

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 07/30/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) remained free from significant medication errors. The facility failed to accurately transcribe Resident 1's admission medication orders onto the Medication Administration Record (MAR), which resulted in the entry of an incorrect medication suboxone (a medication used to help people recover from addiction to pain medication) rather than the ordered pain medication buprenorphine (a medication used to treat chronic pain) transdermal patch (an adhesive patch designed to deliver a specific dose of medication through the skin and into the blood stream) , and failed to remove a previously applied transdermal patch prior to administering a new one, leaving the resident with two active medication patches simultaneously. These failures placed the resident at risk for adverse drug events, toxicity, and potential opioid overdose. Findings included. Review of the medical record showed the resident admitted on [DATE] with diagnoses including cerebral amyloid angiopathy (a serious medical condition where protein builds up in the brain, causing bleeding and tissue damage). The 07/21/2026 comprehensive assessment showed Resident 1's cognition was moderately impaired, and they required the assistance of one staff member with activities of daily living. Review of the hospital discharge orders dated 07/18/2026 showed an order for a buprenorphine transdermal patch to be applied weekly. Review of Resident 1's July 2026 MAR showed that the facility inaccurately transcribed the order as suboxone transdermal patch to be applied weekly. During an interview on 07/30/2026 at 3:25 PM, Staff E, Registered Nurse (RN), stated on 07/19/2026, they received a new order for the buprenorphine transdermal patch, and the transcribed Suboxone order was discontinued. During an interview on 07/30/2026 at 3:35 PM, Staff B, Licensed Practical Nurse, stated upon admission, they transcribed the resident's medication order as suboxone transdermal patch instead of the ordered buprenorphine transdermal patch because they believed suboxone was the same medication. Staff B stated they did not assess the resident's body at the time of admission to determine if the resident had an existing transdermal patch already present, which would have revealed the presence of the active patch and identified the type of medication it contained. Staff B further stated that entering the wrong medication was a significant error. During an interview on 07/30/2026 at 11:22 AM, the Resident Representative (RR) stated on 07/26/2026, facility staff applied a new pain patch to Resident 1 without removing the old patch. The RR stated Resident 1 had two active pain medication patches on simultaneously for three days. The RR stated they discovered both patches on 07/29/2026 and brought them to the attention of Staff C, RN, before removing them. During an interview on 07/30/2026 at 1:26 PM, Staff C, stated the RR notified them Resident 1 had two active pain medication patches applied simultaneously. Staff C stated they assessed the resident and discovered one patch on the right shoulder and a second patch on the left shoulder. Staff C further stated they immediately removed the older patch and reported the incident to Staff D, Resident (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
--	-------	-----------

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 07/30/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Manager (RCM). During an interview on 07/30/2026 at 1:43 PM, Staff D, RCM, stated Staff C, RN, had reported the discovery of the two active patches to them. Staff D further stated they reported the incident to Staff A, Director of Nursing Services (DNS). During an interview on 07/30/2026 at 2:00 PM, Staff A, DNS, stated the facility's process for medication errors included interviewing the involved staff, notifying the physician, initiating alert charting, and implementing specific monitoring for high-alert medications like pain medications. Staff A stated when the two active patches were reported to them, they failed to investigate the incident. Staff A further stated they should have completed a medication error report for the incident. During a follow-up interview at 4:16 PM, Staff A stated there was no documentation from the reviewing nurses on the transfer orders for Resident 1. Staff A stated the facility's admission process required a three-step verification, where two nurses review orders upon admission, followed by a third review the next day or the following Monday. Staff A stated they would expect each nurse to review the transfer orders to ensure the accuracy of those orders, and that process was not followed for Resident 1. Staff A further stated the facility had processes that need fixed and worked out, and confirmed the inaccurate transcription of the medication was a medication error. Reference: WAC 388-97-1060 (3)(k)(iii)		