STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. BUILDING _____ B. WING _____	**09/16/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure appropriate treatment and services were provided to one of five residents (#1) reviewed for behaviors and emotional well-being. Resident #1, who had a history of [REDACTED]. This resulted in actual harm to Resident #1 as he was found five days later in bed with a bed control cord wrapped twice around his neck. Findings included: Record review of the facility's policy titled, Suicidal Precautions Checklist, dated May, 2020, showed the checklist was to guide the facility with steps to be initiated when a resident makes suicidal statements. The checklist included: - safety check of the resident's room - one to one supervision initiated and to continue until otherwise indicated - notify clinical team - physician notified and orders for suicide precautions and mental health consultation received - responsible party notified - social services contacted - mental health professional contacted, and referral made - care plan initiated and individualized - alert charting initiated for each shift and to continue until otherwise indicated - dietary referral made for plastic utensils - suicidal risk assessment completed - interdisciplinary team to meet with resident/representative - interdisciplinary team to review [MEDICAL CONDITION] medications - physician/pharmacist to review medication regimen for possible changes Resident #1. Review of the resident's medical record showed he was admitted to the facility on [DATE] from the hospital with [DIAGNOSES REDACTED]. Review of the comprehensive nursing assessment, dated 06/15/2020, showed the resident had moderate cognitive loss; no behavioral issues; felt tired or had little energy; required two staff to assist with turning in bed and transfers; two staff to assist with dressing, personal hygiene, and toileting; continent of bowel; and occasionally incontinent of bladder. Review of Progress Notes (PNs), dated 07/09/2020, showed the resident had improved with activities of daily living (ADLs) as he only required stand by assistance with transfers, used a hemiwalker (provides support for residents with limited or no use of one hand) for ambulation walking 135 feet, and minimal assistance with ADLs. Review of a facility investigation report, showed the resident was found on the floor of his bathroom on 08/28/2020 at 4:35 PM complaining of pain to his right hip and leg. He was transported to the hospital where x-rays showed a fractured right hip. Review of the hospital History and Physical, dated 08/28/2020, showed the resident had a history of [REDACTED]. On admission to the hospital he was scored as moderate risk and placed on one to one protocol. Documentation showed he had a [MEDICAL CONDITION] disorder and was taking an antidepressant at home. On 08/31/2020 hospital records showed the resident agreed with the surgeon regarding a nonsurgical approach to treat the right [MEDICAL CONDITION]. The resident was not suicidal currently. Review of PNs, dated 09/01/2020, showed the resident was readmitted to the facility from the hospital with an antidepressant ordered to be administered daily. Progress Notes regarding discharge planning, dated 09/02/2020, documented by Staff A, Social Services, showed it was unclear if the resident would be returning home. That was the resident's initial plan, however he might not be able to return home. Progress Notes, dated 09/03/2020, showed the resident was alert and oriented to person, place, and situation. He expressed sadness regarding his [MEDICAL CONDITION] stating, I probably won't go home. A mechanical lift was utilized for all transfers, required extensive assistance with turning in bed and toileting, and was unable to walk. Progress Notes, dated 09/04/2020 and 09/05/2020 by Staff B, Licensed Practical Nurse (LPN), showed the resident expressed dissatisfaction with the [MEDICAL CONDITION] . continues to refuse treatment for [REDACTED]. Review of the resident's plan of care showed no problem addressing the resident's depression, mood changes with suicidal thoughts. Staff B stated during a telephone interview on 09/16/2020 at 1:50 PM, that on 09/04, 05/2020 between approximately 6:00 to 6:30 AM he entered the resident's room to perform blood sugars. The resident was watching television and began crying stating he had a past experience of imagining himself jumping from a boat or ferry but he did not do it because of the boat propeller. The resident expressed he needed help with his feelings. Staff B stated the resident was crying which made it difficult to understand him. Staff B stated he informed Staff C, LPN/Resident Care Manager when she arrived to work at approximately 8:00 AM on 09/04/2020 and she instructed Staff B to write a PN regarding the incident and to ask the resident if he had a suicide plan. Staff B was told by the resident he did not have a plan. When Staff B documented his discussion with the resident on 09/04,05/2020 he thought the physician was reading those PNs as he had marked the PN to be forwarded to the 24 hour report, which would ensure the resident would get help. However, Staff B later learned he had to put information to share with the physician in a blue book located at the nursing station, which he had not done, nor had he notified the physician by phone. An interview with Staff C on 09/16/2020 at 2:30 PM, showed Staff B reported to Staff C that the resident had been tearful, but denied any information given by Staff B regarding the resident needing help with his mood and suicidal thoughts. Staff C stated upon checking on the resident that day he was not crying and he talked about being in the lake and having bad dreams, which was unusual for him. Staff C stated any information the physician needed to be alerted to had to be placed in the blue book at the nursing station. Twenty-four hour reports were discussed amongst the management staff during morning meetings Monday through Friday, but not on weekends. Progress Notes, dated 09/08/2020 at 1:24 AM, showed the resident had been crying out loud stating he could not move and help himself without being a burden to anybody. On 09/08/2020 at 3:35 PM documentation showed the resident expressed dissatisfaction and sadness related to the [MEDICAL CONDITION] and the impact it has made on his daily life. Review of a facility investigation report, dated 09/10/2020 at 6:00 AM, showed Staff D, Nursing Assistant, heard the resident making groaning noises from his room. Upon entering the resident's room his face was blue/purple and he had wrapped the bed control cord around his neck multiple times and positioned the head of the bed straight up. Staff D tried to pry the bed control out of the resident's hand telling him to let go, which he responded by stating, I can't. After releasing the cord from the resident's neck he repeatedly stated, I tried so hard, I tried so hard to kill myself. The resident did not want to be a bother to his spouse and it would be easier for her if I go. When the resident was asked if he would accept help he stated yes. The resident was transported to the hospital with mental health and emergency personnel. Staff D stated during a telephone interview on 09/17/2020 at 1:35 PM, that after the resident's fall with fracture he needed to be changed for incontinency episodes. On the morning of the suicide attempt the resident put the head of the bed all the way up which was strangulating him. She stated it took approximately 20 seconds to get the bed control out of his hand. Staff E, Registered Nurse, stated during a telephone interview on 09/17/2020 at 1:10 PM, that three days prior to the suicide attempt she was taking the resident's blood sugar and he was crying stating he could not move. Staff E stated usually the resident was happy, but he seemed depressed as he was incontinent of stool and needed staff assistance to help him. She denied any awareness of the resident having suicidal thoughts and requesting help. An interview on 09/16/2020 at 11:30 AM with Staff A, showed prior to the resident's fall causing the [MEDICAL CONDITION] he was scheduled to go home on 09/07/2020 and was excited about that. Staff A stated that prior to the resident's fall he was walking. She

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

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) stated she was unaware of the resident making any suicidal statements. A telephone interview on 09/16/2020 at 1:29 PM with the resident's spouse, showed the resident was going to be discharged to home on 09/07/2020 and he was so happy about that. Following his fracture the resident expressed to her how challenging it would be to come home after the [MEDICAL CONDITION]. Reference WAC 388-97-1060(1)(3)(e)