STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (continued on next page)

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.

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

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to provide written notice of room changes that included the reason for the room change for 3 of 3 residents (Resident 1, 2, and 3) reviewed for notification of room changes. This failure prevented the residents from having the necessary information needed to make an informed decision regarding their living situation, placing them at risk for frustration, dissatisfaction, and psychosocial decline. Findings included. <Resident 1>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including broken heart syndrome (temporary heart damage caused by severe emotional or physical stress), spina bifida (a birth defect where the spinal cord fails to develop properly) and weakness. The 07/23/2025 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living and set up assistance of one staff member for eating. The assessment also showed Resident 1 was cognitively intact. Record review of Resident 1's facility census showed they had room changes on 06/20/2025, 06/23/2025, and 07/09/2025. Record review of Resident 1's medical record showed there was no documentation that Resident 1 had received written notice of or reasons for the room changes. During an interview on 08/06/2025 at 10:55 AM, Resident 1 stated they had originally had a semi-private room on the East Hall. They stated about a month ago a housekeeper came into their room and told them they were moving to another room. Resident 1 stated they did not receive written notice or reason why they had to move. Resident 1 stated they had two additional room changes due to conflicts with their roommates. They stated, with all the room changes, I never got any papers; I was told I was long term care and got shoved down here on the long-term care hall. <Resident 2>Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including metabolic encephalopathy (a condition where brain dysfunction results from illness or imbalances in the body's chemistry), altered mental status, and malnutrition. The 07/03/2025 comprehensive assessment showed Resident 2 required supervision of one staff member for activities of daily living. The 07/24/2025 mental status assessment showed Resident 2 had an intact cognition. Review of Resident 2's facility census showed they had room changes on 07/14/2025, 07/24/2025, and 07/29/2025. Record review of Resident 2's medical record showed there was no documentation that Resident 1 and/or their representative had received written notice of or reason for the room changes. During an interview on 08/04/2025 at 4:52 PM, Resident 2's Representative (RR) stated there was no written notice given for the room changes. They stated the facility staff told them Resident 2 was moved from the East Hall on 07/24/2025 to the back hall (long-term care hall) because they were independent and didn't need a room near the nurse's station, there was a door in the back hall where Resident 2 could use to go outside to smoke, and they were painting Resident 2's room on the East Hall. An observation on 08/05/2025 at 10:36 AM showed Resident 2's previous room on the East Hall had not been painted and the room remained vacant. The East Hall was not repainted and there were 18 residents residing in that hall. <Resident 3>Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, muscle weakness, and difficulty walking. The 05/30/2025 comprehensive assessment showed Resident 3 required partial assistance of one staff member for ADLs. The assessment also showed Resident 3 had a moderately impaired cognition. Review of Resident 3's facility census showed Resident 3 had room changes on 03/05/2025, 03/08/2025, 03/11/2025, 07/11/2025, and 07/21/2025. Record review of Resident 3's medical record showed there was no documentation that Resident 3 and/or their representative (RR) had received written notice or reasons for the room changes. During an interview on 08/05/2025 at 11:57 AM, Resident 3's Representative stated they were not notified of the room changes or reasons for the changes, but assume it was related to Resident 3's finances. During an interview on 08/05/2025 at 12:34 PM, Staff C, Social Services Director, stated the process for room changes included speaking to the resident and/or their representative to discuss the move. If they are agreeable to the move, they proceed with moving them. If they refuse the move, depending on the reason for the move, they might issue a 72-hour notice, and proceed with the move. Staff C stated they did not provide the resident and/or their representative with written notice, nor did they provide reasons for the move. During an interview on 08/05/2025 at 1:36 PM with Staff A, Administrator, and Staff B, [NAME] President Regional Director, Staff A stated the process for room changes included speaking to the resident about the room change, and if agreeable, they would move right away or if not agreeable, we would give them 72 hours to decide. They stated they usually notified the resident why there was a room change. Staff B added that the facility did not provide written notice or reasons for room changes. Reference: WAC