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	04/07/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure medication administration services provided met professional standards of practice for 3 of 5 nurses (Staff C, D, and E) reviewed for medication administration. This failure placed the residents at risk for medication errors, unmet medication needs and adverse health consequences.Findings included. Review of a facility titled, Pharmacy Services, Medication Administration, dated 08/2018, showed residents would be provided with safe and accurate medication administration. Medications would be administered following the six rights: the right order, resident, time, dose, route and practices (accepted standards of practice). Staff CReview of the facility investigation dated 04/02/2026, showed a medication error occurred on 03/20/2026 when a resident was provided with two Oxycodone (medication to relieve moderate/severe pain). The investigation showed Staff C assumed the resident could have two Oxycodone instead of one as their pain level was eight out of 10 on the pain scale. Additionally, the resident was not placed on alert charting (nursing documentation for any sudden changes in a resident's condition). Review of the resident's physician order dated 02/19/2026 showed the resident may have one Oxycodone every four hours for moderate pain. Review of a nursing progress note (PN), dated 03/20/2026, showed Staff C misread the physician's order to administer one oxycodone medication and administered two oxycodone medications to a resident in error. During an interview on 04/07/2026 at 11:10 AM, Staff C, Licensed Practical Nurse (LPN), stated they gave two Oxycodone medications based off the resident's pain level. Staff C stated the process to administer medication was to verify the order in the electronic medical record, and the medication prescription labels, document in the narcotic logbook and then administer the medication to the resident. Staff C stated they did not follow the process for accurate medication administration for this resident which resulted in the resident receiving twice the dosage of Oxycodone. Staff C stated they did not place the resident on alert charting. Staff DReview of Resident 1 medical record showed they had diagnoses including lupus [autoimmune disease-that causes the body to attack itself) affecting skin, joints and organs], diabetes (excess sugar in the blood) and respiratory failure. Review of the 02/23/2026 comprehensive assessment showed Resident 1 had an intact cognition. Review of the facility investigation dated 04/02/2026, showed Staff D administered Resident 1 medications that were not prescribed for them. Review of Staff D's PN dated 03/24/2026, showed they provided Resident 1 with another resident's medications. During an interview on 04/02/2026 at 9:57 AM, Resident 1 stated they were provided with the wrong medications as they were medications for another resident. Resident 1 stated they slept for over 12 hours and were very sleepy after they received the medication. Resident 1 stated they would double-check the medications before they take them now. During an interview on 04/09/2026 at 7:41 AM, Staff D, LPN, stated on 03/23/2026, they had prepared medications for a resident, and the resident had refused their medications. Staff D stated they returned to the medication cart and placed the medications into the medication cart. Staff D stated they proceeded to take these medications they placed into the medication cart and administered to Resident 1. Staff D returned to the medication cart and upon preparing Resident 1's medication, they realized they had administered the wrong medications to the wrong resident. Staff D stated the process for when a resident refused their medication was, they were to attempt a second time and when still refused, (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were to dispose of their medications. Staff D stated they were overwhelmed (feeling of extreme stress), and they did not follow the correct process for medication administration or disposal. Staff EReview of the facility investigation dated 04/02/2026, showed Staff E failed to administer morning medications for 14 residents on 03/28/2026. The investigation showed that when Staff E began to feel ill, they were advised to call the on-call nurse and they did not. The investigation showed on 03/28/2026 at 10:30 AM, the Director of Nursing (DON), was called by a resident that they had not received their morning medications. The DON arrived at the facility and found Staff E on a medication cart and most of the residents in their assigned hall had not received their morning medications. Review of a nursing PN dated 03/28/2026, showed the Medical Director was contacted regarding missed medications for 14 facility identified residents. The PN showed the facility received orders to either hold or administer the medications. During an interview on 04/03/2026 at 12:32 PM, Staff E, Registered Nurse (RN), stated shortly after arriving for their shift on the morning of 03/28/2026, they began to feel ill. Staff E stated they informed another nurse they felt ill and were told they would call the supervisor. Staff E stated between 9:00 am and 10:00 am, they needed to leave the facility and change clothes. Staff E stated when they returned, they received a phone call at the nurse's station from a resident's family that the resident's medications had not been provided. Staff E stated they told the family they were aware the residents' medications were late as well as many other residents. Staff E stated they proceeded to prepare the resident's medication and were walking to the resident's room when they were approached by a nurse manager and told to waste the medications, provide the medication cart keys to them and leave the facility. Staff E stated they recognized their failure to administer the resident medications timely were medication errors. During an interview on 04/07/2026 at 10:12 AM, Staff F, RN, stated they were working on 03/28/2026 when Staff E told them they were not feeling well around 9:00 AM. Staff F stated they advised Staff E to notify the on-call nurse. Staff F stated at 10:00 AM Staff E told them they needed to leave the facility to change their clothes. Staff F stated Staff E was gone for approximately 45 minutes before they returned to the facility. Staff F stated they told Staff E again, if they were not feeling well, to notify the on-call nurse. Staff F stated they proceeded to notify the on-call nurse and informed them Staff F was ill. Staff F stated the on-call nurse told them they would come in and relieve Staff E. Staff F stated the process when a staff member, including themselves when they were ill, was to notify the facility and stay home or if they became ill at work was to notify the on-call nurse. During an interview on 04/07/2026 at 3:55 PM, Staff G, Staffing Coordinator, stated staff were instructed to not come to work when ill or when at work they became ill were to call/text the on-call nurse. Additionally, staff were also instructed to notify them by call/text to ensure staffing was covered for the shift. Staff G stated on 03/28/2026 they were notified by Staff F that Staff E was ill. Staff G stated they attempted to call/text Staff E and received no response. Staff G stated they called the DON and the on-call nurse manager to notify them they had not received a response. During an interview on 04/07/2026 at 4:18 PM, Staff H, RN, stated they were the on-call nurse manager on 03/28/2026. Staff H stated they were notified by Staff F at 11:45 AM, that Staff E had not administered the morning medications to their assigned residents as they were ill and left the facility. Staff H stated they notified the DON and they both proceeded to come to the facility. Staff H stated when they arrived at 12:00 PM, Staff E was on the medication cart and told them to dispose of any medications and they would be taking over for them. Staff H stated they proceeded to audit the residents' charts in the assigned area for medications, and many residents' charts had shown their medication pass was ?red', which meant they had not received their medications. During a concurrent interview on 04/07/2026 at 1:24 PM, Staff A, Administrator, stated they were unsure if the process for the medication errors were followed. Staff A stated they referred nursing concerns to the Director of Nursing. Staff B, Interim Director of Nursing, stated through the facility investigation, they identified medication errors when Staff C had prepared one resident's medication and when they went to administer the medications, the resident had refused to take them. Staff B stated Staff C did not discard the medications and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	believed they prepared other medications for a second resident; however, they administered these medications to a second resident. Staff B stated nurses were to follow the rights of medication administration to ensure residents received the correct medications. Staff B stated the process for when a nurse became ill was to contact them and the on-call nurse manager to ensure coverage was provided to administer medication timely. Staff B stated providing a resident another resident's medication, providing wrong dosages of medications and medication omissions were medication errors. Reference: WAC 388-97-1620(1)(2)(b)(ii)