an observation and interview on 05/18/2026 at 3:36 PM, Resident 11 was sitting on their bed. Resident 11 stated the food was below average and lacked flavor. In a continuous observation on 05/22/2026 from 12:09 PM to 1:30 PM, Resident 11 was sitting on their bed, and their lunch tray was in front of them. At 12:29 PM, an unidentified nursing assistant (NA) entered Resident 11's room and asked them if they wanted to drink their cranberry juice and the resident declined. Resident 11 did not consume any of their meal and unidentified NA removed the tray. Resident 11 was not offered anything else to eat. The unidentified NA did not notify the nurse of Resident 11's refusal to consume their meal. At 1:30 PM, Resident 11 was not offered an alternate meal or a nutritional supplement. The meal intake record for Resident 11 showed they ate 26-50% of their lunch meal on 05/22/2026. During a continuous observation on 05/27/2026 from 11:45 AM to 1:35 PM, Resident 11 received their lunch and stated they were not going to eat it. At 12:22 PM, an unidentified NA entered Resident 11's room and picked up their untouched meal tray and the resident was not offered anything else to eat. The unidentified NA did not notify the nurse of Resident 11's refusal to consume their meal. At 1:35 PM, Resident 11 was not offered an alternate meal or a nutritional supplement. <Resident 62>The 05/11/2026 quarterly assessment documented Resident 62 had diagnoses that included diabetes, depression and malnutrition. Resident 62 was cognitively intact and able to make their needs known. The 02/06/2020 nutrition care plan stated Resident 62 had potential for nutritional problems due to diabetes, heart failure, history of malnutrition and swallowing difficulty. The care plan did not instruct nursing staff on what to do for poor intake at meals.A review of Resident 11's weights showed the following:-11/19/2025: 138.6 lbs.-02/03/2026: 142.2 lbs.-04/15/2026: 130.2 lbs.-05/04/2026: 117.2 lbs.A 9.98% loss in one month, 17.58% loss in three months and a 15.44% loss in six months. Resident 62's meal intake was reviewed from 04/27/2026 through 05/25/2026 and showed the following:-0-25% was consumed for no meals-26-50% was consumed for four meals-51-75% was consumed for 45 meals-76-100% was consumed for 36 mealsDuring an interview on 05/18/2026 at 3:15 PM, Resident 62 was sitting in their wheelchair. Resident 62 stated they were losing weight because they did not like the food.In a continuous observation on 05/21/2025 from 9:14 AM to 2:07 PM, Resident 62's meal tray was on their tray table. Resident 62 ate three quarters of their oatmeal, none of their French toast or bacon. At 10:48 AM, Resident 62 was not offered anything else to eat or a nutritional supplement. At 12:00 PM Resident 62 was in their wheelchair eating lunch. The resident was served beef with gravy, rice, Brussel sprouts and lemonade cake. At 12:31 PM, an unidentified NA entered Resident 62's room and asked if they had finished eating and removed the meal tray. Resident 62 ate approximately 30% of their rice and nothing else. Resident 62 was not offered an alternate meal or supplement. At 2:07 PM, Resident 62 had not been offered an alternate meal or nutritional supplement. The meal intake record for Resident 62 showed they ate 76-100% of their breakfast and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch. In a continuous observation on 05/22/2026 from 12:09 PM to 12:41 PM, Resident 62 was eating their lunch. The resident was served cod, potatoes and green beans. At 12:41 PM, Resident 62 put their meal tray in the cart, and an unidentified NA observed the meal tray. Resident 11 consumed their potatoes, a quarter of their fish and no green beans. Resident 42 was not offered an alternate meal or a nutritional supplement. In a continuous observation on 05/26/2026 from 8:04 AM to 9:30 AM, Resident 62 was sitting in their wheelchair eating breakfast. The resident was served oatmeal, sausage, and a muffin. At 8:36 AM Resident 62 brought their meal tray to an unidentified NA. Resident 62 consumed only oatmeal and was not offered an alternate meal or nutritional supplement. The nurse was not notified of Resident 62's poor intake. At 9:30 AM, Resident 42 had not been offered anything else to eat or a nutritional supplement. The meal intake record for Resident 62 showed they ate 76-100% of their breakfast. In a continuous observation on 05/27/2026 from 11:48 AM to 1:45 PM, Resident 62 was sitting in their wheelchair having lunch. The resident was served pasta, meatballs, vegetables and cake. At 12:26 PM, Resident 62 ate approximately 30% of their lunch. An unidentified NA removed the tray and Resident 62 was not offered anything else to eat or a nutritional supplement. The nurse was not notified of Resident 62's poor intake. At 1:45 PM, Resident 62 had not been offered an alternate meal or a nutritional supplement. The meal intake record for Resident 62 showed they ate 76-100% of their lunch. In an observation on 05/28/2026 at 11:33 AM, Resident 62 was asleep in their recliner. Resident 62's breakfast tray was on the tray table. Resident 62 was served a bowl of oatmeal, French toast and bacon. Resident 62 only consumed the oatmeal. The meal intake record for Resident 62 showed they ate 50-75% of their breakfast. In an interview on 05/27/2026 at 12:06 PM, Staff U, NA, stated they reported poor meal intake to the nurse. Staff U stated Resident 11 ate approximately 51-76% of their meals. Staff U stated Resident 11 had a banana for breakfast and picked what they wanted to eat. In an interview on 05/27/2026 at 2:26 PM, Staff AA, NA, stated when meal trays were picked up, the amount of food consumed was documented in the resident's record. Staff AA stated poor meal intake was reported to the nurse and residents were encouraged to eat. Staff AA stated Resident 62's meal intake was variable and at times they did not like the food. In an interview on 05/28/2026 at 10:21 AM, Staff I, Resident Care Manager, stated the expectation was for nursing assistants to notify the nurse of poor meal intake and to offer an alternate meal. In an interview on 05/28/2026 at 10:28 AM, Staff B, Director of Nursing, stated when residents had poor meal intake the nursing assistants were to notify the nurse, and a note was made in the resident's record. Staff B stated they reviewed the 24-hour report and concerns were discussed with the interdisciplinary team. The team contacted the Registered Dietician and provider. Staff B stated their expectation was for residents to be offered an alternate meal and if they declined, a nutritional supplement was to be provided. Staff B added their expectation was nursing staff would document the amount of meals consumed accurately and this was important to ensure the residents were getting the proper nutrition and for their overall health. Reference: WAC 388-97- 1060(3)(h)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (Residents 5 and 11) reviewed for medication administration. Specifically, medications were not held or administered when indicated, according to parameters ordered by the provider. This failure placed residents at risk for adverse health complications and diminished quality of life. Findings included. <Resident 5> A quarterly assessment, dated 03/31/2026, documented that Resident 5 had diagnoses of heart failure and high blood pressure. The resident was alert and made their needs known. Resident 5 had the following blood pressure medication orders: Lisinopril daily, hold for systolic blood pressure (SBP, the top number of a blood pressure reading) less than 110 or heart rate (HR) less than 60 beats per minute. Metoprolol ER (extended release) daily, hold for SBP less than 110 or HR less than 60. A review of the residents April and May 2026, Medication Administration Record (MAR) documented that the Lisinopril and Metoprolol ER was given three times outside of the ordered parameters. On 04/18/2026, the HR was 57 and both medications were given. On 04/23/2026, the HR was 56 and both medications were given. On 05/18/2026, the HR was 57 and both medications were given. The MAR showed the Lisinopril and Metoprolol ER medications were not held when the HR was less than 60. There was not documentation in the residents medical chart on those dates that showed why the medications were given outside the ordered parameters. During an interview on 05/27/2026 at 9:08 AM, Staff G, Registered Nurse (RN) stated that medications should not be given if the vital signs (VS, which included the BP and HR) were outside of the parameters. Staff G stated if the reading was close, they would recheck the BP or HR, and document the result in an additional note, along with why they gave the medication. During an interview on 05/27/2026 at 3:03 PM, Staff H, RN, stated that on evening shift, they would obtain a recent set of VS to determine if a medication should be given or held. During an interview on 05/27/2026 at 3:30 PM, Staff I, Unit Manager, stated that if VS are outside of parameters to administer a medication, the nurse should manually check the results themselves. If the recheck was within the parameters to give the medication, the nurse should add a note with the repeated result that showed why it was given. Staff I stated medications should not be given if their VS were outside of the ordered parameters. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2026 at 3:11 PM, both Staff A, Administrator, and Staff B, Director of Nursing acknowledged that the blood pressure medications for Resident 5 should not have been given when the VS were outside of the ordered parameters. <Resident 11> The 03/12/2026 quarterly assessment documented Resident 11 had diagnoses that included high blood pressure and dementia. Resident 11 had moderate cognitive impairments. Resident 11 had the following medication orders: 1. Clonidine daily for high blood pressure, hold for SBP less than 110 or HR less than 60. 2. Hydralazine three times a day for high blood pressure, hold for SBP less than 110 or HR less than 60. 3. Losartan Potassium twice daily for high blood pressure, hold for SBP less than 110 and HR less than 60. A review of the residents April 2026 MAR documented that the Clonidine, Hydralazine and Losartan Potassium was given seven times outside of the ordered parameters. On 04/29/2026, the SBP was less than 110 and the HR was less than 60 and Clonidine was given. On 04/20/2026 and 04/23/2026 when the HR was less than 60, Hydralazine was given. On 04/03/2026 and 04/08/2026, Losartan Potassium was not given when the SBP and HR were above the ordered parameters. On 04/23/2026 the HR was less than 60 and the Losartan Potassium was given. On 04/29/2026 when the SBP was less than 110 and the HR was less than 60, Losartan Potassium was given The MAR showed the Lisinopril and Metoprolol ER medications were not held when the HR was les than 60. In an interview on 05/27/2026 at 12:15 PM, Staff V, Registered Nurse, stated Resident 11 had blood pressure parameters in place and medications were provided based on the residents blood pressure and pulse. In an interview on 05/28/2026 at 10:49 AM, Staff B stated Resident 11 should have received their medications per the provider ordered parameters. Staff B stated this was important to prevent cardiac complications. Reference: WAC 388-97-1060(3)(k)(iii)

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	05/28/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 25 sampled residents (Residents 132 and 41), reviewed for timeliness in encoding and transmission of Minimum Data Set (MDS, a required 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 1.20.1 revised October 2025, 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 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. Nursing homes are 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. When the transmission file was received by iQIES, the system performs a series of validation edits to evaluate whether 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 regarding 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 132>Review of the 01/27/2026 admission assessment showed Resident 132 admitted to the facility on [DATE]. The assessment further showed an assessment reference date (ARD) of 01/27/2026, CAA care planning documentation was completed on 02/04/2026 and the MDS signed by the RN coordinator as competed on 02/04/2026.During interview and record review on 05/27/2026 at 1:33 PM, Staff N, MDS Coordinator, reviewed Resident 132's medical record. Staff N acknowledged Resident 132's admission MDS dated [DATE], was completed on 02/04/2026 but was late and had not been submitted to CMS yet.<Resident 41>Review of the 01/12/2026 admission assessment showed Resident 41 admitted to the facility on [DATE]. The assessment further showed an ARD of 01/12/2026, CAA care planning documentation was completed on 01/12/2026 and the assessment was signed by the RN coordinator as completed on 05/08/2026.Review of the 05/18/2026 MDS final validation report showed a batch of 52 MDS assessments was submitted and accepted, including Resident 41's admission MDS dated [DATE].During interview and record review on 05/27/2026 at 1:18 PM, Staff N, stated an MDS needed to be submitted to CMS 14 days after the ARD. Staff N reviewed Resident 41's medical record. Staff N acknowledged the 01/12/2026 admission MDS was submitted late on, 05/18/2026. During an interview on 05/28/2026 at 12:23 PM, Staff A, Administrator, stated they expected staff to submit MDS assessments per the required timeframes. Reference WAC 388-97-1000(4)(b)(5)(a)(e)(i)-(iii)