DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505126		C 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HEALTH & REHABILITATION CENTER - PASCO	2004 N 22ND AVENUE PASCO, WA 99301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health & Rehabilitation Center - Pasco on November 19, 2012. A sample of 3 residents was selected from a census of 88 residents. The sample included the records of 3 former and/or discharged residents. The following was a complaint investigated as part of this survey: #2701537 The survey was conducted by: Patti Rose, R.N. The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902 Telephone (509) 225-2800 Fax: (509) 574-5597 11/29/12 Residential Care Services Date	F 000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against Facility, of the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this response. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth, of any facts alleged or correctness of any conclusions set forth in the allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal, which may be filed solely because of the requirements under State and Federal law that mandate submission of the Plan of Correction with ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as an agreement with the allegations of non-compliance or admissions by the Facility. This Plan of Correction is submitted as the Facility's credible allegation of compliance.	
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	F 284		

Received
Yakima RCS
DEC 17 2012

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

ADMINISTRATOR 12/14/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 284	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide pre-discharge preparation and education with participation of the resident and responsible party to assure the resident's post discharge needs relative to medication and wound management would be met for 1 of 3 sampled residents (#1) reviewed who discharged to a home environment. This failed practice had the potential to result in medication errors and unmet needs. Findings include: Resident #1: Admitted from the hospital on [redacted]12 with diagnoses that included diabetes and a neurologic disorder which resulted in an altered mental status. Review of the resident's medical record revealed on 9/19/12 a prescribed treatment was ordered for a blister to the resident's left heel. The area was noted to be healed at the time of the resident's discharge from the facility on 10/19/12; however, orders continued the dressing change every three days. The resident's Medication List for Discharge noted a treatment order which stated to clean the left heel with normal saline and apply duoderm (a skin dressing utilized for wounds) every three days. There were a total of eight prescribed medications which included two different types of insulin; regular insulin (short-acting) to be administered three times daily before meals and Lantus (long-acting) to be given before bedtime. There were omissions of staff and	F 284	F-284 Resident #1 no longer resides in the facility. The nursing department initiated a pre-discharge consultation meeting with residents preparing to leave the facility. Social Services will develop a schedule of potential resident discharges. The nursing department will initiate resident and / or care giver training upon notification of potential resident discharges ensuring post discharge needs are properly educated. Social Services will schedule a discharge consultation with the Nurse Practitioner or designee on the day of resident discharge to ensuring post discharge needs are properly educated. The Social Service Director will monitor for effective pre-discharge education daily through resident and staff interviews. The Unit Managers will monitor for effective care giver training daily through return resident demonstration and nurse documentation. The Administrator will ensure compliance weekly for four (4) weeks, then monthly thereafter and as needed through the quality assurance meeting.	1/8/13

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F 284	Continued From page 2 resident/responsible party signatures on the form in the areas of reviewing the form with resident/responsible party and their understanding of the information provided to them. A telephone interview with the resident's responsible party on 11/20/12 at 1:25 p.m. revealed that when she came to the facility on [redacted]12 to take the resident home a staff person handed her a bag containing the resident's medications. She stated that staff did not go over the medications with her and when she got home with the resident she discovered they had given her the wrong type of insulin which had another resident's name on it. A rapid acting insulin had been placed in the bag rather than the ordered short acting insulin. Staff had not inquired if she knew how to administer insulin (the resident's cognitive status prevented the resident from doing it). She stated she had not given insulin for several years as the resident had been doing it herself. In addition, despite the order to change the dressing to the resident's left heel every three days the facility had not given her any supplies to do this. Many of the labels on the medication bottles in the bag did not match the medication name on the list of medications she was given on discharge due to generic versus non-generic names. She stated she had to get on her home computer to determine what the medications were. She stated it was very "confusing to me and overwhelming." Interviews on 11/19/12 at 12:50 p.m. and 11/20/12 at 2:30 p.m. with Staff Licensed Nurse A revealed she had not looked at the insulin bottle, which she had taken out of the medication cart,	F 284		

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F 284	Continued From page 3 prior to putting it into the bag of medications she gave to the resident's family member on discharge. Thus she was unaware it was the wrong insulin which belonged to another resident in the facility. She acknowledged she had not gone over each medication with the resident's family prior to the discharge. She stated when the another family member returned to the facility that evening (10/19/12) to obtain the correct insulin it was apparent to her the family member was confused regarding some of the resident's medications.	F 284		