STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505510	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46479 Based on observation, interview, and record review the facility failed to assess and obtain consent prior to implementing bed rails for 2 (Residents 1 & 2) of 3 sample residents reviewed for bed rails. The failure to assess and obtain consent prior to implementing bed rails resulted in Resident 1 sustaining a cut to their eyebrow and placed Resident 2 at risk for injury. These failures placed all residents at risk for injury and other negative health outcomes. Findings included . <Resident 1> According to the 10/30/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 1 had diagnoses including an acute condition affecting their brain function that could cause confusion, memory loss, and personality changes. The MDS showed Resident 1 had severe memory impairment. The MDS showed Resident 1 had severely impaired vision and did not use bed rails during the assessment period. The 10/31/24 discharge MDS showed the resident was discharged from the facility and not available for observation or interview. Review of Resident 1's evaluation and documentation tabs in their clinical record showed no assessments indicating Resident 1 was assessed for safe use of bed rails. Resident 1's record showed no consent or risk and benefit documentation for use of the bed rails. Review of Resident 1's 10/25/2024 comprehensive care plan showed no care plan indicating the resident utilized bed rails. Review of an 11/01/2024 nurse progress note showed a care giver providing one-to-one supervision reported to the nurse Resident 1 hit their head on the bed handrail, resulting in a cut above the left eyebrow . In an interview on 11/05/2024 at 2:12 PM, Staff C (Registered Nurse) stated they recalled Resident 1 having bed rails on their bed. Staff C stated unit managers completed assessments and consents for bed rails. In an interview on 11/05/2024 at 2:20 PM, Staff B (Unit Manager) reviewed Resident 1's record and confirmed the resident did not have an assessment or consent for the bed rails. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/05/2024 at 3:20 PM, Staff A (Administrator) stated Resident 1 was moved to a private room as they required one-on-one supervision. Staff A stated the bed rails were accidentally left on the bed in the private room from the previous tenant. Staff A stated they expected assessments and consents to be obtained for bed rails prior to implementation. <Resident 2> According to the 11/04/2024 Admission MDS, Resident 2 had no memory impairment. This MDS showed Resident 2 had a fall prior to their admission to the facility and did not have impairment to their range of motion but required substantial/maximal assistance with bed mobility. The MDS showed Resident 2 did not use bed rails. Review of Resident 2's 10/31/2024 comprehensive care plan showed no care plan indicating the resident utilized bed rails. Observation on 11/05/2024 at 1:00 PM showed Resident 2 lying in bed. Resident 2's bed had bilateral bed rails installed. Review of Resident 2's evaluation and document tabs in their record showed no assessments indicating Resident 2 was evaluated for safe use of bed rails. Resident 2's record showed no consent or risk and benefit documentation of the bed rails. In an interview on 11/05/2024 at 3:20 PM, Staff A stated it was their expectation assessments and consents were obtained prior to the use of bed rails. REFERENCE: WAC 388-97-1060(3)(g).