

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/20/2026
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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to implement safety interventions to prevent an avoidable fall for 1 of 3 residents (Resident 1) reviewed for accidents. This failure placed the residents at risk for additional falls and substantial injuries. Findings included . Review of a policy titled, Quality of Care Accident Hazards/Supervision/Devices, dated 07/2018, showed the facility would provide an environment that was free of accident hazards and provide supervision and assistance devices to residents to avoid preventable accidents. Efforts to minimize the risk to residents includes individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Individualized interventions would be developed to reduce the potential for accidents. Resident specific interventions would be reflected in the resident's person-centered, individualized care plan. Resident 1Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including a broken bone in the neck, quadriplegia (paralysis that affects both arms and legs, and the torso), and major depressive disorder (persistent low mood and loss of interest in activities. The 06/12/2026 comprehensive assessment showed Resident 1 was dependent on one to two staff members for activities of daily living (activities related to personal care). The assessment also showed Resident 1 had an intact cognition. Record review of Resident 1's care plan dated 06/09/2026, showed Resident 1 was dependent on two staff members for repositioning and turning in bed. Record review of an investigation dated 07/12/2026 at 8:20 PM, showed a witness statement written by Staff B, Nursing Assistant. Staff B was instructing Resident 1, verbally, to turn on to their back from their left side, but they rolled completely on their left side and onto the floor. The witness statement showed Resident 1 stated they were trying to roll to their side but there wasn't any space on that side. The investigation showed the root cause (reason why) the fall occurred was staff was assisting the resident with incontinent care. The resident used their grab bars (metal rails attached to a bed to help residents move in bed) for mobility, pulling themselves toward the edge of the bed with their lower extremities coming off the bed. Staff were unable to reach other side of bed prior to the resident falling out of bed. During an interview on 07/20/2026 at 9:56 AM, Resident 1 stated they had a fall when Staff B was placing a mechanical lift sling under them to transfer them to a chair. Resident 1 stated Staff B had first pulled them to the right so they could roll them to the left and placed the sling under them. They stated Staff B then helped them roll to the right, but there was not enough room to roll and there was no one standing on the right side to catch them. Resident 1 stated their left leg came over top of the right leg and pulled their lower body off the bed, and their right arm was caught in the grab bar. They stated they were able to get to the floor, and Staff B went to get help. During an interview on 07/20/2026 at 2:30 PM, Staff B stated they were assisting Resident 1 with incontinent care from Resident 1's left side and had instructed them to roll on to their back. They stated Resident 1 rolled all the way to their right side before they could get to (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/20/2026
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	the other side of the bed. Staff B stated they were unsure if Resident 1 required assistance of one or two staff members for bed mobility. They stated that information would be found on the Kardex (a summary of a resident's care plan and key information that provides quick access for individualized resident care). Staff B stated they had not reviewed Resident 1's Kardex. During an interview on 07/20/2026 at 2:53 PM, Staff C, Resident Care Manager, stated the fall occurred when Staff B was in the resident room alone providing incontinent care to Resident 1. They stated the resident rolled to one side and was not far enough over on the bed. Their lower half fell off the bed, and the weight of their legs pulled them to the floor. They stated it was unacceptable that Staff B was in the room alone. Staff C stated the care plan showed Resident 1 required assistance of two people for bed mobility and the nursing assistants had access to that information. During an interview on 07/20/2026 at 3:41 PM, Staff A, Director of Nursing, stated the fall occurred because Staff B did not follow the Kardex or care plan for assistance with bed mobility. Reference: WAC 388-97-1060(3)(g)		