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	04/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to ensure a safe discharge that included necessary medications, durable medical equipment [(DME) reusable, medically necessary equipment prescribed by a doctor for use in the home to treat an illness or injury, such as a wheelchair, mechanical lift, or hospital bed], and home health services prior to discharge for 1 of 3 residents (Resident 1) reviewed for inappropriate discharges. This failure placed the resident at risk for medical complications and hospitalization.Findings included. Review of a policy titled, Post Discharge Plan, revised 03/2010, showed when a resident discharged the facility, a post-discharge plan would be provided to the resident and/or their representative. The post-discharge plan would identify specific resident needs after discharge such as personal care and self-administration of medications. Appropriate referrals would be made by social services and documented in the medical record. Social services would review the plan with the resident and family, and a copy of the post-discharge plan would be provided to the resident. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including hemiplegia (complete loss of voluntary movement in the muscles on one side of the body) and hemiparesis (mild to moderate muscle weakness) following a cerebral infarction (a blockage in blood vessels supplying the brain that result in tissue death), schizophrenia (a severe mental disorder that affects how people think, feel, and behave) and bipolar disorder (extreme mood swings). The 02/06/2026 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living (activities related to personal care) and set up/clean up assistance of one staff member for eating. The assessment also showed Resident 1 had an intact cognition (the mental action or process of acquiring knowledge and understanding through though, experience, and the senses). Record review of a document titled, Discharge Planning and Summary, dated 04/23/2026 at 12:17 PM, showed Resident 1 was discharged to home under the care of an organized home health service on 04/23/2026. DME was recommended by the Interdisciplinary team (a group of healthcare professionals from different disciplines to help people receive the care they need), however the recommended DME was not listed nor was there an order for the equipment or a delivery date listed. The form showed medications were faxed to the resident's pharmacy. There was no contact information listed for the identified home health agency. The form showed education was provided regarding medications. The remainder of the form was incomplete, including the post-discharge plan and facility contact information for assistance after discharge. During an interview on 04/27/2026 at 11:23 AM, Resident 1's Representative (RR) stated when Resident 1 discharged from the facility, there were supposed to be caregivers waiting for them at their home. They stated the Hoyer lift (a mechanical lift used to transfer a person from one surface to another) was not there and they had to call emergency medical services to help transfer the resident to their bed. The RR stated the facility sent Resident 1 home without medications. They stated the morning following their discharge, Resident 1 was transported to the local hospital because they needed 24-hour care and could not care for themselves at home. During an interview on 04/29/2026 at 1:24 PM, Resident 1 stated the facility did not give them any medications when they discharged and went three days without their medications. During a follow up interview on (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/30/2026 at 9:15 AM, Resident 1 stated they were currently in a different hospital because they were not doing well at home by myself and were unable to care for themselves. They stated the nurse discharged them from the facility and did not provide medications or tell them they could pick them up at a pharmacy. Resident 1 stated they did not receive any instructions for their discharge. During an interview on 04/29/2026 at 1:45 PM, Staff C, Resident Care Manager/Licensed Practical Nurse, stated they discharged Resident 1 to home. They stated the process for discharge included obtaining discharge orders and prescriptions from the provider, ensuring DME and referrals were completed prior to the resident leaving the facility. Staff C stated they were able to send medications home with the resident depending on their insurance and would provide written prescriptions for narcotic (strong pain medications) medications. For residents that did not have insurance that allowed them to take their medications with them, Staff C stated they faxed the prescriptions to the resident's pharmacy. The process also included social service completing the discharge packet and nursing would perform a final skin check. Staff C stated when Resident 1 discharged , social services was not available and nursing picked up the pieces. They stated as Resident 1 was loaded on the van to transport them home, they gave them a discharge packet. They had prescriptions written for a short time for pain medications. They stated they did not send Resident 1 home with their medications and was told by Resident 1 to send the prescriptions to the pharmacy. Staff C stated they faxed the prescriptions to the pharmacy twice; on the day of discharge and a second time on 04/25/2026 as a backup. During an interview on 04/29/2026 at 2:09 PM, Collateral Contact 1 (CC1), Pharmacist, stated the pharmacy received prescriptions for Resident 1 via fax on Saturday, 04/25/2026 at 12:44 PM. They stated there was nothing received by the pharmacy prior to that date and time, and the pharmacy was not open on weekends for customers to pick up medications. During an interview on 04/30/2026 at 8:53 AM, Collateral Contact 2 (CC2), Home Health Services 1, stated they had no referral for Resident 1 and had not provided any services for them, despite the discharge summary listing them as the agency providing home health services. During an interview on 04/30/2026 at 9:32 AM, Collateral Contact 3 (CC3), Home Health Services 2, stated they had received a referral for home health services for Resident 1. They stated they provided a caregiver who was at the resident's home at 3:15 PM on 04/23/2026 (day of discharge). They stated the Hoyer lift was not in the home and the resident's bed was not completely assembled. CC3 stated Resident 1 gave them a written prescription for a pain medication during their visit on 04/23/2026 that they dropped off at the pharmacy for the resident. They stated there were no other prescriptions or medications for the resident. CC3 stated Resident 1 required 24-hour care but did not have hours approved for that coverage. During an interview on 04/30/2026 at 12:09 PM, Staff B, Interim Director of Nursing, stated the facility received a phone call from Resident 1 on 04/24/2026 (the day after discharge) stating they were unable to fill their pain medication at the pharmacy but had not said anything about other medications. They stated the resident's caregiver called the facility on 04/25/2026 midday and asked for discharge paperwork to review how to care for the resident. They stated the nurse that answered the phone told the caregiver to call back Monday for that information. Staff B stated that response was unacceptable and they had personally returned the call to Resident 1 and their caregiver to discuss their concerns, however Resident 1 was being loaded into an ambulance due to their inability to care for themselves at home. Staff B stated no one mentioned the need for prescriptions or medications at that time. They stated they contacted Staff C and told them to call the caregiver and to fax the discharge paperwork to them. Staff B stated the process for safe discharge included obtaining discharge orders from the provider that included medications to continue upon discharge. The facility then contacted the pharmacy, home health services, ordered DME and ensured it was in the home prior to discharge. The facility set up transportation home, and before leaving, staff reviewed the discharge information with the resident/RR and had them sign the discharge paperwork. Medications or prescriptions would then be provided to the resident. Staff B stated the facility did not follow the process for a safe discharge for Resident 1. During an interview on 04/30/2026 at 1:24 PM, Staff A, Administrator, stated the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process was not followed for ensuring Resident 1 had their medications available at home after discharge. They stated the normal process for DME included social services ensuring the DME was in place prior to the resident discharging. They stated the facility had used a new system for obtaining DME for discharging residents that included the provider of the DME only communicating with the resident regarding delivery of the DME once the order for the equipment was received by that provider. Reference: WAC 388-97-0120(3)(a)