

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

PRINTED: 01/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

1362

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>01/18/2013</b>
--	---	--	--

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

(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	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health &amp; Rehabilitation Center - Pasco on January 17, 2013 and January 18, 2013. A sample of 12 residents was selected from a census of 75 residents. The sample included 12 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2737237 #2723308 #2730401 #2736740</p> <p>The survey was conducted by: [REDACTED], R.N.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 1/29/2013 Residential Care Services Date</p> <p>F 241 SS=D /483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in</p>	F 000	<p style="text-align: center;"><b>Received Yakima RCS FEB 8 2013</b></p> <p>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.</p> <p>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)</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>2/7/13</b>
---	-------------------------------	----------------------------

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.

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

PRINTED: 01/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2013</b>
--	---	--	---

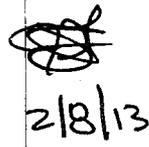
NAME OF PROVIDER OR SUPPLIER  <b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2004 N 22ND AVENUE PASCO, WA 99301</b>
--	--

(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 241	<p>Continued From page 1 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide care in a manner that promoted and enhanced resident dignity for 1 of 6 sampled residents (#1). The failure to provide staff assistance with activities of daily living negatively impacted the resident's quality of life. Findings include:</p> <p>Resident #1: Admitted to the facility on [REDACTED]/12 from the hospital following surgery for a [REDACTED]. Review of Progress Notes dated 12/16/12 revealed the resident required one staff member to assist with transfers, toileting, and bed mobility. On 12/19/12 documentation noted the resident was alert, oriented, and was able to make her needs known without difficulty.</p> <p>Review of a facility investigation report dated 12/18/12 revealed the resident had reported to an Occupational Therapist (OT) that a Nursing Assistant (NA) was rude and threw her clothes on her bed and told her to get dressed. The resident stated to the NA that she wanted to change her disposable brief but the NA stated "no, wasn't wet." The NA told the resident she had to go to the dining room. The resident stated she had not been putting her clothes on or using the bathroom by herself.</p> <p>During an interview on 1/18/13 at 10:15 a.m. the resident stated that the above NA came into her room and she could tell she was upset. The NA grabbed the resident's clothes and threw them on</p>	F 241	<p>days of the survey as a condition to participate in Title 18 and 19 programs.</p> <p>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.</p>	
-------	--	-------	---	--

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

PRINTED: 01/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2004 N 22ND AVENUE PASCO, WA 99301</b>		
(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 241	<p>Continued From page 2</p> <p>the bed stating, "put these on you're going to breakfast." The resident stated the NA was "so put out with what was going on." The resident ate all her meals in her room and was not going to eat in the dining room. She had no recollection at that time regarding issues with her disposable brief and the bathroom. She stated she was upset with the NA and had talked with her daughter and therapist about the incident.</p> <p>A telephone interview on 1/18/13 at 11:00 a.m. with the resident's daughter revealed the resident had informed her either the day it occurred or the following day that a NA had come into her room and threw her clothes at her. The NA stated, "you need to get up out of bed and get dressed." The resident stated to her she was concerned about the NA's attitude, "she wasn't very nice." The resident was not supposed to get up by herself at that time. In addition, the resident had informed the NA she needed to use the bathroom and the NA told her she could do it herself.</p> <p>The above OT was interviewed on 1/17/13 at 3:45 p.m. and stated the resident had reported to her on 12/19/12 (day of occurrence) that a NA had come into her room and stated, "here's your clothes - get dressed, you're going to the dining room." The NA was "really snippy" with the resident. The resident had informed the NA that her disposable brief needed to be changed and the NA responded by stating it did not need to be changed as it was not wet. The NA did not assist the resident as she had requested. The OT stated that observations of the NA working with other residents revealed she does not listen to her residents.</p>	F 241	<p>F-241</p> <p>The employee was terminated from employment. Resident #1 was immediately placed on alert for the potential of psychosocial harm. No negative effects were noted.</p> <p>Upon discovery, an immediate investigation was conducted including the interview of other residents throughout the facility. No other residents were negatively affected.</p> <p>Facility staff have been re-educated on Resident dignity. Facility management conducts routine Dignity and Focused rounds to identify and address any potential resident issues. The Resident Grievance system is utilized as needed to identify and address any potential resident issues.</p> <p>Resident Dignity rounds and Focused rounds are returned to the Administrator to monitor for compliance. Resident grievances are reviewed daily at the Management Stand-up meeting to monitor for compliance.</p> <p>The Administrator will ensure compliance through analysis and trending of Resident Dignity, Focused rounds and Resident grievances at the Quality Assurance meeting.</p>	

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

PRINTED: 01/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2004 N 22ND AVENUE PASCO, WA 99301</b>	
(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 241	Continued From page 3 Staff Licensed Nurse (LN) A stated on 1/18/13 at 11:15 a.m. that the resident had never had any previous complaints. She stated the resident was able to verbalize her concerns. She stated she had interviewed the resident 3-4 times during the course of the investigation and "her story never changed."	F 241	F-323 Resident #2 still resides in the facility. Both Nursing Assistants have been re-educated on how to clearly understand the use of the residents plan of care and kardex records. Both Nursing Assistants certifications have been called to the Department of Health for review.	<del>2/18/13</del> 2/18/13
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to implement planned interventions for safe transfer techniques for 1 of 3 sampled residents (#2) reviewed for incidents. This failed practice resulted in harm to the resident as she sustained a fractured right leg during a transfer. Findings include:  Resident #2: Admitted to the facility on [REDACTED] 12 with diagnoses which included [REDACTED], [REDACTED], and history of [REDACTED]. The resident had been hospitalized in November and December 2012 for changes in her condition. Review of the resident's plan of care revealed she was at risk for falls due to impaired cognition, visual impairment, incontinent of bowel and bladder. Nursing orders were to	F 323	Resident kardex records have been rechecked and verified against the residents plans of care to ensure the accuracy of resident transfer status. Facility staff have been re-educated towards the use of the resident kardex record and resident plan of care.  The Director of Nursing Services and Unit Managers conduct visual audits of resident transfers to ensure Nursing Assistants are knowledgeable and familiar with the use of the kardex record, resident plan of care and proper transfer techniques. Resident kardex files are maintained by the Unit Managers and updated as needed or when a change in resident condition occurs.  Transfer audits are returned to the Director of Nursing Services who will monitor for compliance by analysis and trending of audit results for the Quality Assurance meeting.	

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

PRINTED: 01/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2013</b>
--	---	--	---

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

(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 323	<p>Continued From page 4</p> <p>transfer the resident with two staff members utilizing a mechanical lift device. The resident's weight on 1/6/13 was 209 pounds.</p> <p>Review of a facility investigation report revealed on 1/7/13 two Nursing Assistants (NAs) were attempting to transfer the resident from her bed to the shower chair without the use of a mechanical lift. Upon standing the resident up the NAs noted she was soiled and attempted to provide perineal care before transferring her onto the shower chair. During the process the resident was not able to stand and staff was unable to transfer her to the shower chair. As they lowered the resident to the floor they heard a "pop." Once she was on the floor they observed her right leg was bent back under her. A nursing assessment at that time revealed deformity of the right lower leg. The physician was notified and orders received to transfer the resident to the Emergency Room. X-rays revealed she had a fractured right leg for which surgery was performed.</p> <p>Review of physical therapy (PT) notes between 12/10/12 - 1/3/12 revealed the resident was not able to stand during therapy and required total assistance with transfers utilizing a mechanical lift device.</p> <p>An interview on 1/17/13 at 3:40 p.m. with the PT revealed in late November or early December the resident declined in function due to a [REDACTED] with [REDACTED]. Since that time the therapist stated she was no longer able to stand due to "extreme weakness" on both sides. Therapy staff always used a mechanical lift with any transfer as she was no longer able to bear weight.</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 01/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2004 N 22ND AVENUE</b> <b>PASCO, WA 99301</b>		
(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 323	Continued From page 5 On 1/17/13 at 1:23 p.m. Staff NA B stated that on 1/7/13 she and another NA had attempted to transfer the resident from her bed to the shower chair without using a mechanical lift device. She stated that as the resident was standing they pulled down her pants and noted she was soiled with feces. They then attempted to clean her; however, "little by little I felt her giving out on us." Due to the resident's obesity the NA stated they were unable to transfer her onto the shower chair. She stated they heard a "pop" when the resident started sliding down to which the resident responded, "you broke my foot." The NA stated she knew the resident was a mechanical lift transfer with two staff however, "I figure I could do it" without the lift.	F 323			