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	09/17/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision, monitor, and develop care plans with effective fall prevention interventions, and ensure that planned interventions were consistently implemented to prevent avoidable falls for 2 of 5 residents (Residents 1 and 2) reviewed for accidents. In addition, the facility failed to conduct an investigation following a fall for 1 of 5 residents (Resident 1) reviewed for falls. This failed practice placed residents at risk for serious injury. Findings included .Review of the Facility's policy titled, Accident Hazards/Supervision/Device dated 07/2018 showed the facility will provide an environment that is free from controllable accident hazards as is possible and provide supervision and assistance devices to residents to avoid preventable accidents. When a resident experiences a fall, the facility will evaluate factors to aid in the development and implementation of relevant, consistent and individualized interventions to reduce the likelihood of future occurrences. The facility will initiate and implement a comprehensive, resident-centered fall prevention plan for residents at risk for falls or with a history of falls. When a fall occurs, the facility will revise the residents care plan to reduce the likelihood of another fall. Resident 1Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including throat cancer and dementia (the loss of memory, problem-solving and other thinking abilities that are severe enough to interfere with daily life). The 08/21/2025 comprehensive assessment showed Resident 1's cognition was moderately impaired and required assistance of one to two staff members for activities of daily living (ADLs). Review of the fall risk assessment dated [DATE], showed Resident 1 was at a high risk for falls. Review of the care plan, dated 05/28/2025, showed Resident 1 had no care plan in place for being a fall risk and had no interventions to prevent falls. Record review of the facility incident log showed Resident 1 had falls on 08/26/2025, 08/27/2025, and 08/30/2025 with no care plan in place to prevent falls until after the fall on 08/30/2025 (four days after the first fall).Record review of a facility investigation dated 08/26/2025, showed Resident 1 had an unwitnessed fall and was found sitting on the floor between their bed and bathroom floor. Resident 1 pointed to the bathroom and stated yes when asked if they were trying to go to the bathroom. Further review of the investigation summary showed there were no new preventative measures in place for Resident 1. The investigation summary showed the IDT reviewed and updated Resident 1's care plan (the medical record showed no fall care plan in place for Resident 1). Record review showed there was no investigation completed for the fall on 08/27/2025. Review of Resident 1's care plan showed no fall care plan, updates or interventions were implemented from the falls on 08/26/2025 or 08/27/2025. Resident 2 Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood supply to a part of the brain is interrupted, causing brain cells to die) and dementia. The 08/21/2025 comprehensive assessment showed Resident 2's cognition was severely impaired and required assistance of one to two staff members for ADLs. Record review of a facility investigation, dated 08/05/2025, showed Resident 2 had a fall and was found lying next to their wheelchair in front of the nurse's station. Further review of the investigation showed Resident 2's ordered wheelchair cushion was not in place at the time of the fall. Further review of the investigation summary showed the IDT team updated the care plan to ensure the wheelchair cushion was in place prior to Resident 2 being placed in their chair. Record review of a facility investigation dated 09/01/2025, showed Resident 2 was found on their knees in front of the nurse's station. Further review of the investigation showed Resident 2's ordered wheelchair cushion was not in place at the time of the fall. Further review of the investigation summary showed the IDT reviewed and updated Resident 2's care plan to ensure Resident 2's wheelchair cushion was in place prior to placing the resident in their wheelchair. Review of the care plan dated 03/05/2025, showed no updates or interventions were implemented from the falls on 08/05/2025 and 09/01/2025 for the placement of the wheelchair cushion.During an interview on 09/17/2025 at 3:12 PM, Staff A, Director of Nursing Services, stated the facility fall prevention process involved conducting a Fall Risk Assessment upon admission and developing a care plan with resident specific interventions for staff to follow. Staff A further stated if a resident experienced a fall, the care plan was reviewed and revised to reduce the risk of future incidents. Staff A stated upon review, they identified a failure in the implementation of fall prevention measures and care plan implementation and updates. Staff A stated they had noticed there was no completed incident report for Resident 1's 08/27/2025 fall and that was an issue they needed to investigate. Staff A stated the correct process had not been followed for Resident 1 and 2. Reference: WAC 388-97-1060