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	07/24/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45941 Based on interview and record review, the facility failed to inform residents or their assigned representatives in advance of the risks and benefits associated with psychotropic medication therapy (medications capable of affecting the mind, emotions, and behavior), and obtain resident consent prior to implementing the proposed treatments/therapies for 2 of 5 residents (Residents 61 & 34) reviewed for unnecessary medications. The failure of facility staff to obtain consent for psychotropic medications prior to administration detracted from the residents' and/or their representative's ability to exercise their right to make an informed decision about proposed treatments, and prevented the residents and their representative from exercising their right to decline the treatments/therapies. Findings included . <Facility Policy> The facility's revised 10/04/2022 Psychotropic Medication policy showed residents who used psychotropic drugs would be educated on the risks and benefits of psychotropic drug use. <Resident 61> According to the 05/20/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool) Resident 61 had moderately impaired cognition (impaired memory and problem solving) and had diagnoses of schizophrenia (mental disorder affects a person's ability to think, feel and behave), anxiety, and depression. The MDS showed Resident 61 regularly used Antipsychotic (AP), Antianxiety (AA), and Antidepressant (AD) medications. Review of Resident 61's records showed no consent was obtained for the psychotropic medications prior to implementing the medications. In an interview on 07/23/2024 at 11:07 AM Staff B (Director of Nursing) stated they expected staff to explain risk and benefits for psychotropic medications to residents or their representative prior to implementing the treatments. Staff B reviewed Resident 61's record and stated there was no documentation for consent at the time of order for the psychotropic medications for Resident 61. Staff B stated staff should obtain consent prior to implementing the medications for Resident 61, but they did not. 45720 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	505510	A. Building B. Wing	07/24/2024

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 34> According to 04/15/2024 Admission MDS, Resident 34 had a diagnosis of dementia with agitation. The MDS showed Resident 34 received AP medication. Review of Resident 34's records showed a court order that appointed full guardianship and full conservator for Resident 34 on December 21, 2023. Review of Resident 34's record showed AP Medication Informed Consent, was consented to by Resident 34's family member over the telephone on 4/9/2024. Review of Resident 34's record did not show documentation that the risks and benefits of the medication were discussed, either verbally or written, with the resident or their representative/legal guardian, prior to the resident receiving the medication. During an interview on 07/24/2024 10:08 AM, Staff Q (Social Services Assistant- SSA) and Staff R (SSA) stated if a resident had a guardian, the guardian needed to consent to and be informed of risks and benefits for AP medications. REFERENCE: WAC 388-97-0260(1)(a)(b)(i)(ii)(iii).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to ensure residents had the appropriate Advanced Directives (AD) in place for 2 (Residents 61 & 6) of 7 residents reviewed for ADs. The facility failed to provide information indicating residents were informed, educated, and offered assistance to formulate an AD (Resident 61 and 6), and to obtain guardianship for Resident 61. These failures placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care. Findings included . <Facility Policy> The ,d+[DATE] Advanced Directives facility policy showed the resident and/or the resident's representative would be provided with written information regarding the resident's right to refuse or accept assistance with formulating an AD, and this information would be provided in a manner the resident could understand. Nursing staff would document the resident's decision about formulating an AD in the resident's record. Information about whether or not a resident had an AD would be displayed prominently in the resident's records and retrievable by any staff. Facility staff would periodically review the AD with the residents and/or the resident's representatives. <Resident 61> According to the [DATE] Admission 5 Day Minimum Data Set (MDS - an assessment tool) Resident 61 had moderately impaired memory. Record review of Resident 61's face sheet showed Resident 61 was their own responsible party. There was no copy of an AD for Resident 61 in their record. There was no documentation showing the facility attempted to obtain guardianship for Resident 61. In an interview on [DATE] at 10:34 AM Staff D (Social Services Director) stated they did not obtain a copy of Resident 61's AD because Resident 61 was unable to make decisions and there was no appointed guardian for Resident 61. In an interview on [DATE] at 10:48 AM Staff B (Director of Nursing) stated Resident 61 had no AD in their record and had no appointed guardian at that time. Staff B stated the facility was working to appoint a guardianship for Resident 61 but was unable to provide any documentation. 45720 <Resident 6> Review of Resident 6's record showed a [DATE] letter of limited guardianship expired on [DATE]. According to Resident 6's [DATE] admission record a guardian was listed as the responsible party. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's [DATE] consent documents showed Resident 6 had an AD. Review of Resident 6's record on [DATE] at 9:01 AM showed no documentation of an AD or current guardianship paperwork. During a joint interview on [DATE] at 9:33 AM Staff D stated Resident 6 had a guardian. Staff D and Staff A (Administrator) stated there should be one uploaded in Resident 6's record. During an interview on [DATE] at 9:53 AM Staff A stated they don't have the guardian paperwork for Resident 6. REFERENCE: WAC [DATE](3)(c)(i-ii).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47836 Based on interview and record review the facility failed to initiate a grievance for 2 (Resident 1 & 47) of 2 resident's reviewed for grievances. The facility's failure to initiate, log, investigate verbalized concerns, and inform the resident of their findings and the actions taken, precluded the facility from identifying grievance trends and placed the resident at risk of feeling frustrated, unimportant, and with a decreased self-worth and quality of life. Findings included . <Facility Policy> According to facility policy titled, Resident Rights - Grievances, dated 08/2018, the facility would help residents/representatives file grievances and would investigate and take appropriate actions to address resident grievances. The policy showed grievances could be submitted in writing or orally. The policy showed the administrator has designated the Social Services representative in the facility as the Grievance Officer (GO). The policy showed the GO had the responsibility to oversee the grievance process, receive and track grievances through to their conclusion, and lead any necessary investigations. The policy showed upon receipt of a grievance, the GO would investigate the allegations and submit a written report to such findings to the administrator within five working days of receiving the grievance. This policy showed the GO would immediately report to the administrator any grievance that alleged violations related to potential neglect. <Resident 1> According to a 06/07/2024 Discharge Minimum Data Set (MDS- an assessment tool) Resident 1 had no memory impairment. The MDS showed Resident 1 was discharged to the hospital on 05/28/2024 with a return anticipated. In an interview on 07/17/2024 at 10:52 AM Resident 1 stated they returned from the hospital, and they had two new gowns they had put in the drawer which they didn't lock because staff informed them, they would be returning to the same bed. Resident 1 stated when they returned from the hospital, they were admitted to the same room but in the bed by the door. Resident 1 stated they were previously in the bed by the window but now another resident was in that bed and all their potted plants were missing off the bay window. Resident 1 also stated their daughter had bought them a bunch of bottled waters and snacks and staff informed them they had thrown all of that away. In an interview and record review on 07/23/2024 at 9:51 AM Staff A (Administrator) provided a copy of a care partners routine visit checklist from 06/07/2024 that Staff H (Unit Manager) had completed. The checklist showed Resident 1, and their daughter reported missing items to Staff H. Staff A stated they never received a grievance form about the missing gowns, plants, and grocery items, but Staff H should have completed one at the time of the reported missing items. Staff A stated they usually read through all the care partners checklists as they are turned into them but had not due to being busy preparing for survey, so they were unaware of the missing items. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 47> In an interview on 07/16/2024 at 11:45 AM, Resident 47 reported long call light response times during the night shift, 10:00 PM to 6:00 AM. Review of Resident 47's electronic health record on 07/20/2024 showed a quarterly/annual care conference note with a complaint from Resident 47 that the night shift, 10:00 PM to 6:00 AM, took too long to answer the call light. In an interview on 07/23/2024 at 9:12 AM Staff D (Social Service Director) stated they notified Staff A about the long call light response time complaint from Resident 47. In an interview on 07/23/2024 at 9:27 AM Staff A stated they were not informed and had not received a grievance form regarding the complaint about long call light response times on night shift by Resident 47. Staff A stated a grievance form should have been filled out so they could have investigated immediately. REFERENCE: WAC 388-97-0460 (1)(2).

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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. 47836 Based on interview and record review, the facility failed to document they communicated necessary resident information to the receiving health care institution or provider for 2 of 7 residents (Resident 1 & 31) reviewed for hospitalization s. Failure to ensure necessary resident information was communicated to the hospital placed residents at risk for decreased quality of care, inadequate care/treatment, and decreased quality of life. Findings included . <Facility Policy> According to a facility policy titled, Admission, Transfer, & Discharge - Facility initiated Transfers, or Discharges, dated 11/2017, showed when the facility initiates a transfer or discharge of a resident, the facility would document in the resident's record appropriate information was communicated to the receiving health care institution or provider. The policy showed information would be provided to the receiving provider and will include the following: a. Contact information of the practitioner responsible for the care of the resident b. Resident representative information including contact information c. Advance Directive Information d. All special instructions or precautions for ongoing care, as appropriate e. Comprehensive care plan goals f. Other necessary information, including a copy of the resident's discharge summary as applicable, and any other documentation to support a safe and effective transition of care. <Resident 1> Review of Resident 1's 06/07/2024 Discharge Minimum Data Set (MDS- an assessment tool) showed the resident was transferred to an acute care hospital on 05/28/2024. Record review showed no documentation staff provided any information on Resident 1's health condition or any contact information to the receiving acute care hospital. <Resident 31> Review of Resident 31's electronic health record on 07/20/2024 showed a progress note the resident was transferred to the hospital on 05/27/2024 and 06/04/2024. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 31's 06/10/2024 Discharge MDS showed the resident was transferred to an acute care hospital on 06/04/2024. Record review on 07/20/2024 showed no documentation staff provided any information on Resident 31's health condition or any contact information to the receiving acute care hospital regarding their discharges for 05/27/2024 or 06/04/2024. In an interview on 07/23/2024 at 11:37 AM, Staff H (Unit Manager) stated there was no documentation of a report provided to the receiving acute care hospital for Resident's 1 and 31 when they were sent to the hospital but there should be. Staff H stated it was important to give the receiving facility a thorough report about the resident so they could provide the appropriate care the resident needed. REFERENCE: WAC 388-97-0120(3)(a)(b).

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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. 47836 Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer/discharge, or as soon as practicable for 7 of 7 residents (Residents 94, 31, 1, 20, 26, 23, & 59) reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> A facility policy titled, Admission, Transfer, and Discharge - Notice Requirements Before Transfer/Discharge, dated 07/2018, showed a notice of transfer must be provided to the resident/representative when an emergency transfer to an acute care facility is ordered. <Resident 94> Review of Resident 94's 05/10/2024 Discharge Minimum Data Set (MDS- an assessment tool) showed the resident was transferred to an acute care hospital on 05/08/2024. Record review on 07/20/2024 showed no documentation staff provided the required written notification to Resident 94 and/or their representative regarding their discharge. <Resident 31> Review of Resident 31's Electronic Health Record (EHR) on 07/20/2024 showed a progress note the resident was transferred to the hospital on 05/27/2024 and 06/04/2024. Review of Resident 31's 06/10/2024 Discharge MDS showed the resident was transferred to an acute care hospital on 06/04/2024. Record review on 07/20/2024 showed no documentation staff provided the required written notification to Resident 31 and/or their representative regarding their discharge for 05/27/2024 or 06/04/2024. <Resident 1> Review of Resident 1's 06/07/2024 Discharge MDS showed the resident was transferred to an acute care hospital on 05/28/2024. Record review on 07/20/2024 showed no documentation staff provided the required written notification to Resident 1 and/or their representative regarding their discharge. <Resident 20> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 20's 12/23/2023 Discharge MDS showed the resident was transferred to an acute care hospital on 12/11/2023. Review of Resident 20's 05/03/2024 Discharge MDS showed the resident was transferred to an acute care hospital on 04/28/2024. Record review on 07/20/2024 showed no documentation staff provided the required written notification to Resident 20 and/or their representative regarding their discharges on 12/11/2023 or 04/28/2024. <Resident 26> According to 09/10/2023 Discharge MDS, Resident 26 discharged to an acute care hospital on 09/07/2023 with a return anticipated. Record review on 07/20/2024 showed no documentation staff provided the required written notification to Resident 26 and/or their representative regarding their discharge on 09/07/2023. 46479 <Resident 23> Review of Resident 23's 09/17/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 09/17/2023. Review of Resident 23's 09/28/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 09/27/2023. Review of Resident 23's 01/24/2024 Discharge MDS showed Resident 23 discharged to an acute care hospital on 01/24/2024. Review of Resident 23's records on 07/16/2024 at 1:44 PM showed no documentation staff provided written notifications to Resident 23 regarding their rights related to their 09/17/2023, 09/27/2023, or 01/24/2024 discharges as required. <Resident 59> Review of Resident 59's 07/12/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 07/12/2023. Review of Resident 59's 07/25/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 07/25/2023. Review of Resident 59's 10/27/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 10/27/2023. Review of Resident 59's 11/20/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 11/20/2023. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 59's 12/04/2023 Discharge MDS showed Resident 23 discharged to an acute care hospital on 12/04/2023. Review of Resident 59's 02/07/2024 Discharge MDS showed Resident 23 discharged to an acute care hospital on 02/07/2024. Review of Resident 59's 03/01/2024 Discharge MDS showed Resident 23 discharged to an acute care hospital on 03/01/2024. Review of Resident 59's 04/29/2024 Discharge MDS showed Resident 23 discharged to an acute care hospital on 04/29/2024. Review of Resident 59's records on 07/23/2024 at 8:34 AM showed no documentation staff provided written notifications to Resident 59 or their representative regarding their rights related to their 07/12/2023, 07/25/2023, 10/27/2023, 11/20/2023, 12/04/2023, 02/07/2024, 03/01/2024, or 04/29/2024 discharges as required. In an interview on 07/23/2024 at 9:22 AM Staff A (Administrator) stated they did not have a process for written transfer notifications, so they were not being provided to any of the residents transferred to the hospitals. Staff A stated it was important to provide a written transfer notification to ensure the resident or resident representative was informed of the reason for transfer and to ensure the transfer was in alignment with the resident's stated goals for care and preferences. REFERENCE: WAC 388-97-0120 (2)(a-d).

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46479 Based on interview and record review, the facility failed to establish a system that ensured residents who were transferred to the hospital or went on therapeutic leave were provided a written notice of bed hold that specified the duration of the bed hold policy upon transfer or attempted to contact the resident and/or the resident representative within 24 hours from an emergency transfer for 2 (Resident 59 & 23) of 7 sampled residents reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while hospitalized . Findings included . <Facility Policy> According to the Admission, Transfer, and Discharge - Notice of Bed Hold Policy Before/Upon Transfer facility policy revised 11/2018, the facility would provide information regarding the resident's right to hold their bed at the time of transfer or within 24 hours of the transfer if the transfer was emergent. <Resident 59> According to the 05/29/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 59 was assessed to have impaired memory and thinking abilities. The MDS showed Resident 59's diagnoses included heart failure, a progressive memory loss disease, and weakness to one side of their body. The MDS showed Resident 59 received nutrition via a tube surgically placed in their stomach. Review of Resident 59's census documents showed Resident 59 was hospitalized from: - 11/20/2023 to 11/29/2023 - 12/04/2023 to 12/12/2023 - 02/07/2024 to 02/09/2024 - 03/01/2024 to 03/12/2024 Review of Resident 59's record on 07/23/2024 at 8:34 AM showed no documentation indicating a bed hold notification was provided to Resident 59 or their representative when they discharged to the hospital on 11/20/2023, 12/04/2023, 02/07/2024, and 03/01/2024 as required. <Resident 23> Review of Resident 23's 04/16/2024 Quarterly MDS showed Resident 23 had no memory impairment and had complex medical conditions including diabetes (inability to control their blood sugars), wounds to their feet related to diabetes, and pressure ulcers. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's census documents showed Resident 23 was sent to the hospital on 01/24/2024 and readmitted to the facility on [DATE]. Review of Resident 23's records on 07/16/2024 at 1:44 PM showed no documentation indicating a bed hold notification was provided to Resident 23 when they discharged on [DATE] as required. In an interview on 07/23/2024 at 10:20 AM, Staff I (Admissions Coordinator) and Staff J (Admissions Coordinator) had a binder in which they kept track of hospitalization s and bed hold notifications. Staff I and Staff J reviewed their binder and reviewed Resident 59 and Resident 23's records and confirmed the bed hold notifications were not completed as required. REFERENCE: WAC 388-97-0120(4). .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 46479 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) was completed within 14 days from the date of determination for 1 (Resident 68) of 1 resident reviewed for significant changes in status. The failure to identify the need for a SCSA when Resident 68 had a decline in condition and was started on hospice services placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . According to the Resident Assessment Instrument manual (a document directing staff when assessments of resident status is required) a .SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains in the nursing home. <Resident 68> Review of Resident 68's 04/05/2024 Hospice Certification and Plan of Care showed Resident 68 admitted to hospice services on 04/05/2024 for a diagnosis of protein - calorie malnutrition and the inability to absorb nutrients from food. This certification showed Resident 68 was terminally ill with a life expectancy of less than six months. Review of Resident 68's Minimum Data Set (MDS - an assessment tool) assessments showed staff completed a Quarterly MDS on 05/29/2024. Staff identified Resident 68 was receiving hospice services on the 05/29/2024 Quarterly assessment. A SCSA was completed for Resident 68 on 06/20/2024, 76 days after the date of determination on 04/05/2024, which was the hospice provider's start of care date. In an interview on 07/23/2024 at 10:42 AM, Staff M (MDS Coordinator) reviewed Resident 68's records and MDS assessments. Staff M stated a SCSA should be completed when the resident started on hospice, but staff did not complete the SCSA as required. REFERENCE: WAC 388-97-1000(3)(b).

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	07/24/2024

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45941 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were completed accurately for 1 (Resident 61) of 5 residents reviewed for PASRR screening. The failure to ensure PASRR screening was complete and accurate left residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . <Facility Policy> According to the facility's revised 08/2018 Resident Assessment - PASRR for Mental Disorder (MD) and Intellectual disability policy, all residents must have a PASRR screening prior to admission, and the facility would keep a copy of the screening in the resident's record. The policy showed the facility's Social Services department was responsible for ongoing maintenance of accurate PASRR screenings and PASRR screening should be updated as needed to reflect changes both positive and negative to a resident's mental health status. This policy showed if a PASRR level I was positive, with any MD or a related condition, the resident would be referred to the appropriate State designated authority for a PASRR level II review. <Resident 61> According to the 05/20/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool) Resident 61 had moderately impaired cognition (impaired memory and problem solving) and had diagnoses of schizophrenia and anxiety. The MDS showed Resident 61 regularly used Antipsychotic (AP), and Antidepressant (AD) medications during the assessment period. Review of the 05/16/2024 and 06/07/2024 psychiatry progress notes showed Resident 61 had diagnoses of schizophrenia, anxiety, and major depression disorder, and received AP, Antianxiety (AA), and AD medications. The psychiatrist recommended staff to continue administering AP, AA, and AD medications as ordered, and continue monitoring behaviors for depression and psychosis. Review of the July 2024 Medication Administration Record (MAR) showed Resident 61 received routine AP, AD, and AA medications every day as ordered related to their diagnoses. Review of the 05/15/2024 Level 1 PASRR showed Resident 61 was identified with serious mental illness indicator for Schizophrenia and Anxiety disorder diagnoses, and Level 11 PASRR evaluation was not required. Resident 61's diagnosis of major depression was not checked on the Level 1 PASRR. In an interview on 07/23/2024 at 1:27 PM, Staff D (Social Services Director) stated Resident 61's Level 1 PASRR was updated on 05/15/2024 and Level 11 PASRR was not indicated. Staff D reviewed Resident 61's MAR that Resident 61 received AP, AA, and AD medications every day. Staff D reviewed Resident 61's Level 1 PASRR and stated the form was inaccurate and required revision to check the major depression disorder diagnosis and the resident should be referred for a Level 11 evaluation. Staff D stated they should have reviewed the Level 1 PASRR for accuracy at admission time, but they did not. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1915 (1).

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	505510	A. Building B. Wing	07/24/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CPs) were accurately reviewed and revised to reflect current resident status and needs as required for 5 (Residents 41, 61, 6, 68, & 32) of 20 residents reviewed for CP's. This failure left residents at risk for unmet care needs and a diminished quality of life. Findings included . <Facility Policy> Review of the facility's Quality of Care policy, revised 08/2018, showed the resident's CP would reflect person-centered care and include resident choices, preferences, goals, concerns, and needs. The CP would describe the care and services staff would provide to the resident so the resident could attain or maintain their highest practicable physical, mental, and psychosocial well-being. <Resident 41> According to the 06/12/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool), Resident 41 admitted to the facility on [DATE] with two pressure ulcers (PUs). Resident required maximal assistance with bed mobility and toileting needs. Review of Resident 41's record showed Resident 41 had PUs on right buttock and left buttock. Review of the 06/11/2024 Skin CP showed Resident had a coccyx PU and was at risk for new PU development. Nursing interventions included Resident 41 preferred to be repositioned with two staff members. Observations on 07/18/2024 at 9:39 AM during wound care showed Resident 41 had PU on right buttock and left buttock. There was no PU on Resident 41's coccyx area. In an interview on 07/18/2024 at 10:22 AM, Resident 41 stated staff did not offer or assist the resident to reposition in bed. In an interview on 07/18/2024 at 10:45 AM, Staff G (Unit Manager - UM) stated Resident 41 had PUs on their right and left buttock. In an interview on 07/22/2024 at 10:02 AM. Staff B (Director of Nursing) stated they knew the facility had a CP issue. Staff B stated Resident 41 did not have a PU on coccyx area and the CP is inaccurate. Staff B stated nursing staff should have reviewed the CPs and updated according to the resident's status, but they did not. <Resident 61> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 05/20/2024 Admission 5 Day MDS, Resident 61 admitted to the facility on [DATE] and had moderately impaired memory. Review of the 05/16/2024 Medication CP showed Resident 61 received Intravenous (IV- needle inserted into a vein to provide medication or fluids) medications and nursing interventions included instructions for nursing staff to monitor IV dressing site every shift. Review of the July 2024 medication administration record showed Resident 61 received no IV medication. Observation on 07/18/2024 at 9:21 AM showed no IV insertion site or dressing on Resident 61's body. In an interview on 07/18/2024 at 11:21 AM, Staff E (Licensed Practical Nurse) reviewed Resident 61's record and stated Resident 61 had no IV medication orders. In an interview on 07/22/2024 at 10:02 AM, Staff B stated the CP was not accurate. Staff B stated nursing staff should have reviewed the CPs and updated according to the resident's status, but they did not. 45720 <Resident 6> According to the 06/07/2024 Quarterly MDS Resident 6 was independent with lying to sitting on side of bed, sit to stand, chair-to-bed/bed-to-chair transfer, toilet transfer, and walked ten feet. This MDS showed Resident 6 had intact cognition. During an interview on 07/16/2024 at 9:07 AM Resident 6 stated they transferred from their bed to their wheelchair or walker and back to their bed independently. Review of Resident 6's Potential for Alteration in Activities of Daily Living CP on 07/18/2024 at 8:46 AM showed the CP had contradicting information. One intervention stated the resident required supervision or partial assistance of one staff for transferring. Another intervention stated Resident 6 was able to transfer on their own. Review of Resident 6's bedside Kardex on 07/18/2024 at 9:00 AM showed Resident 6 required substantial to maximal assistance by one staff to turn and reposition in bed, was independent with bed mobility, was able to transfer on their own, and required supervision or partial assistance of one staff for transferring. During an observation on 07/18/2024 12:16 PM Resident 6 went from lying in bed to sitting on the edge of their bed independently. During an interview on 07/23/2024 at 11:21 AM Staff P (UM) stated Certified Nursing Assistants used the CP and Kardex for information on what care to provide for each resident. Staff P stated it was important to update or revise CPs to ensure proper care was provided to the residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/23/2024 at 11:28 AM Staff P stated Resident 6 was mostly independent with bed mobility and transfers. Staff P stated the CP and Kardex should be revised to reflect Resident 6's current care needs. 46479 <Resident 68> Review of the 05/29/2024 Quarterly MDS showed Resident 68 had severe impairment to their thinking abilities. This MDS showed Resident 68 was receiving hospice (end of life care) and had a life expectancy of less than six months. Review of Resident 68's Comprehensive CP on 07/23/2024 at 1:30 PM showed the CP was not revised to include goals or interventions related to Resident 68's hospice services. There were no instructions to staff indicating what care and services hospice staff provided to Resident 68. There were no instructions to staff regarding what measures to implement for Resident 68's comfort or directions for coordination between hospice and the facility. In an interview on 07/23/2024 at 1:35 PM, Staff B stated it was important for CPs to be updated and revised to ensure staff were providing the correct care for residents. Staff B reviewed Resident 68's CP and confirmed it needed to be updated to reflect Resident 68's hospice status. <Resident 32> Review of the 06/26/2024 Quarterly MDS showed Resident 32 had one fall since their admission to the facility. This MDS showed Resident 32 had no behaviors or rejection of care during the assessment period. Review of Resident 32's 07/02/2024 revised Fall CP showed an intervention directing staff to keep Resident 32's bed in a low position. Observations on 07/17/2024 at 9:18 AM and 07/22/2024 at 9:29 AM showed Resident 32 lying in bed. Resident 32's bed was not in the low position. In an observation and interview on 07/23/2024 at 2:03 PM, Resident 32 was lying in bed with the bed not in the low position. At that time, Resident 32 stated they did not like their bed in the low position because it affected their sleep. At that time, Resident 32 grabbed their bed controller and demonstrated how they could independently raise their bed up and down. In an interview on 07/23/2024 at 1:17 PM, Staff B stated Resident 32's bed should be in the lowest position, but the resident was able to position their bed independently. Staff B stated the CP should be updated to identify Resident 32's non-compliance with their plan of care, but the CP was not. REFERENCE: WAC 388-97-1020(5)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45720 Based on interview and record review, the facility failed to ensure services provided met professional standards of practice for 4 (Residents 66, 32, 59, & 67) of 20 residents reviewed. The nursing staff's failure to follow and/or clarify Physician Orders (POs), and notify the provider of resident refusals of treatment, placed residents at risk for unmet care needs, and potential negative outcomes. Findings included . <Clarifying Physician Orders> <Resident 66> According to the 05/08/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 66 received nutrition through a feeding tube (a tube surgically placed in the stomach used to administer artificial nutrition). Review of Resident 66's order summary on 07/23/2024 at 12:45 PM showed Resident 66 had a 02/29/2024 diet order of NPO (nothing by mouth). Review of Resident 66's March 2024 through July 2024 Medication Administration Records (MARs) on 07/23/2024 at 12:45 PM showed Resident 66 had a 03/10/2024 PO for an anti nausea medication, a 03/26/2024 PO for a muscle relaxant, a medication to reduce itching, and a 03/27/2024 PO for a medication to reduce high blood pressure. These orders instructed staff to administer the medications to Resident 66 by mouth. During an interview on 07/23/2024 at 12:45 PM Staff P (Unit Manager - UM) stated Resident 66 received all their medications through the feeding tube. Staff P reviewed Resident 66's July 2024 MAR and confirmed the four medications were ordered to be administered by mouth. Staff P stated this was a mistake. <Following Physician Orders> <Resident 66> Review of Resident 66's June 2024 and July 2024 MAR on 07/18/2024 at 12:45 PM showed a 03/07/2024 PO for a medication to reduce high blood pressure to be held on Tuesday, Thursday, and Saturday mornings prior to dialysis. Review of the June 2024 and July 2024 MAR showed the medication was administered on those days to Resident 66 and not held as ordered by the physician. During an interview on 07/23/2024 at 12:52 PM Staff P stated the medication was not being held as ordered. <Resident 32> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 06/26/2024 Quarterly MDS, Resident 32 was understood and could understand others in conversation. The MDS showed Resident 32 had pain and received scheduled and As Needed (PRN) pain medications. Review of Resident 32's 07/18/2024 order summary showed a 05/17/2024 PO for an opioid medication to be administered every six hours PRN for pain. The PO did not instruct staff at what level to administer the opioid medication. The order summary showed a PO for an over-the-counter pain medication to be administered every eight hours PRN for a pain level of 1-5 on a numerical pain scale. Review of Resident 32's 07/2024 MAR showed staff administered the PRN opioid medication for a pain level of 2 and 4. This MAR showed staff administered the PRN over-the-counter pain medication for a pain level of 6. Review of Resident 32's 06/2024 MAR showed staff administered the PRN opioid medication on two occasions for a pain level of 2, on two occasions for a pain level of 3, and on one occasion for a pain level of 5. This MAR showed staff administered the over-the-counter pain medication for a pain level of 7 on one occasion. Review of Resident 32's 05/2024 MAR showed staff administered the PRN opioid medication on two occasions for a pain level of 2. In an interview on 07/23/2024 at 1:15 PM, Staff B (Director of Nursing) stated it was their expectation staff followed parameters when administering medications to residents. <Resident 59> According to the 05/29/2024 Annual MDS, Resident 59 had severe cognitive impairment. This MDS showed Resident 59 had a feeding tube and received more than half of their daily nutrition via the feeding tube. Review of Resident 59's 07/17/2024 order summary showed a 03/19/2024 PO for the tube feeding to be administered at 50 Milliliters (mls) per hour for 20 hours via a pump. This PO directed staff to start the tube feeding at 8:00 PM and stop the feeding at 4:00 PM the following day. The PO summary showed an additional 03/12/2024 order directing staff to document the amount of tube feeding formula and water administered to Resident 59 every eight hours. Observation on 07/17/2024 at 8:40 AM showed Resident 59 in bed receiving their tube feeding. The pump showed 3,324 mls were administered. Observation on 07/18/2024 at 8:58 AM showed Resident 59 in bed receiving their tube feeding. The pump showed 4,126 mls were instilled at that time. Similar observations were made on 07/22/2024 at 5:57 AM, the pump showed 5,830 mls were instilled. Review of Resident 59's 07/2024 Treatment Administration Record (TAR) showed at 6:00 AM on 07/17/2024, staff documented 660 mls were administered, less than three hours prior to the pump showing 3, 324 mls were administered. The TAR showed staff documented at 6:00 AM on 07/18/2024, 660 mls were administered, three hours prior to the observation of 4,126 mls administered. On 07/22/2024 at 6:00 AM, staff documented 660 mls were administered despite the 5:57 AM observation showing 5,830 mls were administered. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 07/24/2024 at 8:26 AM, the pump showed 1,366 mls were administered. Staff C (Assistant Director of Nursing) observed the pump and confirmed it showed 1,366 mls were administered. Staff C reviewed the 07/2024 TAR and confirmed staff documented 660 mls were administered at 6:00 AM, just two and a half hours earlier. In an interview on 07/24/2024 at 10:53 AM, Staff B stated they expected staff to look at the tube feeding pump and accurately document the amount of tube feeding administered to Resident 59. Staff B stated they expected staff to clear the pump readings in order to obtain the accurate amount of tube feeding Resident 59 received each shift. 45941 <Resident Refusals> <Resident 67> According to the 05/09/2024 Quarterly MDS, Resident 67 admitted to the facility on [DATE] and had no memory impairment. The MDS showed Resident 67 received pain medications to relieve pain and had no rejection of care during the assessment period. Review of Resident 67's July 2024 POs directed staff to administer a laxative powder twice daily for constipation. Review of the July 2024 MAR showed Resident 67 refused to take the laxative medication on twenty out of thirty-four opportunities. Review of Resident 67's record showed no documentation the provider was notified related to Resident 67's refusal of the laxative medication. In an interview on 07/17/2024 at 1:22 PM, Staff G (UM) stated if any resident refused care or treatment, Staff G expected staff to document the refusals in the resident's record and notify the providers. In an interview on 07/23/2024 at 10:04 AM, Staff B reviewed Resident 67's record and stated Resident 67 refused to take the medication nearly every day and there was no documentation staff notified the provider regarding Resident 67's refusals. Staff B stated staff should discuss with the resident the reason for the refusals, notify the provider, and document in Resident 67's record, but they did not. 46479 REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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	07/24/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 61) of 3 sampled residents reviewed for communication, including language and speech, were provided a functional system to address their communication needs. Failure to identify and provide services which enhanced and or ensured effective communication, placed residents at risk for unmet care needs, social isolation, and a diminished sense of well-being. Findings included . <Resident 61> According to the 05/20/2024 Admission 5 Day Minimum Data Set (an assessment tool), Resident 61 admitted to the facility on [DATE], had impaired memory, was never able to understand others, and had unclear speech. The assessment showed Resident 61 had no behavior or rejection of care during the assessment period. Observations on 07/16/2024 at 9:40 AM, and 07/17/2024 at 11:59 AM showed Resident 61 was lying in their bed in their room. During an interview on 07/17/2024 at 11:59 AM, Resident 61 mumbled and was unable to make themselves understood to the surveyor. During observation and interview on 07/18/2024 at 12:45 PM, Resident 61 was lying in their bed with head of bed up and Staff S (Certified Nursing Assistant) was feeding Resident 61 their lunch. Staff S stated Resident 61 would only shake their head for yes or no and did not speak clearly to make their needs known. There was no communication book or board observed in Resident 61's room. Review of the 05/24/2024 Communication Care Plan (CP) showed Resident 61 had a communication problem and nursing interventions instructed the staff to anticipate Resident 61's needs, ask yes or no questions of the resident, OT/PT (Occupational Therapy/Physical Therapy) was to evaluate Resident 61's ability to use a communication board, and use a computer or sign language as an alternate communication to speech. In an interview on 07/23/2024 at 10:51 AM, Staff B (Director of Nursing) stated Resident 61 could not talk and communicated with staff by shaking their head for yes or no. Staff B stated they tried a communication binder but the binder did not work. Staff B reviewed Resident 61's record and stated staff did not document the resident's inability to use the communication binder. Staff B stated they would provide OT documentation. In an interview on 07/23/2023 at 1:10 PM, Staff T (Rehab Director) stated Resident 61 was evaluated and treated by a Speech Therapist only for swallowing issues, not for communication or speech. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/23/2024 at 3:13 PM, Staff B provided Speech Therapist notes which showed Resident 61 was not evaluated for speech or communication. Staff B did not provide the OT evaluation or treatment documentation for communication problem as documented in the CP. REFERENCE: WAC 388-97-1620 (2)(a)(v).

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	07/24/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 2 (Residents 61 & 62) of 20 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with shaving (Resident 61), and nail care (Resident 62), placed the residents at risk for poor hygiene, long facial hair, embarrassment and diminished quality of life. Findings included . <Facility Policy> According to the facility's 11/2017 Quality of Life- Activities of Daily Living policy, the facility would provide ADLs in accordance with resident's comprehensive assessment, Care Plan (CP), and resident preferences to ensure a resident's ADL abilities do not diminish unless decline in function was unavoidable. <Shaving> <Resident 61> According to the 05/20/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool), Resident 61 admitted to the facility on [DATE], had impaired memory, and required maximal assistance with personal hygiene. The MDS showed Resident 61 had no behavior of refusing care during the assessment period. Observations on 07/16/2024 at 9:40 AM, 07/17/2024 at 11:59 AM, and 07/18/2024 at 9:51 AM showed Resident 61 was in bed and had long facial hair. According to the 05/16/2024 ADL self-care performance deficit CP, Resident 61 was dependent on staff for personal hygiene including shower and oral care. In an interview on 07/23/2024 at 11:52 AM, Staff B (Director of Nursing) stated they expected staff to check all resident's preferences related to ADLs and provide assistance as needed every morning. Staff B stated staff should have shaved Resident 61's facial hair as they allowed. If the resident refused, staff should document the refusals. Staff B reviewed Resident 61's record and stated the facility should have documented Resident 61's preferences and provided assistance with shaving their facial hair, but they did not. <Resident 62> According to the 06/16/2024 Admission MDS, Resident 62 admitted to the facility on [DATE] and had no memory impairment. The MDS showed Resident 62 required one person assistance with personal hygiene and had no rejection of care behavior during the assessment period. (continued on next page)

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	07/24/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 07/16/2024 at 10:31 AM, 07/17/2024 at 8:30 AM, and 07/18/2024 at 2:12 PM, showed Resident 62 had long fingernails, and facial hair. In an interview on 07/19/2024 at 12:33 PM, Resident 62 stated they did not have a razor to shave their facial hair. Resident 62 stated they needed help to clip fingernails. According to the 06/10/2024 ADL self-care performance deficit CP, Resident 62 required maximal assistance from staff with personal hygiene, including shower and oral care. In an interview on 07/23/2024 at 11:52 AM, Staff B stated staff should have shaved Resident 62's facial hair during morning care, but they did not. Staff B stated Staff should provide the assistance with ADLs to Resident 62 to clip their fingernails weekly and as needed, but they did not. REFERENCE: WAC 388-97-1060(2)(C).

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	07/24/2024

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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** 45941 Based on observation, interview, and record review, the facility failed to ensure 3 of 20 residents (Residents 41, 67, & 59) reviewed, received the necessary care and services in accordance with professional standards of practice, and the comprehensive person-centered care plan. The facility failed to complete weekly skin checks and provide the treatment for 2 of 4 residents (Residents 41 & 67) reviewed for non-pressure ulcers and failed to accurately set air mattress setting according to resident's weight for 1 of 4 residents (Resident 59) reviewed for air mattress setting. These failures placed residents at risk for decline in medical status, unmet care needs, and a decreased quality of life. Findings included . <Facility Policy> According to the facility's revised 08/2018 Quality of Care policy, the facility would ensure care plans included resident care needs and described the services and care required; ensure residents with non-pressure-related skin ulcers/wounds were assessed by a clinician, including documentation of underlying conditions contributing to ulceration, characteristics of the wound edge and wound bed, location, shape and condition of surrounding tissues; ensure treatment of such conditions were in accordance with physician orders and incorporated appropriate preventive measures. <Non-Pressure Skin> <Resident 41> According to the 06/12/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool), Resident 41 admitted to the facility on [DATE], cognitively intact and had diagnoses including below the right knee amputation, asthma, and reduced blood circulation to body parts. The assessment showed Resident 41 had unhealed pressure ulcers, other wounds included infection of the foot, and open lesions other than ulcers, rashes and cuts. Resident 41 required maximal assistance for bed mobility, toileting, and shower. Review of the 07/15/2024 weekly skin assessment showed Resident 41 had no new skin issues. The facility staff documented no skin concern at that time. Observations on 07/16/2024 at 10:23 AM showed Resident 41 was lying in bed with left lower leg exposed (blanket pulled up to shins and no sock in place on left foot). Multiple opened and scabbed areas observed on left shin and left foot toes were macerated with debris between toes. On 07/17/2024 at 9:15 AM, Resident 41 was again observed lying in bed with left lower leg exposed and the skin issues were still present on left shin and left foot toes. Resident 41 stated they had those open sores on left shin and infection on their left foot for a while. Resident 41 stated the facility nurses were aware of the skin issues on left leg, but they did not apply any treatment on left lower leg or foot. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/18/2024 at 9:39 AM of wound care provider and nursing staff providing the wound care to Resident 41's pressure wounds showed Resident 41 had multiple open and scabbed areas on left shin and left foot toes were still macerated and brown debris between the toes. The wound care provider assessed left shin wounds, measured 8.2 centimeter (cm) X 2.2 cm and left toes were assessed with fungal infection. Record review showed no indication the facility was treating or monitoring Resident 41's left shin wounds and left toes fungal infection. Review of the July 2024 Treatment Administration Record (TAR) showed facility failed to treat or monitor Resident 41's skin issues on left shin and toes. In an interview on 07/18/2024 at 10 :01 AM, Staff G (Unit Manager) stated Resident 41 was admitted with cellulitis on left lower leg and these wounds were not new. Staff G reviewed Resident 41's record and stated there was no treatment order for the left shin wounds. Staff G stated they did not know about Resident 41's left foot toes fungal infection. In an interview on 07/23/2024 at 11:23 AM, Staff B (Director of Nursing) stated they expected the facility staff to complete weekly skin check and document accurately in resident's record. Staff B stated staff should notify the provider for any skin issue to receive a treatment order and documentation in TAR as ordered. Staff B stated no matter it was pressure ulcer or non-pressure ulcer, staff should have completed weekly skin check accurately and documented in resident's record, but they did not. Staff B stated there should be treatment order for Resident 41's skin issues on left shin and toes, but there was not. <Resident 67> According to the 05/09/2024 Quarterly MDS, Resident 67 admitted to the facility on [DATE] with left lower leg cellulitis and had no memory impairment. The MDS showed Resident 67 had skin tears and infection on left foot. Observation on 07/17/2024 at 10:58 AM showed Resident 67 had bruises on left arm and dry skin tears on left hand. Resident 67's left foot was observed wrapped with dressing. Review of the 02/13/2024 Skin integrity Care Plan (CP) instructed nurses to perform and document weekly skin checks, and to notify the provider for any skin issues. Review of Resident 67's record showed the last weekly skin check was performed on 06/12/2024. After 06/12/2024, there was no weekly skin check was performed or documented in Resident 67's record. In an interview on 07/23/2024 at 10:01 AM, Staff B stated they expected the facility staff to perform and document weekly skin check in all residents record every week. Staff B reviewed Resident 67's record and stated staff should have completed weekly skin check and documented in Resident 67's record, but they did not. 46479 <Air Mattress Settings> <Resident 59> (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Annual 05/29/2024 MDS, Resident 59 had severe cognitive impairment. The MDS showed Resident 59 had weakness to one side of their body and required substantial/maximal assistance from staff to move in bed. The MDS showed Resident 59 was at risk for developing pressure ulcers or injuries. The MDS showed Resident 59 had a pressure reducing device for their bed. Observation on 07/18/2024 at 9:10 AM showed Resident 59 lying in bed. In an interview at that time, Resident 59 stated they were uncomfortable because the bed was very firm and was hurting their legs. Observation of the bed at that time showed Resident 59 was lying on an air mattress. The air mattress was set to 300 LBS [pounds], normal pressure. Review of Resident 59's weights showed on 07/17/2024, staff obtained Resident 59's weight and documented the resident weighed 147 pounds. Review of Resident 59's 07/17/2024 order summary showed there were no orders for the resident's air mattress. There were no directions to staff regarding what setting the mattress should be on or how often the settings should be verified. Review of Resident 59's .risk for impairment to skin integrity . CP revised on 11/29/2023 showed the resident had an air mattress. The CP did not give directions to staff regarding what setting the mattress should be on or how often the settings should be verified. In an observation and interview on 07/18/2024 at 9:23 AM, Staff B stated air mattress settings were determined by the resident's weight unless a resident had a specific preference for the air mattress setting. Staff B stated instructions regarding the air mattress should be in the resident's CP. At that time, Staff B looked at Resident 59's mattress settings and confirmed the mattress was not on the proper setting given the resident's current weight. REFERENCE: WAC 388-97-1060 (1).

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	07/24/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 41) of 5 residents reviewed for Pressure Ulcers (PU's) received the necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure of the facility to consistently complete weekly skin assessment, assess skin integrity to identify PUs timely, and implement interventions to include updating the Care Plan (CP), placed Resident 41 at risk to develop new PU, and diminished quality of life. <Facility Policy> According to the facility's 08/2018 Quality of Care- Skin Integrity policy, the facility would assess residents upon admission and thereafter, to identify if the resident had existing PU's or was at risk for developing PUs. A resident at risk for developing PUs would have individualized interventions implemented to prevent new PUs from developing. The policy showed the resident's CP would reflect the treatment strategies for residents identified with PUs and preventative interventions for residents identified at risk for developing PU's. The policy showed repositioning was an effective intervention for treatment and prevention of PU's and would be addressed in the resident's comprehensive CP. <Resident 41> According to the 06/12/2024 Admission 5 Day Minimum Data Set (MDS - an assessment tool), Resident 41 admitted to the facility on [DATE], cognitively intact and had diagnoses including below the right knee amputation, asthma, high blood sugars, pressure ulcers, and peripheral vascular disease (reduced blood circulation to body parts). According to the assessment, Resident 41 had stage 3 (full thickness tissue loss) PU's on their right and left buttocks and was at risk for developing new PU's. Resident 41 required maximal assistance for bed mobility, rolling from back to left and right side in bed, toileting, and showering and Resident 41 had no behavior of rejection of care during assessment period. Review of the 06/12/2024 CAA (Care Area Assessment) showed Resident 41 required a special mattress to reduce or relieve pressure related to PU's. Review of Resident 41's record showed the facility was aware Resident 41 had existing PU's and was at risk for developing new PU's but failed to evaluate the need for and implement additional pressure relief until 07/18/2024 to heal the existing PU's and to prevent new PU's According to the 06/06/2024 nursing admission skin assessment, Resident 41 admitted with two stage 3 PU's. A review of Resident 41's June and July 2024 weekly skin assessments showed the facility failed to complete the weekly skin assessments consistently as ordered. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 06/11/2024 PU CP showed Resident 41 had coccyx PU and was at risk for PU development related to immobility. Nursing interventions included instructions for staff to administer treatment as ordered, avoid positioning the resident on their back, to follow facility policy for the prevention/treatment of skin issues, to perform and document weekly skin checks, and to notify the provider for any skin breakdown. Review of The 07/11/2024 contracted wound care provider's progress note showed Resident 41 remained fully dependent on nursing staff for repositioning and offloading. Observations on 7/16/2024 at 8:52 AM, 11:00 AM, and 12:54 PM, on 07/17/2024 at 9:15 AM, 11:00 AM, 1:04 PM, and 3:00 PM, on 07/18/2024 at 8:11 AM and 9:35 AM showed Resident 41 was lying on their back in bed. Resident 41's left lower leg had multiple open and scabbed sores, a left medial foot (base of the big toe) with dark purple spot, and left foot toes with maceration and debris between the toes. Observation on 07/18/2024 at 9:39 AM of the wound care provider and nursing staff providing the wound care to Resident 41's wounds showed right buttock and left buttock wounds. The observation showed Resident 41 had a dark purple spot on their left medical foot. The wound care provider and nursing staff did not acknowledge the left medial foot wound and left the room. In an interview on 07/18/2024 at 10:22 AM, Resident 41 stated they stayed in bed all the time because they had bed sores. Resident 41 stated they had only one leg and needed assistance from staff to reposition in bed. Resident 41 said they were lying on their back in bed all the time. In an interview and observation on 07/18/2024 at 1:01 PM, Staff B (Director of Nursing) Staff B stated Resident 41 was admitted with PU's and non PU's due to poor blood circulation. Staff B assessed Resident 41's left medial foot and confirmed Deep Tissue Injury (DTI- discolored intact skin due to damage or underlying soft tissue from pressure) on the base of big toe, measured 2.0 cm X 1.0 cm. Staff B stated all these wounds were unavoidable related to Resident 41's diagnoses. In an interview on 07/23/2024 at 10:07 AM, Staff B stated weekly skin assessment, early identification of skin impairment and implementing PU prevention timely were important to maintain skin integrity to prevent new PU from developing. Staff B stated they were aware of Resident 41's PU's on their buttocks and expected staff to reposition Resident 41 in bed every 2-3 hours and as needed. Staff B stated the left medial foot DTI was a new PU and staff should have identified during wound rounds, documented in Resident 41's record, and notified the provider but they did not. Staff B reviewed Resident 41's record and stated staff should have completed weekly skin checks every week and document in the resident's record, but they did not. Staff B stated Resident 41 was admitted with PU's and staff should have ordered an air mattress and heel floater in Resident 41's bed to prevent new in-house PU from developing, but they did not. REFERENCE: WAC 388-97-1060(3)(b).

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	07/24/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to provide restorative/rehabilitative treatment/services for 7 of 8 residents (Residents 47, 20, 40, 41, 61, 32, & 59) reviewed for limited Range of Motion (ROM) and mobility to ensure the residents maintained and/or improved their highest level of functioning. This failure placed residents at risk of further decline in ROM, loss of function, and/or permanent immobility. Findings included . <Facility Policy> According to a facility policy titled, Quality of Care Restorative Nursing Programs, revised 06/2018, showed Restorative Nursing Programs (RNP) would be developed and/or formalized by a supervising nurse. <Resident 47> According to a 05/31/2024 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 47 had functional limitation in ROM to both arms and both legs. The assessment showed Resident 47 did not have any memory impairment. The MDS showed Resident 47 had medically complex conditions which included, but were not limited to, depression, generalized muscle weakness, difficulty in walking, and fibromyalgia (chronic disorder characterized by pain, stiffness, and tenderness). Review of a 02/23/2024 Activity of Daily Living (ADL) Care Plan (CP), Resident 47 required substantial/maximal assistance from staff with bathing/showering, bed mobility, dressing, and toilet use. The CP showed Resident 47 required two staff maximal assistance with a mechanical lift machine for transfers. In an interview on 07/16/2024 at 11:56 AM Resident 47 stated they were unable to raise either arm up to shoulder level and unable to bend both of their knees to a 90-degree angle. Resident 47 stated they were informed by therapy they can't work with therapy, and they could not have restorative nursing services until they were approved for Medicaid insurance. In an interview on 07/24/2024 at 9:52 AM Staff G (Unit Manager - UM) stated Resident 47 was assessed to have limited ROM to both arms and both legs. Staff G stated Resident 47 should have started a RNP to prevent ADL decline, but they were not. Staff G stated they did not assess residents for RNP's and believed therapy was responsible for these recommendations. Staff G stated it was important when a resident with limited ROM finished working with therapy to continue exercises with a RNP, so they did not become contracted or develop a decrease in their ROM and mobility. <Resident 20> (continued on next page)

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	07/24/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 05/06/2024 Annual MDS, Resident 20 had no memory impairment. The MDS showed Resident 20 was [AGE] years old and originally admitted on ,d+[DATE] with a rehospitalization in December 2023 and April 2024. The assessment showed Resident 20 had diagnoses of, but not limited to, generalized muscle weakness, and difficulty in walking. Review of a 06/10/2024 nursing admission assessment/evaluation showed Resident 20 required assistance from one staff with walking daily. In an interview and observation on 07/17/2024 at 10:06 AM Resident 20 stated their right shoulder had limited ROM. Resident 20 demonstrated the inability to raise their right arm on its own by using their left hand to lift their right arm up and stated they could not even raise their right arm up to shoulder height anymore. Resident 20 stated when staff gave me the power chair, they stopped physical therapy and walking with me. Resident 20 stated walking was the one thing they really looked forward to, but staff had not been walking with them anymore. In an interview on 07/19/2024 at 10:07 AM, Staff B (Director of Nursing) stated the RNPs were removed by the higher-ups. Staff B stated the facility did not have any dedicated staff to provide RNPs to residents and was told the RNPs would be incorporated/performed by all Certified Nursing Assistants (CNA) during the provision of ADL care. Review of Resident 20's records on 07/24/2024 there was no assessment of their right arm/shoulder in the resident's chart showing the decrease in their ROM. A daily task for staff to document they assisted Resident 20 with walking 10 feet every shift showed activity did not occur for the months of October, November, December in 2023, and January, February, March, April, May, June and July 2024. In an interview on 07/24/2024 at 10:14 AM Staff G stated Resident 20 had limited ROM to their right shoulder. Staff G stated staff were to assist Resident 20 with walking daily and they should be on a RNP to prevent a decline in their level of function and ROM, but they were not. Staff G stated there was no documentation staff assisted Resident 20 with daily walking. 45720 <Resident 40> According to a 06/13/2024 Quarterly MDS, Resident 40 was understood and could understand others in conversations and had intact cognition. The MDS showed Resident 40 had functional limitation in ROM to both legs, used a wheelchair for mobility, was dependent on staff assistance with rolling side to side, bathing, and chair/bed-to-chair transfers. The MDS showed Resident 40 had no rejection of care and did not receive a RNP during the assessment period. The revised 12/28/2023 limited physical mobility CP directed staff to provide a Nursing Rehab/Restorative: Active Assist ROM program for Resident 40 three to six days per week and a Nursing Rehab/Restorative: Mobility program three times per week. During an interview on 07/16/2024 at 8:50 AM Resident 16 stated staff assisted them to get out of bed about once a week. Resident 40 stated staff don't assist them with any exercises. (continued on next page)

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	07/24/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/23/2024 at 11:19 AM Staff P (Unit Manager) stated this facility does not have a RNP, the CNAs are expected to provide this service when a resident needs it. Staff P reviewed Resident 40's revised 12/28/2023 limited physical mobility CP and stated it directs staff to provide Resident 40 with restorative exercises. Staff P reviewed Resident 40's task documentation for July 2024 and stated there were no tasks listed for staff to sign off on, therefore Resident 40 did not receive these interventions. 45941 <Resident 41> According to the 06/12/2024 Admission 5 Day MDS, Resident 41 admitted to the facility on [DATE], cognitively intact and had a diagnosis of below the right knee amputation. The assessment showed Resident 41 had impairment on both upper and lower extremities with functional limitation in ROM and was required maximal assistance for bed mobility rolling from back to left and right side, toileting, and shower. Resident 41 had no rejection of care during the assessment period. Review of the 06/07/2024 ADL CP showed Resident 41 required two staff members for repositioning in bed and for locomotion. Observations on 07/16/2024 at 10:13 AM and 12:55 PM, on 07/17/2024 at 9:10 AM, and 07/18/2024 at 12:23 PM showed Resident 41 lying in their bed on their back. In an interview on 07/18/2024 at 12:23 PM, Resident 41 stated they had only one leg and they need two staff members to get them out of bed and even to reposition in bed. Resident 41 stated they worked with therapy till end of June 2024 and after that Resident 41 did not receive any exercise. In an interview on 07/23/2024 at 11:26 AM, Staff B stated the facility did not have any dedicated RNPs to residents and was told the RNPs would be performed by all CNAs during care and sometimes activity department would perform exercise program with a group of residents. Review of Resident 41's record showed a daily task for staff to document they assisted Resident 41 with walking 10 feet every shift and staff documented activity did not occur every day. In an interview on 07/23/2024 at 1:10 PM, Staff T (Rehab Director) stated Resident 41 received rehab services from 06/06/2024 thru 06/30/2024 until insurance covered the services. Staff T stated Resident 41 had limited ROM and would benefit from more therapy or RNP to prevent a decline in their level of function and ROM, but the facility did not have RNP. <Resident 61> According to the 05/20/2024 Admission 5 Day MDS, Resident 61 admitted to the facility on [DATE], had limited ROM on right arm and required maximal assistance with personal hygiene, bed mobility, and toileting. The MDS showed Resident 61 had no behavior of refusing care during the assessment period. Review of the 05/16/2024 ADL CP showed Resident 61 was dependent on staff for ADLs and locomotion. (continued on next page)

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	07/24/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 07/16/2024 at 9:40 AM, 07/17/2024 at 11:59 AM, 07/18/2024 at 2:45 PM showed Resident 61 was lying in their bed and was trying to get out of bed. In an interview on 07/23/2024 at 11:14 AM, Staff B stated the facility did not have any dedicated RNPs to residents and was told the RNPs would be performed by all CNAs during care. Staff B stated CNAs were assisting Resident 61 with ADLs and feeding all meals. Review of Resident 61's record showed a daily task for staff to document they assisted Resident 61 with walking 10 feet every shift and staff documented activity did not occur every day. In an interview on 07/23/2024 at 1:10 PM, Staff T stated Resident 61 was non weight bearing status on right their arm. Staff T stated Resident 61 had limited ROM and would benefit from a RNP to prevent a decline in their level of functioning and ROM, but the facility did not have a RNP. 46479 <Resident 32> According to the 06/26/2024 Quarterly MDS, Resident 32 had clear speech, was understood and could understand others in conversation, and had some impairment with their thinking/processing abilities. The MDS showed Resident 32 had limited ROM to one side of their upper extremities and to both lower extremities. The MDS showed Resident 32 did not receive restorative nursing services during the assessment period. In an interview on 07/17/2024 at 9:22 AM, Resident 32 stated they used to have a RNP but it stopped a while ago and the resident was unsure why the program ended. Review of Resident 32's .limited physical mobility . CP showed a 07/10/2022 revised intervention directing staff to assist the resident in completed upper and lower extremity ROM exercises five to seven times per week. Review of Resident 32's May 2024, June 2024, and July 2024 task report, showed staff did not offer or provide Resident 32 their RNP as care planned. <Resident 59> According to the 05/29/2024 Annual MDS, Resident 59 was understood and able to understand others in conversation. This MDS showed Resident 59 had severely impaired thinking/processing abilities. This MDS showed Resident 59 had limited ROM to one side of their upper body and one side of their lower body. The MDS showed Resident 59 did not receive RNP services for their limited ROM during the assessment period. Observation on 07/17/2024 at 8:48 AM showed Resident 59 lying in bed on their left side toward the wall. A palm protector was observed in Resident 59's left hand (continued on next page)

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	07/24/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 59's limited physical mobility CP revised 11/29/2023, showed Resident 59 had generalized weakness related to a stroke and weakness to one side of their body. This CP showed a goal for Resident 59 to remain free of complications related to their immobility including contractures. Resident 59's ADL - self-care performance deficit . CP showed Resident 59 was totally dependent on staff for turning/repositioning in bed, dressing, bathing, toilet use, transfers, and personal hygiene. This CP had no directions to staff regarding the palm protector and did not indicate Resident 59 was receiving a RNP despite have limited ROM. In an interview on 07/24/2024 at 10:43 AM, Staff B stated the CNAs were expected to provide walking assistance for resident who could walk. Staff B stated other activities such as encouraging a resident to brush their hair was considered active ROM. Staff B stated the CNAs were not documenting these activities. Staff B stated they did not have a list of residents who had formal RNPs in place. Staff B stated they expected CNAs to be trained to perform RNP tasks but they were not trained. REFERENCE: WAC 388-97-1060 (3)(d).

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	505510	A. Building B. Wing	07/24/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46479 Based on observation, interview, and record review the facility failed to ensure the resident environment was free of accident hazards for 1 of 8 (Resident 68) sample residents reviewed for accident hazards. The failure to assess devices such as wedges placed Resident 68 at risk for accidents, injury, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's Quality of Care - Accident Hazards/Supervision/Devices policy dated 07/2018, the facility would provide an environment that was free from accident hazards. This policy showed risks and benefits of assistive devices that could pose an entrapment risk would be considered prior to implementing the device. <Resident 68> According to the 06/20/2024 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 68 had severely impaired thought processes. The MDS showed Resident 68 had a progressive memory loss disorder and was receiving end-of-life services. This assessment showed Resident 68 admitted to the facility on [DATE] and had two or more falls since their admission to the facility. Observation on 07/16/2024 at 1:21 PM showed Resident 68 lying in bed with three pillows and one wedge cushion positioned under the right side of the mattress and the bed frame. One pillow was positioned under the left side of the mattress and the bed frame. Similar observations were made on 07/17/2024 at 11:03 AM. On 07/18/2024 at 12:21 PM, the wedge cushion was positioned between the right side of the mattress and bed frame. In an interview at that time, Staff E (Licensed Practical Nurse) stated the wedge was positioned under the mattress to keep the resident from falling out of bed. On that same date at 12:33 PM Staff F (Certified Nursing Assistant) stated the wedge and pillows were placed under the mattress to keep Resident 68 from falling out of bed. Similar observations of the pillows and/or wedge positioned between the mattress and bed frame were made on 07/19/2024 at 1:37 PM, 07/22/2024 at 9:31 AM and 07/23/2024 at 10:51 AM. In an interview on 07/23/2024 at 1:54 PM, Staff B (Director of Nursing) stated the pillows and wedge cushion should not be placed between the mattress and the bed frame because they could restrain the resident in bed and prevent them from freely moving about. Staff B stated there was no assessment completed to determine if the pillows and wedge did or did not restrain Resident 68's movement. REFERENCE: WAC 388-97-1060(3)(g).

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	505510	A. Building B. Wing	07/24/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to obtain consent for Bed Rails (BR) for 3 (Residents 1, 297, & 20) of 3 residents reviewed for BR's. Facility failure to attempt alternatives before implementing BR's, assess residents for safe use of BR's, or obtain informed consent for the use of BR's placed all residents at risk for harm or injury and other negative health outcomes. Findings included . <Facility Policy> According to a facility policy titled, Resident Rights Planning and Implementing Care, dated 11/2017, the residents had the right to be informed of their treatment and care. The policy stated staff would inform residents in advance of the treatment risks and benefits, options, and alternatives. According to a facility policy titled, Quality of Care - Bed Rails, the facility would attempt alternative measures prior to utilizing BR's and if it was determined the alternative measures were not effective, the facility would assess the resident for risks of entrapment. The policy showed staff would obtain consent from the resident/representative prior to installing the BR's. The policy showed if BR's are utilized, the resident would be re-assessed at routine intervals to verify the ongoing need for the BR's and they would be used for the shortest time necessary to meet the residents needs. <Resident 1> According to 06/07/2024 Discharge Minimum Data Set (MDS - an assessment tool), Resident 1 did not have BR's. The MDS showed Resident 1 had no memory impairment. Review of a 06/19/2024 revised Care Plan (CP) showed Resident 1 had BR's on their bed. In an observation on 07/16/2024 at 11:06 AM, Resident 1 had BR's attached to both sides of their bed. Review of Resident 1's Electronic Health Records (EHR) on 07/20/2024 showed no consent was obtained for the bilateral BR's. In an interview on 07/23/2024 at 9:53 AM, Staff H (Unit Manager - UM) stated they screened residents for BR's, but they did not obtain consent from the resident. Staff H stated it is important to involve the residents in their care, so they are making their own decisions. Staff H stated they could see why it was important to get the residents consent before initiating treatments. <Resident 297> (continued on next page)

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	07/24/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 07/22/2024 Admission MDS, Resident 297 did not have BR's. The MDS showed Resident 297 had no memory impairment. During an observation and interview on 07/17/2024 at 1:47 PM., Resident 297 had BR's attached to both sides of their bed. Resident 297 stated they did not know why the BR's were on their bed. Review of Resident 297's EHR on 07/20/2024 showed no Physician Order (PO) for bed rails, no BR screening/evaluation, and no consent for the BR's. In an interview on 07/23/2024 at 11:39 AM, Staff H stated they did not obtain a PO, complete a BR screening/evaluation, or get Resident 297's consent for the BR's to both sides of their bed, but they should have. Staff H stated the BR's were probably already on the bed when they admitted to the facility and were not removed. <Resident 20> According to a 05/06/2024 Annual MDS, Resident 20 did not have bed rails attached to their bed. The MDS showed Resident 20 had no memory impairment. According to 05/02/2024 revised Activity of Daily Living CP, Resident 20 had BR's attached to both sides of their bed. Resident 20 also had a revised 05/06/2024 mobility bars to bed CP. In an interview on 07/17/2024 at 10:17 AM Resident 20 stated they did not sign a consent for the BR's to be on their bed and the BR's were on their bed when they readmitted to the facility on [DATE]. Review of Resident 20's EHR showed an enabler bar screening evaluation and PO dated 01/01/2024 for the bilateral BR's. Resident 20's EHR had no consent from the resident. In an interview on 07/24/2024 at 10:04 AM Staff G (UM) stated Resident 20 had bilateral BR's to their bed but they did not obtain consent for these BR's. Staff G stated it was important to obtain resident consent for BR's to ensure they wanted the BR's. REFERENCE WAC: 388-97-0260, -1060(3)(g).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45720 Based on interview and record review, the facility failed to ensure licensed pharmacist's monthly Medication Regimen Reviews (MRRs) were added to resident records and that recommendations were reviewed and carried out in a timely manner for 3 of 5 residents (Residents 32, 67, & 34) whose medication regimens were reviewed. This failure placed residents at risk for delays in necessary medication changes, at risk for adverse side effects, and negative outcomes. Findings included . <Facility Policy> According to the facility's Pharmacy Services - [MRR] policy dated 11/2017, the facility would develop a system by which medication irregularities would be acted on in order to minimize adverse consequences to the resident. This policy showed the pharmacist would conduct monthly MRRs. Any irregularities would be provided in a separate report and reviewed by the physician, medical director, and director of nursing. The irregularities would be responded to in a timely manner dependant on the nature of the concern. The policy showed the pharmacist recommendations were considered part of the resident's record. <Resident 34> According to a 04/15/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 34 had a diagnosis of non-Alzheimer's Dementia (a progressive disease that destroyed memory and other mental functions) and used an antipsychotic medication during the assessment period. Review of a pharmacist consultation report provided by the facility on 07/21/2024 at 10:54 AM, showed the facility's pharmacy consultant reviewed Resident 34's medication records each month. This report showed in May 2024 and June 2024, the pharmacist made recommendations regarding Resident 34's medication regimen. Review of Resident 34's records showed no May or June 2024 MRR was available in the resident's records. In an interview on 07/23/2024 at 1:59 PM, Staff B (Director of Nursing) stated the facility should have each month's MRR for all residents in their record. Staff B reviewed Resident 34's record and confirmed the May and June 2024 MRRs were not in Resident 34's record. Staff B provided the MRR form for June 2024 with recommendations. Staff B stated they could not locate Resident 34's May 2024 MRR record. 45941 <Resident 67> (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 05/09/2024 Quarterly MDS, Resident 67 admitted to the facility on [DATE] and had diagnoses of high blood sugars, heart failure, and a left lower leg infection. The assessment showed Resident 67 had no memory impairment and no behaviors or rejection of care during the assessment period. Record review showed a 03/20/2024 pharmacy recommendation to decrease the dosage for a smoking cessation patch for 14 days and then to discontinue altogether after the 14 days. Another recommendation advised staff to decrease the frequency of Resident 67's blood sugar checks from twice daily to once daily related to the resident having stable blood sugars. Under the Physician's response section, the provider checked I accept the recommendations and signed the form on 03/24/2024. The recommendations were not noted by a facility nurse until 04/10/2024 (16 days later). Review of Resident 67's Physician's Orders (POs) showed the order to discontinue the smoking patch and to reduce blood sugar checks were not carried out until 04/10/2024. In an interview on 07/23/2024 at 10:08 AM, Staff B indicated the order should be carried out the day the provider approved the recommendations. Staff B reviewed Resident 67's record and stated staff should have carried out the provider's recommendations in time but they did not. 46479 <Resident 32> According to the 06/26/2024 Quarterly MDS, Resident 32 had diagnoses of a progressive memory loss disorder, anxiety, and depression. The MDS showed Resident 32 took antianxiety and antidepressant medications during the assessment period. This MDS showed Resident 32 did not have behaviors during the assessment period. Review of Resident 32's 07/18/2024 order summary showed a 01/16/2023 order for staff to administer an antianxiety medication to the resident three times daily. This order summary showed a 12/19/2023 order for staff to administer an antidepressant medication to Resident 32 once daily. Review of a pharmacist consultation report provided by the facility on 07/22/2024 at 11:30 AM showed the pharmacist reviewed Resident 32's records each month. This report showed in May of 2024, the pharmacist made recommendations regarding Resident 32's medication regimen. Review of Resident 32's records showed no May 2024 MRR was available in the resident's records. At this time, Staff B reviewed Resident 32's record and confirmed the May 2024 MRR was not in the record. In an interview on 07/22/2024 at 12:20 PM, Staff B provided the MRR form dated 05/08/2024, stating they called the pharmacist to have the form sent over. Review of the MRR showed the pharmacist recommended Resident 32 be placed on the facility's psych meeting schedule to discuss a gradual dose reduction of Resident 32's psychotropic medications. Staff B stated this recommendation was not implemented because the MRR form was not received by Staff B until now. REFERENCE: WAC 388-97-1300(1)(c)(iii).

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	505510	A. Building B. Wing	07/24/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45941 Based on interview and record review, the facility failed to ensure 2 (Residents 24 & 32) of 5 residents reviewed for unnecessary medications, were free from unnecessary psychotropic (medication that affected behavior, mood, thoughts, or perception) medications. This failure left residents at risk for unnecessary medications, adverse side effects, and other negative health outcomes. Findings included . <Facility Policy> Review of the facility's Pharmacy Services - Psychoactive Medication policy revised 10/04/2022, showed the facility implemented Gradual Dose Reductions (GDRs) unless contraindicated, prior to initiating, or instead of continuing a psychotropic medication. The policy showed supportive documentation included but was not limited to consideration of other factors addressed prior to initiating a psychotropic medication or in conjunctions with GDRs. <Resident 24> According to the 07/01/2024 Medicare 5 Day Minimum Data Set (MDS - an assessment tool), Resident 24 admitted to the facility on [DATE] and had a diagnosis of bipolar disorder (mental illness causing unusual shifts in a person's mood), anxiety disorder, and depression. Resident 24 received Antianxiety (AA), Antidepressant (AD), and Antipsychotic (AP) medications during the assessment period, and was assessed with no behavior or rejection of care during the assessment period. Review of Resident 24's July 2024 Physician Orders (POs) showed a 06/26/2024 order for an AA medication to be administered every 12 hours as needed for anxiety. Review of Resident 24's Medication Administration Record (MAR) showed Resident 24 received the as needed AA medication 6 times in 5 days of June and 13 times in 16 days of July 2024. In an interview on 07/22/2024 at 10:02 AM, Staff D (Social Services Director) stated as needed AA medications should be ordered for a limit of 14 days. Staff D stated staff should have clarified the order with the provider to have stop date. In an interview on 07/23/2024 at 10:27 AM, Staff B (Director of Nursing) stated as needed AA medications should be ordered for only 14 days. Staff B stated if a resident had behaviors affecting the resident, staff should communicate with the provider and the provider should document in the resident's record the reason for extending an AA medication. Staff B reviewed Resident 24's record and stated staff should clarify the order and should obtain a stop date for the as needed AA medication after 14 days, but they did not. 46479 (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 32> According to the 06/26/2024 Quarterly MDS, Resident 32 had diagnoses of anxiety and depression. The MDS showed Resident 32 took medications to treat their anxiety and depression, and did not display any behaviors during the assessment period. Review of Resident 32's 07/18/2024 order summary showed Resident 32 was taking an AA medication three times per day since 01/16/2023, for nearly 18 months. The order summary showed a 12/19/2023 PO for an AD medication to be administered once daily to Resident 32. A 07/05/2024 PO directed staff to administer an anticonvulsant medication twice daily for behaviors and to give a double dose of the anticonvulsant at bedtime for behaviors. Review of Resident 32's records showed the Interdisciplinary Team (IDT) last reviewed the resident's psychotropic medication use on 12/13/2023. This form showed the IDT did not recommend a GDR of the AA medication at that time because Resident 32 was having worsening verbal agitation, anxiety, and calling out. The team recommended to re-assess the resident quarterly. No other IDT assessments were available in the resident's record indicating Resident 32 was re-assessed quarterly as recommended. Review of Resident 32's 05/08/2024 pharmacy consult report summarized the resident was receiving AA, AD, anticonvulsant, and over the counter sleep aide medications. This report showed the last time Resident 32's medications were reviewed by the IDT was 12/12/2023. The report showed the pharmacist recommended Resident 32 be placed on the IDT's schedule to discuss GDRs of their medications. Review of a 06/18/2024 psychiatry provider progress note showed Resident 32 had a GDR of their antidepressant medication on 12/20/2020, over three years ago, and a GDR of the anticonvulsant medication on 05/12/2022, over two years ago. Review of a 07/05/2024 psychiatry provider progress note showed the psychiatrist was following up with Resident 32 for agitation, impulsivity, and difficulty being redirected. This note showed the psychiatrist recommended staff increase the anticonvulsant medication Resident 32 was taking for behaviors. The psychiatrist indicated Resident 32 was to continue all other medications without changes. Review of Resident 32's 07/07/2024 physician visit note showed the physician acknowledged the resident was taking an AA medication three times daily. The physician documented Resident 32 should continue the medication and that the resident was being followed by psychiatry. There was no rationale documented for continuing the medication as ordered. Review of Resident 32's behavior monitor documentation for 07/01/2024 to 07/21/2024 showed staff documented the resident had behaviors on 4 of the 42 opportunities. Review of Resident 32's June 2024 behavior documentation showed staff documented the resident had behaviors on 6 of 60 opportunities. Review of Resident 32's May 2024 behavior documentation showed staff documented the resident had behaviors on 4 of 62 opportunities. Review of Resident 32's comprehensive progress notes from 07/29/2023 to 07/22/2024 showed no documentation indicating a GDR of the antianxiety medication should be attempted or why a GDR was contraindicated. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/23/2024 at 12:59 PM, Staff B stated GDRs were important for maintaining the resident's quality of life. Staff B stated it was important to monitor resident behaviors to evaluate if the psychotropic medication could be reduced. Staff B stated they expected GDRs to be attempted and/or physician documentation indicating a reason why a GDR was contraindicated or not. REFERENCE: WAC 388-97-1060(3)(k)(i).

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	505510	A. Building B. Wing	07/24/2024

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Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46479 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 percent (%). Failure of 1 of 5 nurses (Staff N - Licensed Practical Nurse) to properly administer 2 of 25 medications for 1 (Resident 203) of 8 residents observed during medication pass resulted in a medication error rate of 8%. This failure placed residents at risk for adverse side effects and/or not receiving prescribed medications as ordered. Findings included . <Facility Policy> Review of the facility's General Dose Preparation and Medication Administration policy revised 01/01/2013 showed the facility staff administering the medication should ensure the resident's consumption of the medication. <Staff N> Observation on 07/18/2024 at 9:02 AM showed Staff N preparing to administer morning medications to Resident 203. Staff N brought Resident 203 their morning medications. As Resident 203 took their medications, 2 medication tablets dropped in the resident's lap. Staff N did not notice and started to leave the resident's room. At that time, the surveyor stopped Staff N and asked if Resident 203 missed any medication tablets. Staff N went to Resident 203, found two tablets in the resident's lap, and handed the resident the tablets to take. In an interview on 07/18/2024 at 9:08 AM, Staff N stated they did not notice Resident 203 dropped the two tablets in their lap. Staff N stated they usually made sure the resident swallowed their medications before they left Resident 203's room but did not that time. REFERENCE: WAC 388-97-1060(3)(k)(ii). 45941

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 - Few	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. 46479 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were secured for 3 (Resident 90, 23, & 52) of 21 sample residents observed with medications in their rooms. These failures placed residents at risk for receiving the wrong medications, contaminated medications, and non-assessed, self-administration of medications by residents. Findings included . <Facility Policy> According to the facility's Storage and Expiration of Medications, Biologicals, Syringes, and Needles policy revised 10/31/2016, the facility would store bedside medications or biologicals in a locked compartment within the resident's room. This policy showed the facility would not provide bedside medications or biologicals without a Physician's Order (PO). <Resident 52> Observation on 07/18//2024 at 8:38 AM showed Resident 52 in bed. The facility's contracted wound team entered Resident 52's room to provide a treatment to Resident 52's skin. Resident 52's windowsill contained several skin treatments and ointments including a tube of antibiotic ointment, wound cleansing spray, a medicated topical cream, and a prescription lotion used to treat dry/scaly skin. The wound team and facility staff applied the medicated treatments from the windowsill to Resident 52 and placed the various ointments and creams back on the windowsill when the treatment was completed. <Resident 90> Observation on 07/18/2024 at 9:49 AM showed Staff O (Registered Nurse) administer morning medications to Resident 90. At that time, a large bag of Over The Counter (OTC) cough suppressant lozenges were observed on Resident 90's nightstand. Record review showed no assessment or PO indicating Resident 90 was safe to self-administer the OTC cough suppressant lozenges. In an interview on 07/18/2024 at 1:22 PM, Staff O stated they did not notice the bag of OTC cough suppressants. Staff O went to Resident 90's room and confirmed the OTC medication on the nightstand. Staff O confirmed Resident 90 would need a PO to keep the OTC cough suppressants in their room for self-administration. Staff O stated the medications should be in a locked drawer. <Resident 23> (continued on next page)

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	07/24/2024

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/18/2024 at 1:06 PM showed Resident 23 lying in bed watching TV. Beneath the TV was a dresser that contained several wound treatment supplies stored on top of the dresser. The top of the dresser contained three bottles of wound cleanser spray, a bottle of an antifungal powder, skin preparation wipes, 2 bottles of a topical gel used to kill bacteria in wounds, 2 bottles of medical grade wound dressing gel, and one tube of antimicrobial wound gel. In an interview on 07/18/2024 at 1:30 PM, Staff P (Unit Manager) stated once staff took medicated treatment supplies into a resident's room, those treatment supplies stayed in the room with the resident. In an interview on 07/19/2024 at 9:43 AM, Staff B (Director of Nursing) stated medicated treatment supplies should not be left at a resident's bedside. Staff B stated OTC cough lozenges should not be left at a resident's bedside. Staff B stated those items were considered a medication and should not be unattended at a resident's bedside. REFERENCE: WAC 388-97-1300(2).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46479 Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, and served under sanitary conditions. Facility staff failed to: consistently perform hand hygiene when preparing resident meal trays; label food items and discard expired food items from unit refrigerators; keep the kitchen dishwasher machine free from grime and debris build up; and maintain accurate documentation for the dishwasher temperature and chlorine chemical logs. These failures contributed to an unsanitary kitchen environment, placed residents at risk for food borne illness, and/or contaminated food. Findings included . <Facility Policy> Review of the facility's Food and Nutrition Services - Food Safety policy dated ,d+[DATE], showed facility staff would use good hygienic practices when handling food. This policy showed facility staff would follow manufacturer's guidelines based on the type of dishwasher used to sanitize dishware and chemical solutions would be checked for concentration levels at least once per shift. Review of the facility's Food's Brought by Family/Visitors policy revised ,d+[DATE] showed perishable foods would be stored in the refrigerator and the container would be labeled with the resident's name and use by date. The policy showed the nursing staff were responsible for discarding perishable foods on or before the use by date. <Meal Tray Service> Observation on [DATE] at 11:59 AM showed kitchen staff plating resident meals for the day's lunch service. Staff U (Dietary Aide) was placing drinks, desserts, and silverware rolled in napkins on the resident trays. Staff U was observed to have their hairnet placed behind their ears leaving hair around their eyes and forehead not contained within the hairnet. Staff U was observed to use their gloved hands to wipe their hair out of their eyes and wipe sweat away from their face using the back of their gloved hand and/or the thumb side of their hand on five occasions throughout the plating of resident meals. Staff U did not remove their gloves and perform hand hygiene during the meal service and continued wearing the contaminated gloves while touching resident drink cups, dessert plates, and rolled napkins containing silverware. During the lunch service observation on [DATE] at 12:22 PM, Staff V (Dietary Manager) was assisting with the plating of the lunch meal. Staff V wiped their face with their forearm and then rested their forearm on a large, uncovered bin of lettuce. Staff V's watch band was resting in the bin of lettuce. Staff V then used their gloved hands to adjust their shirt, walked away from the tray line, obtained a large stack of trays, and continued assisting with putting toppings like cheese and lettuce on plated lunch meals. Staff V did not change their gloves or perform hand hygiene after touching their face or shirt. <Dishwashing Machine> (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 8:40 AM of the facility's dishwasher machine showed the machine was a low temperature dishwasher machine. A sign near the machine, above the dish sink showed the dishwasher temperature should be between ,d+[DATE] degrees Fahrenheit (F) and the chemical test strips should have a result of ,d+[DATE] Parts Per Million (PPM) of chlorine (chemical used to ensure proper sanitization of dishes washed in a low temperature dishwasher machine). The sign instructed staff to dip the chlorine test strip on droplets of water leftover on dishes after a dishwashing cycle was completed. Observation of the top of the dishwasher machine at that time showed a large amount of rust colored debris, crumbs, and grime build-up. Observation on [DATE] at 8:49 AM showed Staff W (Cook) and Staff V running a test cycle on the dishwasher machine. Staff W placed dishware in the dishwasher machine, took a chemical test strip and placed it on a dish, closed the dishwasher, and ran a cycle. When the cycle was complete, the chemical test strip was washed off the dish and down into the drain. Staff W and Staff V repeated the same process again and the chemical test strip was washed away in the machine by the end of the cycle. On the third attempt, the instructions on the sign on the wall were pointed out the the kitchen staff. At that time, staff performed the chemical test strip per the instructions. Staff V's test strips remained unchanged, indicating the chlorine chemical was ineffective. In an interview at that time, Staff V stated they were having issues with their test strips and needed to obtain new ones. Observation on [DATE] at 9:03 AM of a cycle of the dishwasher machine showed the machines temperature during the wash cycle was 150 degrees F and the rinse cycle was 157 degrees F. Review of the facility's [DATE] Dish Machine Log showed on 74 dishwashing cycles, the facility staff documented the dishwasher temperature was above 140 degrees F temperature for the low temperature machine. This same log showed staff documented the PPM of chlorine was greater than the indicated , d+[DATE] PPM range on 30 occasions. The bottom of the Dish Machine Log showed directions to staff that a low temperature dishwasher machine's wash and rinse cycle should be between ,d+[DATE] degrees F. There was a spot on the form reading: Manufacturer's Recommended PPM with a blank area to be filled in. This was left blank. In an interview on [DATE] at 8:50 AM, Staff V confirmed the discrepancies on the Dish Machine Log. Staff V confirmed the dishwasher temperature was high during the test cycle and the machine needed to be checked. <Unit Refrigerators/Freezers> Observation on [DATE] at 5:26 AM of the [NAME] Hall unit refrigerator/freezer showed a sign on the door directing staff that the refrigerator was for resident items only. The sign showed the food items must have a name, date, room number, and the item must be tossed after three days. Observation of the freezer showed a coffee mug containing an opened, unlabeled ice cream sandwich with a bite taken out of it. The back of the freezer contained an unlabeled and undated plastic cup with a slice of cake and a spoon. The freezer contained one ice cream cake dated [DATE] and another ice cream cake dated ,d+[DATE]. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 5:43 AM showed the East Hall unit refrigerator/freezer contained three yogurts with a handwritten date of ,d+[DATE], a piece of cake unlabeled and undated, and three meals in food storage containers and/or fast-food bags without resident names or dates. The refrigerator contained a grocery bag with three food containers. The bag had a resident name but no date. The refrigerator also contained an undated pizza box and a grocery bag that had two chicken breasts, a package of four yogurts, and two bags of store-bought hard-boiled eggs. The bag was unlabeled and undated. In an interview on [DATE] at 11:53 AM, Staff A (Administrator) stated it was their expectation staff changed gloves and performed hand hygiene after touching their face. Staff A stated they expected staff disposed of food in unit refrigerators after three days. REFERENCE: WAC [DATE](3), -2980.

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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** 47836 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to ensure staff: consistently performed Hand Hygiene (HH) before and after resident care/contact; apply/remove Personal Protective Equipment (PPE) in accordance with the Transmission Based Precaution (TBP- implement precautions based on the means of transmission in order to prevent or control infection) signs posted outside of resident rooms; and implement interventions to prevent Legionnaires disease (a serious severe respiratory infection caused by inhalation of bacteria growing in the water system) within the facility. The facility was unable to provide documentation of completed McGeer's or Loeb's infection surveillance criteria forms for each resident with an infection who received, or was currently on, an antibiotic. These failures placed all residents and staff at risk for contracting and/or spreading infections, possible future antibiotic resistance, and a decreased quality of life. Findings included . <Facility Policies> According to a facility policy titled, Infection Prevention and Control Program (IPCP), revised 06/08/2022, the IPCP would utilize a system for prevention, identifying, reporting, investigating, and controlling infections, and communicable disease. The policy showed the program would provide infection surveillance to assist in identification of infections and communicable diseases before they can spread. The policy showed the program would provide guidance to staff on TBP to be followed, PPE use, and HH practices. The policy showed resident room assignments would be made while taking into consideration resident diagnoses and risk factors such as not placing residents with active contagious infections in a room with residents who are at greater risk of contracting an infection. This policy showed when a resident had an infection or was potentially infectious, the infection would be tracked, and interventions would be implemented to minimize the additional risks to the residents. The policy showed the facility would monitor for proper HH, use of PPE and TBP, and proper infection prevention techniques were used during wound care. According to an undated facility policy titled, Legionnaires' Disease, the maintenance director would keep logs to assure that routine preventative measures were being done for the prevention of Legionnaires Disease. According to a facility policy titled, Infection Prevention and Control Antibiotic Stewardship, revised 03/2019, the facility would utilize McGeer's and Loeb's criteria for infections and antibiotic use. <Legionella Prevention> Record review on 07/19/2024 showed no documentation of Legionella prevention. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/19/2024 at 8:44 AM Staff L (Maintenance Director) stated they did not know where Legionella was at higher risk of development and did not have monitoring or prevention techniques for Legionella in place. In an interview on 07/22/2024 at 8:57 AM Staff C (Infection Preventionist) stated they were not involved with the facilities Legionella prevention process. <Hand Hygiene> During an observation and interview on 07/18/2024 at 12:19 PM, Staff K (Certified Nursing Assistant - CNA) entered room [ROOM NUMBER] to bring the resident their lunch. Staff K was observed, without gloves, to move the over the bed table to the resident, assisted the resident to sit up, and set their meal tray up for them. Staff K exited room [ROOM NUMBER] without performing HH, collected room [ROOM NUMBER] lunch tray from the meal cart and proceeded to room [ROOM NUMBER]. Staff K setup 216-1 lunch tray for the resident and the resident requested fresh ice water, so Staff K collected the water pitcher and exited room [ROOM NUMBER] to collect fresh ice water for the resident at the ice machine without performing HH. Staff K then collected room [ROOM NUMBER]'s lunch tray from the meal cart and brought to room [ROOM NUMBER] without gloves or performing HH, cleared and moved the over the bed table over the resident, and setup their meal tray. Staff K collected dirty cups and glasses from room [ROOM NUMBER] and exited the room without performing HH. Staff K stated they only had to perform HH if they contacted a resident or provided care, otherwise they did not have to perform HH. In an interview on 07/19/2024 at 1:28 PM both Staff B (Director of Nursing) and Staff C stated they expected staff to perform HH before entering a room or exiting a room, between dirty and clean cares, before and after glove change, before and after resident contact, and between passing meals to residents. <Resident 41> Observation on 07/18/2024 at 9:26 AM showed Resident 41 had a bowel movement and Staff G (Unit Manager) was holding Resident 41 on their side and Staff X (CNA) was providing incontinency care to Resident 41 in their bed. Staff X was wearing gloves on both hands during providing the care. Staff X removed the dirty brief and cleaned the resident, removed one glove from their right hand and still had another glove on right hand (was wearing double gloves on right hand), did not wash their hands, grabbed the clean brief with the same gloves and put on the resident, grabbed the clean linens and fixed Resident 41's bed, put dirty linens in a bag, removed their gloves, washed their hands and left the room with the soiled linens in a bag. In an interview on 07/18/2024 at 9:39 AM, Staff X stated they were wearing double gloves on right hand because Resident 41 had Bowel movement everywhere in their bed. Staff X stated after they cleaned the resident, they removed the dirty glove from right hand and continued with changing the clean brief and linens in Resident 41's bed. Staff X stated they should have removed the dirty gloves and washed their hands between dirty to clean care, but they forgot to do so. In an interview on 07/18/2024 at 1:33 PM, Staff B stated they expected staff not to wear double gloves during any care and to perform HH before entering a room or exiting a room, between dirty and clean cares, before and after glove change. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Transmission Based Precautions> <room [ROOM NUMBER]> Observation on 07/16/2024 at 1:36 PM showed room [ROOM NUMBER] door had two signs posted: one for Enteric Barrier Precautions (EBP) for bed one and another Contact Precaution sign for bed two. Contact Precaution sign was directed staff to wear gown and gloves before entering the room. Observations on 07/17/2024 at 9:57 AM showed Staff Y (Licensed Practical Nurse - LPN) went to room [ROOM NUMBER] to administer medications to the resident. Staff Y was not wearing the gown while administering medications to the resident inside the room. In an interview on 07/17/2024 at 10:00 AM, Staff Y stated they should have followed the sign posted outside the door to wear gown and gloves, but they forgot to do so. In an interview on 07/18/2024 at 8:42 AM, Staff B stated they expected staff to follow the sign posted outside the door. <room [ROOM NUMBER]> Observation on 07/16/2024 at 11:30 AM showed room [ROOM NUMBER] door had sign posted for Contact Enteric Precautions with instructions for the staff to follow: Prior to entering the room- wash or gel hands, use soap and water upon leaving the room. Wear gown and gloves. In an interview on 07/16/2024 at 11:36 AM, Staff E (LPN) stated Resident in room [ROOM NUMBER] had C-Diff (Clostridium Difficile- contagious bacterial infection of the colon) infection and staff had to follow the sign posted on the door. Observation on 07/16/2024 at 12:05 PM showed Staff S (CNA) was delivering lunch hall trays in resident's rooms. Staff S went to deliver tray in room [ROOM NUMBER], did not wear gloves or gown when entered the room, delivered the meal tray, came outside the room, and sanitized their hands. In an interview on 07/16/2024 at 12:08 PM, Staff S stated they only had to wear gown and gloves if they contacted a resident or provided care, otherwise they did not have to wear PPE. In an interview on 07/18/2024 at 8:38 AM, Staff B stated their expectation from staff is to follow the sign posted outside the door and to wear PPE as instructed on the sign, but they did not. <McGeer's/Loeb's Infection Surveillance Criteria> In an interview on 07/19/2024 at 1:59 PM Staff B and Staff C stated they used the McGeer's and Loeb's criteria for their antibiotic stewardship/surveillance program. Review of ABO stewardship records on 07/22/2024 showed no McGeer's or Loeb assessment documentation for a sample of six residents that had taken or were currently on antibiotics. (continued on next page)

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	07/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/22/2024 at 8:09 AM Staff C stated the McGeer's and Loeb's criteria was documented in different software. Staff C stated it does not have the McGeer's or Loeb's documentation of the assessments and only showed a box to check yes /no if they met the criteria. Staff C stated they did not have documentation to support they completed the McGeer's or Loeb's assessment on any of the residents, so they did not have the symptoms documented that supported they met these criterions. Refer to F812 - Food Procurement, Store/Prepare/Serve - Sanitary Refer to F881 - Antibiotic Stewardship REFERENCE: WAC 388-97-1320(1)(c)(2)(b). 45720 45941

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 47836 Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program (ASP), to promote appropriate use of Antibiotics (ABO), reduce the risk of unnecessary ABO use, and decrease the development of an ABO resistance for 6 of 6 sample residents (Resident 204, 80, 77, 64, 47, & 3) reviewed. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of ABO's. Findings included . <Facility Policy> According to a facility policy titled, Infection Prevention and Control ABO Stewardship, revised 03/2019, the program would validate that antibiotics were prescribed for the correct indication, the correct dose, the correct route and the correct duration. The policy showed the program would implement a data gathering system and analyze the collected data to ensure unnecessary ABO prescribing did not take place. The policy showed the facility would monitor the use of ABO's using the McGeer's (a set of signs and symptoms that verify active infection) and Loeb's (tool used to assess antibiotic appropriateness) criteria as a guide for protocols for prescribing ABO's. This policy showed when a resident was admitted on an ABO regimen, the facility would review for appropriateness of the ABO. The policy titled, Antibiotic Stewardship Program, revised 04/2022, showed documentation related to the ASP, including meeting minutes, tracking information, and logs would be maintained in a binder to facilitate comparisons and review. The policy showed within 48 -72 hours following initiation of an ABO, an ABO Time-Out Checklist would be completed and reviewed with the prescriber. Record review on 07/22/2024 showed incomplete and inaccurate antibiotic line listing for the facility's ASP. Review of the ASP showed no documentation of a positive McGeer's or Loeb's criteria to meet the need of ABO use for Residents 204, 80, 77, 64, 47, or 3. The facility was unable to provide accurate and complete ABO line listing documentation from the last survey to the current survey. <Residents 204> Review of Resident 204's records showed two ABO's that were not documented on the ASP line listing and had no documentation of McGeer's or Loeb's data. <Residents 80> Review of Resident 80's records showed they had completed an ABO without any documentation of symptoms that met McGeer's or Loeb's criteria. <Residents 77> Review of Resident 77's records showed they had completed an ABO without any documentation of symptoms that met McGeer's or Loeb's criteria. (continued on next page)

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	505510	A. Building B. Wing	07/24/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Residents 64> Review of Resident 64's order summary showed they were admitted on an ABO for colitis (inflammation of the colon), but review of hospital history and physical showed the colitis was resolved and Resident 64 was placed on the ABO for Pneumonia (inflammation of the lungs). Review of Resident 64's hospital records showed a chest X-ray which was clear of pneumonia. <Residents 47> Review of Resident 47's records showed they had completed an ABO without any assessment or ABO time-out. <Residents 3> Review of Resident 3's records showed they had completed an ABO without any assessment or ABO time-out. In an interview on 07/22/24 at 8:09 AM Staff C (Infection Preventionist) stated they did not maintain an ASP binder with meeting minutes, tracking information, and logs for comparison and review. Staff C stated they did not have the ASP up to date and did not have residents who are on ABO's, or were on an ABO, logged for July 2024. Staff C stated they had three job titles, Assistant Director of Nursing, Staff Development Coordinator, and Infection Preventionist, which made it difficult to keep up with their workload. Staff C stated they did not complete a McGeer's or Loeb's assessment on any resident that used to be or was currently taking an ABO. Staff C stated the facility had a software with a question . meets McGeer's or Loeb's criteria? Yes or no, but the software did not document the data that qualified the resident to take an ABO. Staff C stated it was important to complete a McGeer's & Loeb's assessment to ensure the resident was receiving the correct ABO and to ensure the ABO was necessary. REFERENCE: WAC 388-97-1060(3)(k)(i),-1320(2)(a-c).