

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2026
NAME OF PROVIDER OR SUPPLIER  Avalon Health & Rehabilitation Center - Pasco		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to address and provide feedback related to identified concerns brought forth by the Resident Council [(RC) a group of residents that meet regularly to improve the quality of life and care in the nursing home] representatives for 4 of 4 residents (Resident 1, 2, 3, and 4) reviewed for grievances. This failure prevented the residents from reporting concerns that placed them at risk for abuse/neglect, frustration, and diminished self-worth. Findings included. Review of a policy titled, Resident Rights - Right to Organize and Participate in Resident Groups in the Facility, dated 07/2018, showed the facility would consider the views and act promptly upon the grievances and recommendations brought forth by the resident and/or family group concerning the issues of resident care and life in the facility. The facility would demonstrate a response and rationale for the response in relation to the expressed grievances and recommendations. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including respiratory failure, kidney failure, and anemia (a condition where there are not enough healthy red blood cells to carry oxygen to the body's tissues). The 02/23/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 1 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 03/13/2026 at 1:13 PM, Resident 1 stated they were Resident Council president. They stated a few weeks ago the facility corporate staff were at the facility doing a mock survey (a simulated, proactive inspection of a healthcare facility to ensure compliance with regulations). Resident 1 stated they had a special Resident Council meeting with the corporate staff. They stated the residents presented the corporate staff with several grievances, including activities, dietary concerns, resident rights, staffing concerns, showers, and call light response times. Resident 1 stated the Resident Council had not received any response to their grievances from the facility or corporate staff. They stated they felt slapped in the face, betrayed, and genuinely hurt. During a follow-up interview on 03/19/2026 at 9:24 AM, Resident 1 stated they still had not received a response from the corporate staff regarding the grievances. The lack of response made them feel like the corporate staff didn't care and their concerns were unimportant. Resident 2Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), muscle weakness, and depression. The 12/12/2025 comprehensive assessment showed Resident 2 was independent with ADLs. The assessment also showed Resident 2 was cognitively intact. During an interview on 03/13/2026 at 11:03 AM, Resident 2 stated they had attended the Resident Council meeting with corporate staff. They stated there had been no improvement on the issues that were brought forward and no actions on their concerns. During a follow-up interview on 03/19/2026 at 9:58 AM, Resident 2 stated there was still no response to their concerns from corporate staff. They stated that made them feel ignored, insignificant, and a little bit hopeless. Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including high blood pressure, (continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>heart failure, depression, and anxiety. The 09/29/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for ADLs. The assessment also showed Resident 3 was cognitively intact. During an interview on 03/13/2026 at 10:54 AM, Resident 3 stated they were at the Resident Council meeting with other residents and corporate staff. They stated the facility administrator was not present at the meeting. Resident 3 stated they had concerns about their activities program and dietary issues. They stated they had not received any feedback on their concerns. During a follow-up interview on 03/19/2026 at 9:11 AM, Resident 3 stated they felt disappointed and had expected the corporate staff to at least consider what was presented to them. Resident 3 stated for nothing to change for the better is frustrating to say the least. Resident 4</p> <p>Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including Takotsubo Syndrome (a temporary, reversible heart condition triggered by intense emotional or physical stress), spina bifida (a condition that occurs when the spine and spinal cord don't form properly), and diabetes. The 01/12/2026 comprehensive assessment showed Resident 4 required moderate to dependent assistance of one to two staff members for ADLs. The assessment also showed Resident 4 was cognitively intact. During an interview on 03/19/2026 at 9:18 AM, Resident 4 stated they were at the corporate Resident Council meeting. They stated it felt odd that corporate staff said they would get back to us and we are still waiting; we have not heard a thing. During an interview on 03/17/2026 at 3:35 PM, Staff C, Social Services Director, stated the residents had invited them to attend the corporate Resident Council meeting. They stated they listened to the concerns brought forth by the residents and would have considered some of them grievances. They stated the process should have been to complete a grievance form and follow up with the residents. Staff C stated they did not complete the grievance forms because corporate staff were running the meeting and taking notes. During an interview on 03/17/2026 at 4:11 PM, Staff A, Administrator, stated the process for filing a grievance could be done verbally or in writing. Grievances were reviewed in the daily morning meeting. Grievances were logged in the grievance logbook and assigned to the appropriate manager to follow up with the resident. Staff A stated the expected follow-up time frame was three to five days. Staff A stated they were not sure if corporate staff would have given them a list of the grievances from the Resident Council meeting held on 02/19/2026. During an interview on 03/17/2026 at 4:44 PM, Staff D, Regional [NAME] President, stated they attended the Resident Council meeting on 02/19/2026. They stated some of the concerns presented were addressed immediately with the residents. They stated the process should have been to generate grievance forms for tracking and follow through with the residents. During an interview on 03/17/2026 at 5:20 PM, Staff E, Chief Nursing Officer, stated the concerns brought forth at the Resident Council meeting were grievances. They stated the facility had received a list of the grievances and should have followed up on them and provided feedback to the residents. Staff E stated the facility should have followed the grievance process. Reference: WAC 388-97-0460(2) This is a repeat deficiency from the Statement of Deficiencies dated 05/27/2025.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to identify an incident of verbal abuse in a timely manner, failed to protect the resident's right to be free from verbal abuse, and take timely action to prevent further abuse for 1 of 5 residents (Resident 5) reviewed for abuse. This failure placed the residents at risk of continued verbal abuse, mental anguish, and emotional distress. Findings included. Review of a policy titled, Freedom From Abuse, Neglect, and Exploitation, dated 09/13/2022, showed verbal abuse included conduct which causes or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered a type of mental abuse. Verbal abuse may be oral, written, or gestured communication or sound that residents may hear regardless of the resident's ability to comprehend. Staff were expected to be in control of their own behavior at all times, act professionally, and understand how to work with the facility population. Retaliation by staff is abuse, regardless of whether harm was intended. Resident 5 Review of the medical record showed Resident 5 was admitted to the facility with diagnoses including kidney and urinary disorders, high blood pressure, and bipolar II disorder (a mental health condition with alternating episodes of major depression and elevated mood). Review of a nursing Function Data collection tool dated 03/07/2026, showed Resident 5 required set up/clean up assistance of one staff member for activities of daily living (activities related to personal care). The 03/10/2026 comprehensive assessment showed Resident 5 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. During an interview on 03/17/2026 at 10:00 AM, Resident 5 stated there were some things that should not have happened when I first got here. They stated they tried to advocate for themselves but there was resistance from one of the staff. Resident 5 stated there was one nurse that made inappropriate remarks and would not leave the room when they wanted to talk with a different nurse. Record review of Resident 5's incident statement dated 03/07/2026, showed they had approached Staff G, Registered Nurse (RN), regarding their catheter (a thin tube used to drain urine from the body) leaking. They stated Staff G was not listening to me and didn't feel comfortable with Staff G providing their care and had asked for a different nurse. Resident 5 reported they were in their room when Staff G entered and stated, I need to know what your problem is with me and continued to argue with the resident. Resident 5 told Staff G they had urinated on the dining room floor, was so embarrassed and needed Staff G to help them, however Staff G stated that was a nursing assistant thing. They stated Staff G continued to argue with them, so they asked them to please leave their room. Staff G told Resident 5 they were not going to leave the room until Resident 5 settled down. Resident 5 stated they told Staff G they would not settle down until they left the room. Staff G again stated they would not leave the room. Resident 5 told Staff G to get out now. Staff G told Resident 5 they weren't going anywhere, you need to settle down. Staff G left the room when Staff F, RN, entered the room and told them to leave. Resident 5 stated they had asked Staff G to leave more than four times and they wouldn't leave. Record review of a witness statement dated 03/07/2026 at 1:45 PM, showed Staff F, was notified that Resident 5 would like to speak to a different nurse than the one assigned to them (Staff G, RN). Resident 5 stated they were uncomfortable with Staff G and wanted a different nurse. Staff G approached Staff F and wanted to know why Resident 5 had requested a different nurse. Staff F informed Staff G that Resident 5 asked for a different nurse and if Resident 5 wanted to disclose the reason, that was their decision. Staff G told Staff F they needed to know what the problem was. Staff F then noticed Staff G enter Resident 5's room. Staff F overheard Resident 5 speaking to Staff G in a frantic tone regarding an incident with their catheter leaking in the dining room and stated to Staff G do you have any idea how embarrassing that was? Staff G replied to Resident 5 that the catheter problem was a nursing assistant problem, and they had not done anything wrong. Resident 5 told Staff G they were uncomfortable talking to (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>them. Staff G told Resident 5 they needed to settle down. Resident 5 stated they were not going to settle down until Staff G left the room. Resident 5 again stated please leave my room. Now. Leave. Staff G stated, I'm not going to leave until you settle down. Resident 5 wheeled themselves with their walker towards Staff G and stated MOVE. GET OUT OF MY ROOM! Staff F intervened at that time and told Staff G you need to leave now. Staff G stated no, I am not leaving. Resident 5 stated GET [THEM] OUT OF MY ROOM NOW! MAKE [THEM] LEAVE! Staff F told Staff G again that they needed to leave the room. Resident 5 reported to Staff F after the incident that they had a headache and wanted to know when they had their last blood pressure medication. Staff F approached Staff G and asked when Resident 5 received their last dose of blood pressure medication; Staff G replied, you had no right to intervene and Resident 5 doesn't get to choose their nurse. During an interview on 03/17/2026 at 1:52 PM, Staff B, Director of Nursing Services, stated they became aware of the incident between Resident 5 and Staff G the same day the incident occurred (03/07/2026). They stated they had informed staff to obtain interviews. Staff B stated if abuse was alleged, Staff G would have been suspended. Staff B stated they had reported the incident to their regional staff and then was out sick. They stated Resident 5 did not want Staff G in their room to provide care. Staff G had gone back into Resident 5's room to have a conversation. Staff B stated they informed Staff G that another nurse would take over care for Resident 5, gather statements, and the resident was placed on alert charting. Staff B stated, at the time, I didn't hear abuse allegations. The process for allegations of abuse would have been to suspend Staff G pending investigation. Staff B stated they informed Staff G they needed to switch residents with Staff F to protect Resident 5, then stated I don't know why that didn't happen. During a concurrent interview on 03/17/2026 at 1:00 PM with Staff A, Administrator, and Staff D, Regional [NAME] President, Staff A stated they were not fully aware of the incident between Resident 5 and Staff G until 03/13/2026, six days after the incident. Staff A stated the process would have been to immediately initiate an investigation and suspend Staff G until the investigation was completed. Staff D stated the facility needed to do their due diligence for investigating at the time of the incident. During a follow-up interview on 03/19/2026 at 12:35 PM, Staff A stated Staff G should not have gone back into Resident 5's room after they asked Staff G not to. They stated Resident 5 was not protected from Staff G. Staff A stated the incident was verbal abuse due to the confrontation by Staff G. They stated Staff G should not have had continued contact with Resident 5 and Staff F, Staff B, and Staff A should have reported the incident to the State Agency hotline. Reference: WAC 388-97-0640(1)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to implement their abuse prevention policy in the areas of identification, investigation, protection, and reporting for 1 of 5 residents (Resident 5) reviewed for abuse. This failure placed the residents at risk for unidentified abuse and neglect. Findings included. Review of a policy titled, Freedom From Abuse, Neglect, and Exploitation Preventing and Prohibiting Abuse, revised 09/13/2022, showed the facility's policy is to prevent abuse and neglect of residents. Staff will receive training related to identifying, recognizing, and reporting abuse/neglect. Allegations of abuse/neglect will be investigated to determine whether the abuse/neglect occurred and to what extent. During an investigation of alleged abuse/neglect, to the extent possible, the facility will protect residents from harm during and after the investigation. Staff will immediately report alleged violations to the administrator, state agency, and other required agencies. Resident 5 Review of the medical record showed Resident 5 was admitted to the facility with diagnoses including kidney and urinary disorders, high blood pressure, and bipolar II disorder (a mental health condition with alternating episodes of major depression and elevated mood). Review of a nursing Function Data collection tool dated 03/07/2026, showed Resident 5 required set up/clean up assistance of one staff member for activities of daily living (activities related to personal care). The 03/10/2026 comprehensive assessment showed Resident 5 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. Record review of a facility follow up investigation, undated, showed on 03/07/2026, Staff G, Registered Nurse (RN) was assigned to care for Resident 5. During their shift, Resident 5 informed Staff F, RN, that they no longer wanted Staff G to care for them. Staff F informed Resident 5 that they would assume their care for the rest of the shift. Staff G, aware of Resident 5's request, approached Resident 5 in their room and asked what happened to cause them to request another nurse. Resident 5 stated Staff G did not help them with their catheter (a thin tube used to drain urine from the body) when they requested assistance earlier, which caused Resident 5 to urinate on themselves. Staff G left the room when Staff F entered the room. Staff F immediately reported the incident to Staff B, Director of Nursing Services. Staff B educated Staff G that resident requests for a change in caregiver must be respected. The investigation summary showed the facility immediately initiated an investigation into the allegation that Staff G did not respect Resident 5's rights. Staff B removed care of Resident 5 from Staff G's responsibilities. The investigation confirmed that Staff G's failure to respect Resident 5's rights did not result in abuse or neglect. During an interview on 03/17/2026 at 12:33 PM, Staff F stated they had written a witness statement regarding an allegation of verbal abuse regarding an incident between Resident 5 and Staff G. They stated Staff G was arguing with Resident 5 and demanding the resident provide a reason for their request change nurses. Staff F stated Staff G would not leave Resident 5's room after multiple requests by the resident, despite the resident yelling at Staff G to get out. They stated they informed Staff B of the incident immediately but did not report the incident to the State Agency. Staff F stated the incident happened on 03/07/2026, and as of 03/17/2026, there had been no progression on the investigation and Staff G was currently providing care to Resident 5. Staff F stated they would have reported the incident to the State Agency on 03/17/2026, however a State Agency investigator was in the building. During an interview on 03/17/2026 at 12:52 PM, Staff B stated if there was alleged abuse, Staff G should have been suspended pending investigation to protect Resident 5. They stated Staff F had reported the allegation of abuse on 03/07/2026, and they had requested staff to gather witness statements. Staff B stated they reported the incident to the regional staff and then went out sick. Staff B stated they did not report the incident to the State Agency, but Staff A, Administrator, was aware of the incident. Staff B stated they told Staff G, after the incident, that another nurse would take over care of Resident 5, however Staff G continued to provide care to the resident. Staff B stated the process should have been to suspend Staff G pending investigation. They stated, I would have suspended (continued on next page)</p>		

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F 0607  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	them, I don't know why that didn't happen. During an interview on 03/17/2026 at 1:00 PM, Staff A, Administrator, stated they were not made aware of the staff to resident incident on 03/07/2026 until 03/13/2026 (six days after the incident). Staff A stated the process would have included suspending Staff G and completing an investigation. During a follow-up interview at 1:43 PM, Staff A stated Staff G had been suspended, an investigation had been started, and the facility would be reporting the incident to the State Agency (six days after the incident). Record review of the facility's incident reporting log, dated 03/02/2026 through 03/14/2026, showed no entries for an allegation of abuse that occurred on 03/07/2026. Refer to F600 for further information. Reference: WAC 388-97-0640(1)(2)(a)(b)(3)(a)(5)(6)(a)(b)(c)		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of verbal abuse was reported to the State Agency as required for 1 of 5 residents (Resident 5) reviewed for abuse. This failure placed the residents at risk for additional/continued abuse. Findings included. Review of the policy titled, Freedom From Abuse, Neglect, and Exploitation Abuse Reporting and Responsibilities of Covered Individuals, revised 09/13/2022, showed the facility will report to the State Agency any reasonable suspicion of a crime against any individual residing in or receiving care from the facility. The facility will report alleged violations involving abuse, neglect, exploitation, or mistreatment and submit investigation results within timeframes required by federal and state law. Resident 5 Review of the medical record showed Resident 5 was admitted to the facility with diagnoses including kidney and urinary disorders, high blood pressure, and bipolar II disorder (a mental health condition with alternating episodes of major depression and elevated mood). Review of a nursing Function Data collection tool dated 03/07/2026, showed Resident 5 required set up/clean up assistance of one staff member for activities of daily living (activities related to personal care). The 03/10/2026 comprehensive assessment showed Resident 5 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 03/17/2026 at 10:00 AM, Resident 5 stated they tried to advocate for themselves but there was resistance from one of the staff. Resident 5 stated there was one nurse that made inappropriate remarks and would not leave the room when they wanted to talk with a different nurse. During an interview on 03/17/2026 at 12:33 PM, Staff F, Registered Nurse (RN), stated they had written a witness statement regarding an allegation of verbal abuse regarding an incident between Resident 5 and Staff G, RN. Staff F stated they immediately informed Staff B, Director of Nursing Services, of the incident but had not reported the incident to the State Agency, despite being a mandated reporter (a person that is legally required to report suspected incidents of abuse, neglect, abandonment, or financial exploitation of an elderly person). During an interview on 03/19/2026 at 12:20 PM, Staff B stated they were notified of the incident on the day it happened (03/07/2026) and should have reported it within two hours of the incident. Staff B stated Staff F also should have reported the incident to the State Agency. During an interview on 03/19/2026 at 12:35 PM, Staff A, Administrator, stated the incident was verbal abuse and Staff F, Staff B, and Staff A should have reported the incident to the State Agency Hotline. Cross reference to F600 and F607 for further information. Reference: WAC 388-97-0640(1)(5)(a)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 5 residents (Resident 5) reviewed for abuse. This failure placed the residents at risk for further unidentified and/or further abuse. Findings included . Review of a policy titled, Freedom From Abuse, Neglect, and Exploitation Preventing and Prohibiting Abuse, revised 09/13/2022, showed the facility will investigate allegations of abuse, neglect, exploitation, and misappropriation of residents property, including identifying staff responsible for the investigation, identifying and interviewing involved persons, witnesses, and others that may have knowledge of the incident, determining if abuse, neglect, exploitation and/or mistreatment occurred, and documenting the investigation. Resident 5 Review of the medical record showed Resident 5 was admitted to the facility with diagnoses including kidney and urinary disorders, high blood pressure, and bipolar II disorder (a mental health condition with alternating episodes of major depression and elevated mood). Review of a nursing Function Data collection tool dated 03/07/2026, showed Resident 5 required set up/clean up assistance of one staff member for activities of daily living (activities related to personal care). The 03/10/2026 comprehensive assessment showed Resident 5 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an interview on 03/19/2026 at 12:20 PM, Staff B, Director of Nursing Services, stated their process for addressing allegations of abuse included notifying the administrator of the allegation, launching an investigation that included collecting witness statements, and reporting the allegation to the required reporting agencies. They stated they had initiated an investigation into the allegation of verbal abuse from Staff G, Registered Nurse, towards Resident 5 the day the incident occurred (03/07/2026). They stated they gave the initiated investigation to Staff A, Administrator, to complete as they were out sick the week following the incident. They stated the investigation did not get finished. During an interview on 03/19/2026 at 12:35 PM, Staff A stated the incident of verbal abuse should have been investigated by Staff B or turned over to the Resident Care Manager to complete the investigation if Staff B was unable to. Cross reference F600 and F607 for further information. Reference: WAC 388-97-0640(6)(a)(c)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 residents (Resident 6) reviewed for accidents. This failure placed the residents at risk for serious injury and/or exposure to the elements. Findings included. Review of a policy titled, Quality of Care Accident Hazards/Supervision/Devices, dated 07/2018, showed the facility would provide an environment free of accident hazards and provide supervision and assistance devices to avoid preventable accidents. Review of a user and installation manual (provided by the facility) for the WanderGuard Departure Alert System (a wearable bracelet that triggers door locks to alert staff immediately upon a resident approaching an exit, used to prevent at-risk resident's from wandering), undated, showed if attempts to use a wrist placement for the wanderguard bracelet have failed, mount the bracelet away from the metal frame of a wheelchair. The metal in a wheelchair frame, or any other metal items, may interfere with the bracelet's signal to the door modules. Call technical service before putting the bracelet on a wheelchair. Resident 6 Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), disorientation (a state of mental confusion), and aphasia (impaired speaking caused by brain damage). Review of the 12/11/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff for activities of daily living (activities related to personal care). The assessment also showed Resident 6 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and had no wandering behaviors. Record review of a facility investigation dated 03/08/2026 at 11:23 AM, showed Resident 6 was found outside the facility on the ground by good Samaritans, who assisted the resident off the ground and back into their wheelchair. They sustained a small cut noted on the right side of their head. A WanderGuard was on the resident's wheelchair and alarmed when they were assisted back into the building. The investigation showed Resident 6 had a recent reduction in their psychotropic medication (drugs that alter brain chemistry to treat mental health conditions by managing symptoms like depression, anxiety, and mood swings), which resulted in an increase in their exit seeking. After this was identified on 03/05/2026, the medication was returned to the previous dose and a WanderGuard alarm was placed on the resident's wheelchair. A root cause analysis (a process used to identify the underlying cause of a problem or incident) was completed and showed the WanderGuard placement on Resident 6's wheelchair resulted in the wheelchair blocking the system from reading the WanderGuard. During an interview on 03/13/2026 at 3:27 PM, Staff H, Maintenance Director, stated they were notified of an elopement on 03/08/2026 around 12:00 PM. They stated they tested all the doors, and all alarms were working. They checked the security footage that showed Resident 6 leaving the building through the service door. The alarm was not sounding. Staff H stated Resident 6 had the WanderGuard on their wheelchair. Staff H stated they removed the WanderGuard from the resident's wheelchair, passed it through the door, and the alarm worked. They placed the WanderGuard back on the resident wheelchair, in the same location, and the alarm didn't trigger. Staff H stated the entire back of Resident 6's wheelchair was metal. They stated the metal was blocking the signal to the door module. During an interview on 03/17/2026 at 2:39 PM, Staff I, Registered Nurse, stated they had placed the WanderGuard on Resident 6's wheelchair on 03/05/2026, on the back, bottom right side of the wheelchair. They stated they did not push the wheelchair through the door to ensure the alarm was working. Staff I stated they had not received training or instructions on how or where to place the WanderGuard. During an interview on 03/19/2026 at 12:20 PM, Staff B, Director of Nursing Services, stated the facility had no staff trained on the correct placement of a WanderGuard. Staff B stated the Maintenance Director verified the placement of Resident 6's WanderGuard was incorrect. During an interview on 03/19/2026 at 12:35 PM, Staff A, Administrator, (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2026
NAME OF PROVIDER OR SUPPLIER  Avalon Health & Rehabilitation Center - Pasco		STREET ADDRESS, CITY, STATE, ZIP CODE  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	stated staff needed to follow the manufacturer instructions for placement of the WanderGuard to ensure it was working properly. Reference: WAC 388-97-1060(3)(g)This is a repeat deficiency from the Statement of Deficiencies dated 05/27/2025.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control interventions were implemented during a medication pass for 1 of 3 staff (Staff G) reviewed for infection control. This failure placed the residents at risk for infection, illness, and cross contamination. Findings included. Review of a policy titled, Infection Prevention and Control Program, revised 06/08/2022, showed the facility will establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The program provides guidance related to standard precautions (minimum infection prevention practices apply to all resident care that includes hand hygiene) to be followed, hand hygiene practices, and staff education and competency regarding infection prevention and control practices. Staff will perform hand hygiene before and after contact with a resident, before performing an unsterile task, after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in resident room. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including respiratory failure, kidney failure, and anemia (a condition where there are not enough healthy red blood cells to carry oxygen to the body's tissues). The 02/23/2026 comprehensive assessment showed Resident 1 was independent with activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 1 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During an observation on 03/13/2026 at 10:15 AM, Staff G, Registered Nurse, at a medication cart. Staff G's fingernails extended beyond the end of their fingers and there was dark brown matter under their nails. Staff G obtained a card of narcotic medication, popped the pill out of the back of the medication card into their hand and placed the pill into a medication cup. During an interview on 03/13/2026 at 1:13 PM, Resident 1 stated Staff G did not handle medications properly. They stated Staff G did not wear gloves, did not wash their hands before or after passing medications, popped medications into their bare hand and then put them into a medication cup. Resident 1 stated they had observed Staff G with poor infection control practices on more than one occasion, then touch the medications. During a concurrent observation and interview on 03/17/2026 at 10:52 AM, Staff G entered a resident room with a medicine cup containing medications. They handed the medication cup and a plastic cup of water to the resident. The resident took their medications and water and handed both the medication cup and empty plastic water cup back to Staff G. Staff G exited the resident room, returned to their medication cart and obtained a medication card for a different resident. They popped the medication into a medication cup. Staff G did not perform hand hygiene after exiting the resident room or before preparing the next resident's medication. Staff G stated it was not their normal practice to pop medications into their bare hand, except maybe narcotics sometimes if they are little. Staff G stated their normal practice was to perform hand hygiene before entering a resident room and when exiting the room. They stated they did not recall missing hand hygiene. During an interview on 03/17/2026 at 11:49 AM, Staff B, Director of Nursing Services, stated the process for passing medications included ensuring the right medication was administered to the right resident, with the right dose. They stated staff should not touch medications with their bare hands; the medication should be popped from the card into a medication cup. Staff B stated staff were expected to perform hand hygiene before entering each resident room and upon exiting the room. They stated the process was not followed for infection control with medication pass. During an interview on 03/19/2026 at 12:35 PM, Staff A, Administrator, stated staff should never touch medications/pills with their bare hands. They stated staff were expected to have clean hands and were to perform hand hygiene between residents. Reference: WAC 388-97-1320(c)(2)(a)(b)</p>