

|   |  |  |  |   |
|---|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505126 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>C<br>12/22/2014 |
| NAME OF PROVIDER OR SUPPLIER<br><br>AVALON HEALTH & REHABILITATION CENTER - PASCO |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2004 N 22ND AVENUE<br>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   | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health &amp; Rehabilitation - Pasco on December 16, 2014 and December 22, 2014. A sample of 3 residents was selected from a census of 79 residents. The sample included 3 current residents.</p> <p>The following was a complaint investigated as part of this survey:</p> <p>#3056090</p> <p>The survey was conducted by Patti Zimmer, R.N.</p> <p>The survey team is from:<br/>Department of Social &amp; Health Services<br/>Aging &amp; Long Term Support Administration<br/>Residential Care Services, District 1, Unit C<br/>3611 River Road, Suite 200<br/>Yakima, Washington 98902</p> <p>Telephone (509) 225-2800<br/>Fax: (509) 574-5597</p> <p><i>Penja Jones ARNP 01/02/15</i></p> | F 000  | <p><b>This Plan of correction constitutes the facilities "Credible Allegation of Compliance" with the following deficiencies.</b></p> <p><b>*Note:</b> this Plan of Correction constitutes my written allegation of compliance for the deficiencies noted. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was noted correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p><b>F-226 483.75(e) NURSE AIDE PERFORMANCE REVIEW-12 HR/YR INSERVICE</b></p> <p>It is the policy of Avalon Health and Rehab to develop and implement written policies and procedures that allow completion of performance reviews of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours/ year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for the nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> |   |
| F 497<br>SS=E   | <p>Residential Care Services Date</p> <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be</p>  | F 497  |  |   |

**RECEIVED**  
JAN 14 2015  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jane Boh* TITLE: *Administrata* (X6) DATE: *1-8-15*

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.

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>505126</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>12/22/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2004 N 22ND AVENUE<br/>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 497  | <p>Continued From page 1</p> <p>sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interviews the facility failed to ensure completion of the required performance reviews for 4 of 4 Nursing Assistant Certified (#'s A,B,C,D) at least once every 12 months. This failed practice had the potential to affect the competency of Nursing Assistant Certified (NACs) and quality of care provided to residents. Findings include:</p> <p>NAC #1: Review of personnel files revealed the staff member was hired by the facility as a NAC on [REDACTED]. Despite yearly performance reviews being required annually there was no evidence an evaluation had been completed on the employee since her date of hire.</p> <p>NAC #2: Review of personnel files revealed the NAC was hired by the facility on [REDACTED]. There was no evidence a performance review had been completed on the staff member since 4/24/13.</p> <p>NAC #3: Review of personnel files revealed the NAC was hired by the facility on [REDACTED]. There had been no performance review completed on the staff member since his date of hire.</p> | F 497   | <p>1 The staff members A,B,C and D received evaluations per the regulation on 12-26-14.</p> <p>2.All C.N.A. files were reviewed for compliance on 12-22-14 by the Staff development Coordinator. 38 C.N.A. charts were reviewed and 20 evaluations where completed to ensure compliance.</p> <p>3.The Director of Nursing Services and the Staff Development Coordinator were educated on 12-22-14 regarding the annual evaluation policy.</p> <p>4. The Staff Development Coordinator updated a list of all C.N.A hire dates on 12-22-14 to assist in the system for continuous evaluations. Each C.N.A will have a yearly competency evaluation completed by the Director of Nursing Services or designee prior to their anniversary date of hire. All completed evaluations will be reviewed and signed by the Administrator while being compared to the updated hire list for accuracy and to ensure that all required C,N.A's evaluations are completed timely. Results will be monitored by the Director of Nursing Services or designee and brought to the Monthly Quality Assurance meeting for 3 consecutive months. Further review will continue as deemed appropriate by the Quality Assurance committee.</p> <p>5. The required annual evaluations for C.N.A's were all completed by 12-26-14 by the Director of Nursing Services and designee.</p> | 12-26-14             |   |

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

PRINTED: 01/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>505126</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>12/22/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AVALON HEALTH &amp; REHABILITATION CENTER - PASCO</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2004 N 22ND AVENUE<br/>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 497  | Continued From page 2<br>NAC #4: Review of personnel files revealed the NAC was hired by the facility on [REDACTED]. There was no evidence a performance review had been completed on the staff member since hired by the facility.<br><br>Staff Member E (Administrator) stated during an interview on 12/16/14 at 4:30 p.m. that he was aware annual performance reviews had not been completed on NACs as required. | F 497   |   |                      |   |