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	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to provide care in a manner that maintained and promoted dignity and respect for 2 of 2 residents (Resident 19 and 33) when staff spoke Spanish to each other when providing cares. This failure placed residents at risk for diminished self-worth, frustration and embarrassment. Findings included . Review of a policy titled Resident Rights, Exercise of Rights, revised 08/2018, showed the facility would treat each resident with respect and dignity in a manner that promoted or enhanced their quality of life. <Resident 19> Review of the medical record showed Resident 19 was admitted to the facility with diagnoses including diabetes (a disease that results in too much sugar in the blood), neuropathy (damaged nerves causing numbness, weakness and a burning sensation in hands and feet), and pain. The 03/10/2025 comprehensive assessment showed Resident 19 required substantial/dependent assistance of one to two staff members for activities of daily living (ADLs) and had an intact cognition. During an interview on 05/19/2025 at 1:30 PM, Resident 19 stated there were some nursing assistants (NA) that spoke Spanish to each other when they were providing personal cares for them. Resident 19 stated they did not know what the NAs were saying as they did not speak or understand Spanish and was unsure if they were discussing them (Resident 19). During an interview on 05/21/2025 at 3:52 PM, Resident 19 stated during their morning care that morning, two NAs came into their room and spoke Spanish to each other as their care was provided. Resident 19 did not say anything as they worried it would offend the NAs and affect their care. Resident 19 stated when the NAs spoke Spanish it made them feel uncomfortable. During an interview on 05/22/2025 at 3:23 PM, Resident 19 stated during their morning care two NAs came into their room to assist them in bed. Resident 19 stated one of the NA spoke in Spanish to the other NA and Resident 19 asked them to stop and not speak Spanish. Resident 19 stated they felt they had offended one of the NA as their facial expression changed and they left the room. Resident 19 stated they had not meant to offend anyone, they felt they had the right to speak up and ask the NAs to not speak Spanish as they did not understand what was being said. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 33> Review of the medical record showed Resident 33 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD -a group of lung diseases that block airflow and make it difficult to breathe), diabetes, post-traumatic stress disorder (PTSD, a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) and pain. The 02/13/2025 comprehensive assessment showed Resident 33 required substantial/dependent assistance of one to two staff members for ADLs and had an intact cognition. During an interview on 05/20/2025 at 9:11 AM, Resident 33 stated there were NAs that spoke Spanish to each other when they were having their cares provided. Resident 33 stated they do not know what they were saying as they did not understand Spanish. Resident 33 stated they did not like it and made them angry and upset. During an interview on 05/27/2025 at 8:50 AM, Staff I, NA, stated they did speak Spanish with their co-workers when they provided cares to residents. Staff I stated speaking Spanish was natural and sometimes easier to communicate faster with their co-workers. Staff I stated there had been residents that had asked them to not speak Spanish during their cares. During an interview on 05/27/2025 at 12:26 PM, Staff A, Administrator, stated staff should not be speaking Spanish around residents who did not speak or understand Spanish, when care was provided. Staff A stated residents might not know what was being said and should have language spoken around them in a language they understand. Reference WAC: 388-97-0180(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on interview and record review, the facility failed to inform residents of their rights and responsibilities and facility rules and regulations both orally and in writing upon admission and during their stay for 4 of 4 residents (Residents 2, 6, 7, and 13) reviewed for communication of resident's rights and responsibilities. This failure placed the residents at risk for the inability to execute their rights and make informed decisions about their care and services while living in the facility. Findings included . Review of a policy titled, Resident Rights - Right to Information and Communication, dated 07/2018, showed the facility would provide a notice of rights and services to the resident upon admission and during the resident's stay. The facility would inform the resident orally and in writing of their rights, rules, and regulations regarding resident conduct and resident responsibilities. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including heart failure, depression, and bacterial infections. The 03/28/2025 comprehensive showed Resident 2 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 2 had an intact cognition. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including chronic pain, anxiety, and muscle weakness. The 02/26/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff members for ADLs. The assessment also showed Resident 6 had an intact cognition. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including spina bifida (a condition that occurs when the spine and spinal cord don't form properly), takotsubo syndrome (a temporary heart condition caused by intense emotional or physical stress), and weakness. The 04/22/2025 comprehensive assessment showed Resident 7 required maximal/dependent assistance of one to two staff members for ADLs. The assessment also showed Resident 7 was cognitively intact. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required partial/maximal assistance of one staff member for ADLs. The assessment also showed Resident 13 had an intact cognition. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent observation and interview during a Resident Council (a group of residents that meet regularly to improve the quality of life and care in the nursing home) meeting held on 05/20/2025 at 10:00 AM, showed Resident 2, Resident 6, Resident 7, and Resident 10 in the main dining room, seated in their wheelchairs around a dining table. At 10:18 AM, Residents 2, 6, 7, and 10 responded no when asked if staff reviewed resident rights and the rules of the facility. At 10:17 AM, Resident 6 and Resident 7 stated they attended RC meetings regularly and there were no resident rights reviewed at the meetings. At 10:18 AM, Resident 2 and Resident 13 stated they did not received any information related to facility rules and resident rights when they were admitted . During a concurrent observation and interview on 05/23/2025 at 10:40 AM, Staff J, Admissions Director, stated during the admissions process, they gave the resident a resident's rights packet and reviewed the information with them. Staff J obtained a packet of papers clipped together titled Resident Guidebook that contained information regarding the rules of the facility, services provided, and the residents rights. During a follow up interview on 05/27/2025 at 9:07 AM, Staff J stated they had not handed out any resident guidebooks. They stated Staff K, Nursing Assistant (NA), had been doing the admissions and was handing them out. Staff J stated they did not know how residents were being informed of the rules and their rights upon admissions if the resident guidebooks were not being handed out. During an interview on 05/23/2025 at 4:48 PM, Staff K stated they were helping out with new admits. They stated they reviewed the admissions paperwork with the resident and/or their representative and gave printed copies if the resident/representative requested them. Staff K stated they did not review resident rights or rules for the facility and did not know what a resident guidebook was. Record review of the RC minutes for 01/23/2025 and 02/27/2025, showed an area on the Council Minutes form labeled Review of Resident Rights: Review at least 2 specific rights per meeting. The form was incomplete and showed no rights were reviewed at those meetings. During an interview on 05/27/2025 at 7:58 AM, Staff D, Activity Coordinator, stated they followed the paper form for recording the RC meeting minutes. They stated they tried to review two resident rights at each meeting. Staff D stated they were not at the 01/23/2025 RC meeting and was not sure why there was no review completed on 02/27/2025. Staff J stated the process for reviewing resident rights was to ensure they were reviewed at RC meetings. During an interview on 05/27/2025 at 10:41 AM, Staff A, Administrator, stated the resident rights was part of the admissions packet. They stated the resident guidebook was just implemented this week. During an interview on 05/27/2025 at 10:44 AM, Staff L, Regional Nurse Consultant, stated staff should be following the printed forms and reviewing resident rights during every RC meeting. Staff L stated the facility rules and resident rights should also be reviewed with the resident at their first care conference. Reference: WAC 388-97-0300(1)(a)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview, and record review, the facility failed to provide the required written notices and contact information for advocacy groups and how to file a complaint with the State Agency for 4 of 4 residents (Resident 2, 6, 7, and 13) reviewed for required notices and contact information. This failure placed the residents at risk for abuse, neglect, and not having rightful resources available to them. Findings included . Review of a policy titled, Resident Rights – Right to Required Notices and Contact Information, dated 07/2018, showed the facility would provide the resident with a list of names, addresses (mailing and email) and telephone numbers of all pertinent and regulatory agencies and resident advocacy groups such as the State Survey Agency and State Long Term Care Ombudsman [(ombudsman) an advocate for resident's rights in long term care) program. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including heart failure, depression, and bacterial infections. The 03/28/2025 comprehensive showed Resident 2 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 2 had an intact cognition. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including chronic pain, anxiety, and muscle weakness. The 02/26/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff members for ADLs. The assessment also showed Resident 6 had an intact cognition. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including spina bifida (a condition that occurs when the spine and spinal cord don't form properly), takotsubo syndrome (a temporary heart condition caused by intense emotional or physical stress), and weakness. The 04/22/2025 comprehensive assessment showed Resident 7 required maximal/dependent assistance of one to two staff members for ADLs. The assessment also showed Resident 7 was cognitively intact. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required partial/maximal assistance of one staff member for ADLs. The assessment also showed Resident 13 had an intact cognition. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent observation and interview on 05/20/2025 at 10:00 AM, showed four residents (Resident 2, Resident 6, Resident 7, and Resident 13) sitting at a table in the main dining room. At 10:23 AM, Resident 2 and Resident 13 stated they did not know what a Long-Term Care Ombudsman was. Both Resident 2 and Resident 13 stated they did not know when or how to contact an Ombudsman. At 10:27 AM, Resident 2, Resident 6, Resident 7, and Resident 13 stated they did not know how to contact the State Agency or why they would need to contact them. During an interview on 05/27/2025 at 8:01 AM, Staff D, Activity Coordinator, stated they reminded the residents of the poster hanging in the main entrance of the building that had the required contact information on it. Staff D stated they were not informing residents about the Long-Term Care Ombudsman or how to report to the State Agency. During an interview on 05/27/2025 at 10:50 AM, Staff A, Administrator, stated the facility had room to grow towards meeting the regulatory requirements. Reference: WAC 388-97-0300(7)(c)(d)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. AMENDED Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice [(ABN) a written notification upon a change in coverage that provides an estimated cost of services that may no longer be covered by Medicare Part A] upon a change in coverage for 1 of 3 residents (Resident 157) reviewed for liability notification requirements. This failure placed the residents at risk for the inability to make informed financial and healthcare decisions related to their stay in the facility. Findings included . Review of a policy titled, Resident Rights - Medicaid/Medicare Coverage/Liability Notice, revised 09/20/2022, showed the facility would inform residents before or at the time of admission and periodically during the resident's stay, of services available and the charges for those services, including any charges for services not covered under Medicare/Medicaid. <Resident 157> Review of the medical record showed Resident 157 was admitted to the facility with diagnoses including rib fractures, weakness, and arthritis. The 01/06/2025 comprehensive assessment showed Resident 157 required setup assistance from one staff member for activities of daily living. The assessment also showed Resident 157 had an intact cognition. Resident 157 discharged from the facility on 01/06/2025. Review of the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility, showed Resident 157 received Medicare Part A skilled services starting on 10/31/2024, with their last covered day as 12/31/2024. Resident 157 stayed in the facility and transitioned to Medicaid coverage starting on 01/01/2025. Resident 157 had remained in the facility an additional five days and discharged from the facility on 01/06/2025. Resident 157 had not been issued the required ABN. Review of Resident 157's medical record showed no documentation that an ABN was provided to the resident. During an interview on 05/27/2025 at 8:59 AM, Staff M, Business Office Manager, stated they were responsible for issuing the ABN when a resident no longer had coverage under Medicare Part A, and they stay in the facility. Staff M stated Resident 157 should have received an ABN when they came off Medicare Part A coverage on 12/31/2024 and did not discharge until 01/06/2025. During an interview on 05/27/2025 at 10:47 AM, Staff A, Administrator, stated there were some gaps identified in the liability notification process. They stated staff roles have been defined, and the process had been changed to meet regulatory requirements. Reference: WAC 388-97-0300(1)(e)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide an environment that allowed for safe care and services, adequate lighting, and use of personal items for 2 of 2 residents (Resident 4 and 13) reviewed for environment. This failure placed the residents at risk for compromised dignity, low self-esteem, and dissatisfaction with their living environment. Findings included . Review of a policy titled, Resident Rights Safe, Clean, and Comfortable Environment, dated 07/2018, showed the facility would provide a safe, clean and comfortable environment, allowing the resident to use their personal belongings. The facility would provide adequate and comfortable lighting levels. The environment would support the resident in receiving care and services safely. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including heart disease, depression, and weakness. The 02/28/2025 comprehensive assessment showed Resident 4 was dependent on one to two staff members for activities of daily living (ADLs), set up assistance of one staff member for eating and had an intact cognition. The assessment also showed, while in the facility, it was very important to take care of their personal belongings. A concurrent observation and interview on 05/19/2025 at 10:37 AM, showed Resident 4 was lying in bed, fully clothed. To the right side of the resident, there was a recliner between the bed and the wall that had personal clothing items on the seat area. Along the side of the bed, in front of the window, was an over the bed table with personal items. At the foot of the bed in front of the window, was a wheelchair with a flattened cushion and two footrests on the seat. In the corner of the room there was a stack of cardboard boxes. On top of the boxes were packages of personal wipes and briefs. There was a television hanging on the wall next to the boxes, above a dresser. There was a second over the bed table across the resident's bed (on the resident's left side). There was no space for Resident 4 to have visitors. The privacy curtain was pulled around the resident's personal space, against the side of the bed. Resident 4 stated they would like to get out of bed into their recliner but the did not bother with it because the room was too small. During a follow up interview on 05/23/2025 at 8:41 AM, Resident 4 stated they would like to use a bedside commode to help with toileting, pointed to the pulled curtain, and stated but there would be no room for it. During an interview on 05/23/2025 at 10:58 AM, Staff E, Resident Care Manager, stated housekeeping had been trying to get Resident 4 to downsize their recliner as there is no room for the chair they have. They stated the privacy curtains divided the room space and it was not equal between the two residents. <Resident 13> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, muscle weakness, depression, and unsteadiness on their feet. The 03/03/2025 comprehensive assessment showed Resident 13 required substantial/maximum assistance from one staff member for sit to stand and bed to chair transfers. The assessment also showed Resident 13 had an intact cognition. A concurrent observation and interview on 05/19/2025 at 1:48 PM, showed Resident 13 in the center room space of a three-bed room. There were two privacy curtains pulled on either side of the bed that defined the resident's living space. The bed was against the privacy curtain on the window side of the room. There was a nightstand on the door side of the room, next to the head of the bed. The over the bed table was parallel to the bed, in front of the nightstand. Resident 13 was in their wheelchair at the remaining space between the foot of the bed and the privacy curtain. There was a three foot 10-inch walking space at the end of the resident's bed to the wall that was used to access their roommate's area. The room was dimly lit. Resident 13 stated their room was too small. They stated they were unable to get to the nightstand and it was hard to get in and out of bed. During a follow up observation on 05/21/2025 at 8:34 AM, showed Resident 13 resting in bed. There was a trashcan in front of the nightstand. The bedside table was in front of the trashcan, parallel to the bed. The wheelchair was in the remaining space at the end of the bed. There was no clear access to the resident. During a follow up interview on 05/21/2025 at 10:20 AM Resident 13 stated there was no room for anything in their room. Resident 13 stated their room was dark and they were unable to see any light from the window or the hallway. There was no space for Resident 13 to have visitors. During an interview on 05/22/2025 at 12:20 PM, Staff B, Director of Nursing, stated they considered the floor space Resident 13's roommate used to get to their living area would be considered as part of Resident 13's usable living space, despite their inability to put personal items in that area. During an interview on 05/21/2025 at 2:03 PM, Staff A, Administrator, stated the walk-through area at the end of Resident 13's bed was not usable living space for the resident. They stated Resident 13 didn't have much room for their living area. A concurrent observation and interview on 05/22/2025 at 12:20 PM, showed Resident 13 had moved into a two-bed room. Resident 13 was sitting in their wheelchair next to their bed, looking out of the window. Their bed was centered with a nightstand between the bed and window, with space for the resident to access the nightstand. There was a chair against the wall for visitors to use. Their bedside table was on the door side of the room with ample space for the resident to move about their area. Resident 13 was smiling and stated they liked their new room. They stated they had a window they could look out of and room to move around. Resident 13 stated there was plenty of light and room for their belongings. During an interview on 05/22/2025 at 4:35 PM, Staff E stated Resident 13 did not like their room. They stated there was not enough room for three residents to live comfortably in one room. Staff E stated when there were three residents in one room and they needed to use the mechanical lift for transfers, it was not safe due to the lack of room space. Reference: WAC 388-97-0880(1)(5)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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] group for 3 of 4 residents (Resident 6, 2, and 7) reviewed for grievances. Additionally, the facility failed to ensure residents were not in fear of retaliation for reporting identified concerns for 3 of 5 residents (Resident 3, 13, and 2) reviewed for the grievance process. 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 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. Review of a policy titled, Resident Rights Grievances, revised 12/2020, showed any resident or there representative, family member, or appointed advocate may file a grievance without fear of discrimination, threat, or reprisal (retaliation) in any form. <Identified Concerns/Feedback> <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including a urinary tract infection, muscle weakness, and chronic pain. The 02/26/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff members for activities of daily living (ADLs) and required set up assistance of one staff member for eating and oral hygiene. The assessment also showed Resident 6 had an intact cognition. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including heart failure, diabetes (a group of diseases that result in too much sugar in the blood), and kidney disease. The 03/28/2025 comprehensive showed Resident 2 was dependent on one to two staff members for ADLs and required set up assistance of one staff member for eating, oral cares, and personal hygiene. The assessment also showed Resident 2 had an intact cognition. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including spina bifida (a condition that occurs when the spine and spinal cord don't form properly), diabetes, and heart failure. The 04/22/2025 comprehensive assessment showed Resident 7 required maximal/dependent assistance of one to two staff for ADLs and set up assistance of one staff member for eating. The assessment also showed Resident 7 was cognitively intact. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the RC minutes dated 01/23/2025, showed the residents requested additional arts and crafts supplies on the library cart, were interested in having a Spanish language class, and preferred the 2:00 PM activities over morning activities. Record review of the RC minutes dated 02/27/2025, showed no response to the RC requests/recommendations made at the 01/23/2025 meeting. Additionally, the RC requested the addition of Wii games (an interactive video gaming console), gardening, and more activities in the evening at 3:00 PM before dinner time. Record review of the RC minutes dated 03/27/2025, showed no response to the requests/recommendations made at the 01/23/2025 and 02/27/2025 meetings. Additionally, at the 03/27/2025 RC meeting, the RC again requested activities to be scheduled at 2:00 PM or later and would like bus rides added to the activities calendar. Record review of the RC minutes dated 04/23/2025, showed no response to the previous 01/23/2025, 02/27/2025, and 03/27/2025 RC requests. During a RC meeting dated 05/20/2025 at 10:02 AM, Resident 6 stated they regularly attended the RC meetings. They stated the Staff D, Activities Coordinator, took minutes during the RC meetings but residents never got to review those minutes. Resident 6 stated there was no feedback provided to the residents or the RC at the next meeting. During the same meeting at 10:04 AM, Resident 2 stated they rarely attended RC meetings. They stated they never hear back from the facility when ideas were brought up during the RC meetings. Also, at 10:04 AM, Resident 7 stated they attended the RC meetings regularly. They stated things that were talked about during the RC meetings were not followed up on by the facility. During an interview on 05/27/2025 at 7:53 AM, Staff D stated that concerns or recommendations brought up at the RC meetings were passed on to the appropriate departments, unless they were converted into grievances. All grievances followed the grievance process and went to the Administrator for review. Staff D stated the feedback for specific activities such as the request for increased arts and crafts included having arts and crafts once a month and they added the Spanish language lessons to the next activities calendar. Staff D stated the process would be to follow up with the residents at the RC meetings. Record review of the Activities Calendar dated May 2025, showed no scheduled Spanish language lessons. During an interview on 05/27/2025 at 10:34 AM, Staff A, Administrator stated the process for providing feedback to RC included a review of the concerns and recommendations brought forth by the RC group. They stated after the review; the facility would work to resolve those identified concerns/recommendations and report the findings and/or resolutions back to the RC president and the RC group. Staff A stated that going forward, they would ensure the process for feedback to the RC group would meet the regulatory requirements. <Retaliation> <Resident 3> (continued on next page)

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	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, diabetes (a group of diseases that result in too much sugar in the blood), anxiety, and depression. The 02/25/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for activities of daily living (ADLs) and required set up for eating/oral cares. The assessment also showed Resident 3 had an intact cognition. Record review of a grievance dated 01/02/2025, showed Resident 3 reported they did not feel comfortable complaining because social services staff had confronted them when they had reported two grievances in the past. Review of the investigation and resolution to Resident 3's grievance showed no resolution to their concerns related to feeling uncomfortable with reporting. During an interview on 05/21/2025 at 8:36 AM, Resident 3 stated they would not report any concerns to the staff. They stated the last time they reported something they got in trouble. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required partial/maximal assistance of one staff member for ADLs. The assessment also showed Resident 13 had an intact cognition. During a concurrent interview at a Resident Council (a group of residents that meet regularly to improve the quality of life and care in the nursing home) meeting on 05/20/2025 at 10:07, Resident 13 stated they would not report any concerns/file a grievance because they did not know what would happen to them if they reported. Resident 2 stated they would not report a concern or file a grievance for fear of retaliation. During an interview on 05/27/2025 at 8:31 AM, Staff C, Social Services Director, stated the process for ensuring a resident is protected from retaliation included informing Staff A, Administrator, of the grievance or concern and both Staff C and Staff A would meet with the resident, in a private area, to discuss the concern. Staff C stated the process included changing the care staff for that resident if necessary. During a concurrent interview on 05/27/2025 at 10:53 AM, Staff A stated the process was to bring forth and complaint or concern to ensure the investigation would be completed swiftly and privately. Staff L, Regional Nurse Consultant, stated the process included informing the residents that they could report any concerns and if a resident expressed concerns about fear the facility would address that. Reference: WAC 388-97-0460(1)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate and take preventative action following an avoidable accident for 1 of 2 residents (Resident 3) reviewed for falls. This failure placed the resident at risk for additional falls, serious injury, and death. Findings included . Review of a policy titled, Quality of Care Accident Hazards/Supervision/Devices, dated 07/2018, showed when a fall occurred, the facility would determine what may have caused or contributed to the fall. Assistive devices and equipment would be used and maintained according to the manufacturer's recommendations. Staff would be trained on the use of assistive devices and transfer equipment. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, depression, weakness, and need for assistance with personal care. The 02/20/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for activities of daily living, including transfers. The assessment also showed Resident 3 was cognitively intact. During an interview on 05/19/2025 at 11:06 AM, Resident 3 stated the staff had dropped them from a mechanical lift during a transfer. They stated the mechanical lift tipped over and they fell onto a shower chair, causing pain to their right shoulder and neck. Review of a facility investigation dated 02/08/2025, showed Resident 3 was being transferred from their bed to a shower chair by a shower aide and a nursing assistant (NA), with the use of a mechanical lift. The investigation showed the NA was preparing to give Resident 3 a shower. Due to the resident's weight, the mechanical lift tilted, and staff assisted the resident safely back in preventing a fall. The investigation showed no interview with Resident 3. There were no observations of staff performing mechanical lift transfers during the investigation or interviews with other residents and staff that used the mechanical lifts. There was no documentation that the Maintenance Director had inspected the mechanical lift and found no defects. There was no education provided to the NA or shower aide involved in the incident to prevent further falls with mechanical lift use. During an interview on 05/27/2025 at 11:25 AM, Staff L, Regional Nurse Consultant, stated the investigation was poorly done. They stated there were many pieces missing, including education. Staff L stated there was no prevention in place to prevent future incidents. Reference: WAC 388-97-0640(6)(a)(b)

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	505126	A. Building B. Wing	05/27/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed hold at the time of transfer to the hospital for 2 of 2 residents (Resident 50 and 27) reviewed for hospitalization. This failure placed the residents at risk of not having the necessary information to make an informed decision regarding their ability to return to the facility, Findings included . <Resident 50> Review of the medical record showed Resident 50 was admitted to the facility with diagnoses including Parkinsonism (a group of movement disorders such as slow movement, stiffness, and tremors), diabetes (a group of diseases that result in too much sugar in the blood), and heart failure. The 04/24/2025 comprehensive assessment showed Resident 50 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 50 had a severely impaired cognition. Record review of nursing progress notes (PN) dated 04/23/2025, showed Resident 50 was not responding verbally, more sleepy than usual, and refusing their medication. The facility's provider assessed the resident and ordered Resident 50 to be transferred to the hospital for evaluation and treatment. Further review of the PN showed there was no documentation that a bed hold notification was completed at the time of transfer. <Resident 2> Review of the medical record showed Resident 27 was admitted to the facility on [DATE] with diagnoses including quadriplegia (the complete or partial paralysis of all four limbs), depression, and chronic pain. The 03/22/2025 comprehensive assessment showed the resident required total assistance of one to two caregivers for all ADLs and was cognitively intact. Record review of the PN dated 02/15/2025, showed Resident 27 had swelling and pain of both lower legs. The physician and family were notified and requested the resident be transferred to the hospital for evaluation and treatment. Further review of the progress note showed there was no documentation that a bed hold notification was completed at the time of transfer. During an interview on 05/21/2025 at 11:25 AM with Staff F, Resident Care Manager (RCM), they stated if there was no notification in Resident 27's record that a bed hold had been given at the time of discharge, it must have been missed. During an interview on 05/27/2025 at 9:25 AM, Staff B, Director of Nursing, stated the process for bed hold notification at the time of transfer was to speak to the resident and/or their representative to explain the bed hold and obtain the signature. Staff B stated in that situation, the resident was not responding, and the resident representative was overwhelmed with the Resident 50's current situation. Staff B stated the facility should have followed up with the representative and obtained the bed hold within the required time frame. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/2025 at 11:02 AM, Staff L, Regional Nurse Consultant, stated the standard requirement for bed hold included a 24-hour follow-up with the resident/representative with a nursing progress note that showed the follow-up was completed. Reference: WAC 388-97-0120(4)(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Level II Preadmission Screening and Resident Review [(PASARR) a federal requirement to ensure individuals were not inappropriately placed in nursing homes for long term care] evaluations were not completed prior to admission for 3 of 5 residents (Resident 3, 42, and 10) reviewed for PASARR. This failure placed the residents at risk for inappropriate long term care placement and not receiving necessary mental health care and services. Findings included . Review of a policy titled, Resident Assessment - Preadmission Screening and Resident Review (PASRR), dated 11/2017, showed prior to admission, individuals identified with a mental disorder or intellectual disability were evaluated and received care and services appropriate to their needs. The PASARR screening would be completed prior to admission. The facility would not admit any new residents with a mental disorder/intellectual disability unless the State mental health authority has determined if the individual required specialized services. Specialized services would be offered to individuals in accordance with the determination of the appropriate state designated authority. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including major depressive disorder (a serious mental illness that causes a persistent low mood, loss of interest in activities, changes in sleep, appetite, energy, and concentration), and adjustment disorder with mixed anxiety and depressed mood (a blend of symptoms related to both anxiety and depression in response to a specific stressor). The 02/25/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for activities of daily living (ADLs) and required set up for eating/oral cares. The assessment also showed Resident 3 had an intact cognition. Record review of Resident 3's Level I PASARR form, completed 03/11/2025, showed the resident had mood and psychotic disorders. The form showed a Level II evaluation was required. There was no documentation in the record that a Level II evaluation had been completed. <Resident 42> Review of the medical record showed Resident 42 was admitted to the facility on [DATE] with diagnoses including dementia with behaviors and depression. The 03/10/2025 comprehensive assessment showed Resident 42 required moderate assistance of one caregiver for ADLs and had a moderately impaired cognition. Record review of Resident 42's Level I PASARR forms, the first one initially completed on 12/02/2024 with no level II listed as required, though the diagnoses of dementia and depression were on the admission diagnosis list. The second PASARR was dated 03/08/2025 and not completed or signed as requiring a level II evaluation. Further there was no documentation in the record that a Level II evaluation had been completed. <Resident 10> (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 10 was admitted to the facility with diagnoses including stroke, panic disorder (a mental and behavioral anxiety disorder with sudden periods of intense fear), major depressive disorder (a serious mental illness that causes a persistent low mood, loss of interest in activities, changes in sleep, appetite, energy, and concentration), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity level, and concentration) , and post-traumatic stress disorder (PTSD, a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event). The 03/04/2025 comprehensive assessment showed Resident 10 was dependent on one to two staff members for ADLs and required set up for eating/oral cares and had an intact cognition. Record review of Resident 10's Level I PASARR form, undated, showed the resident had mood and psychotic disorders. The form showed a Level II evaluation was required. There was no documentation in the record that a Level II evaluation had been completed. During an interview on 05/21/2025, Staff C, Social Services Director, stated Resident 3 had a Level II referral that had been sent into the evaluator. They stated the evaluator had not been sending the evaluations back. Staff C stated the company that is processing the Level II evaluations had a backlog and have not yet caught up with the backlog. Staff C stated they last contacted the evaluator on 03/06/2025 to follow up on the backlogged evaluations. Staff C stated the process was to ensure the hospital completed the Level II referral and evaluation prior before the resident was admitted . They stated the facility was admitting residents even though we don't have the right paperwork. Staff C stated the previous administrator was aware of the concerns and that it was a broken process. During an interview on 05/27/2025 at 9:29 AM, Staff B, Director of Nursing, stated the facility admissions director was providing education to the hospitals to ensure accuracy of the PASARR on admission. During an interview on 05/27/2025 at 11:05 AM, Staff A, Administrator, stated the PASARR Level II evaluation backlog was a Statewide issue. They stated they were aware that the PASARR Level II evaluation should be completed prior to admission. Reference: WAC 388-97-1915(2)

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	505126	A. Building B. Wing	05/27/2025

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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 record review and interview, the facility failed to ensure services provided met professional standards of practice for 1 of 5 residents (Resident 13) reviewed for physician orders. This failure placed the resident at risk for medication errors and adverse outcomes. Findings included . Review of a policy titled, Physician Services, dated 06/2018, showed the physician would communicate directly to a licensed nurse any changes to a resident's plan of care for timely implementation of new orders. <Resident 13> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, depression, weakness, and need for assistance with personal care. The 02/20/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for activities of daily living, including transfers. The assessment also showed Resident 3 was cognitively intact. Record review of physician progress notes (PPN) dated 05/20/2025, showed Resident 13 reported persistent pain in their right hip. They stated their current dose of hydrocodone [(Norco) narcotic pain medication used to treat moderate to severe pain] 5 milligrams [(mg) a unit of measurement] had been ineffective. Further review of the PPN showed the physician's plan that included increasing the Norco 5 mg to Norco 10 mg every six hours as needed for pain. The plan also showed the physician would order a renal function panel (a group of blood tests used to evaluate the kidneys' ability to filter waste and fluids from the blood, and maintain electrolyte balance) and, if stable, they would increase the resident's lisinopril (a medication used to treat high blood pressure) from 2.5 mg to 5 mg daily. During an interview on 05/23/2025 at 1:07 PM, Staff E, Resident Care Manager (RCM), stated the process for receiving physician orders included the physician entering the orders into the computer system. They stated they checked for pending orders after the physician was done rounding on residents. Staff E stated they were not aware of the physician's orders related to the medication changes and they did not review the PPNs after a resident was seen. Staff E stated they did not know if anyone read those notes. During an interview on 05/23/2025 at 1:23 PM, Staff B, Director of Nursing, stated they expected the RCMs to review the PNN the same day as the physician made their rounds. During an interview on 05/23/2025 at 1:55 PM, Staff E stated they had contacted Staff BB, Medical Director, and they stated they did not change the Norco order because Resident 13 had controlled pain at the lower dose, despite the PPN that showed the 5 mg pain medication was ineffective. At 2:06 PM, Staff E stated they spoke with Resident 13, and they wanted an increase in their dosage of pain medication. Staff E stated they contacted Staff BB, and they were agreeable to the increase. During a follow up interview on 05/27/2025 at 10:20 AM, Staff E stated they had reviewed the PPN dated 05/20/2025 that showed increase lisinopril from 2. 5 mg to 5 mg. Staff E stated when they reached out to Staff BB regarding the pain medications, Staff BB stated to increase the lisinopril to 5 mg. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/2025 at 10:05 AM, Staff BB stated they were unaware the lisinopril had been increased. They stated they completed an exam on Resident 13 on 05/20/2025 and 05/24/2025 and their blood pressures were normal. Staff BB stated they would have expected a call from the nursing staff regarding the lisinopril order and they would have had a conversation with the nurses regarding the blood pressures and changing the dose. Staff BB stated the nursing staff should be reviewing the assessment and plan on the PPN after rounding. During an interview on 05/27/2025 at 11:24 AM, Staff L, Regional Nurse Consultant, stated the facility needed to look at a process to streamline the process of reviewing PPNs. Reference: WAC 388-97-1620(2)(b)(i)(ii)

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	505126	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities for 6 of 6 residents (Resident 2, 6, 7, 13, 19, and 34) reviewed for activities. This failure placed the residents at risk for dissatisfaction with their activity choices, poor psychosocial well-being, and boredom. Findings included . Review of a policy titled, Quality Of Life Activities, dated 11/2017, showed the facility would provide an ongoing resident centered activities program to support the residents in their choice of activities. The programs would be based on the comprehensive assessment, care plan, and preferences of each resident to support their physical, mental, psychosocial well-being, and independence. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including diabetes (a group of diseases that results in too much sugar in the blood), depression, and anxiety. The 03/28/2025 comprehensive assessment showed Resident 2 was dependent on one to two staff members for activities of daily living (ADLs), set up assistance from one staff member for eating and personal hygiene, and had an intact cognition. The assessment also showed it was very important for them to have books, newspapers, and magazines to read, and to be around animals/pets. It was somewhat important for Resident 2 to keep up with the news, do their favorite activities, and participate in religious services/practices. Review of a care plan dated 05/23/2024, showed Resident 2's preferred activities were watching television, reading, word search, relaxing, and napping. During an interview on 05/20/2025 at 10:48 AM, Resident 2 stated they had asked Staff D, Activities Coordinator, if the facility had a sewing machine for resident use. They stated they were told no and were not offered any other options. Resident 2 stated they enjoyed sewing and needle work and would attend a sewing group if it were offered. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including a urinary tract infection, chronic pain, and anxiety. The 02/26/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff members for ADLs, set up for eating, and had an intact cognition. The assessment also showed Resident 6 felt down, depressed, or hopeless almost every day. Review of an activity assessment dated [DATE], showed Resident 6 wanted to be invited to group activities and preferred to join in social activities. The assessment showed Resident 6 enjoyed crochet, gaming, and bingo. Spiritual/religious activities were very important to them. The assessment activity summary showed . has little interest in group programs such as bingo, games, special events .likes to watch television, reading, crochet, word search, visiting with family and relaxing. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/20/2025 at 10:49 AM, Resident 6 stated there were not many activities at the facility that interested them. They stated at their previous facility, they had knitting, crocheting, and woodworking. Resident 6 stated they wanted to have their personal sewing machine from home but was told there was no space for it. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including takotsubo syndrome (a temporary heart condition where the heart muscle weakens and changes shape), diabetes, and heart failure. The 04/22/2025 comprehensive assessment showed Resident 7 was dependent on one to two staff members for ADLs, set-up for eating, and was cognitively intact. The assessment also showed it was very important for Resident 7 to have books, newspapers, and magazines to read, listen to music they liked, do things with groups of people, do their favorite activities, get fresh air, and participate in religious services/practices. Review of an activity assessment dated [DATE] showed Resident 7 wanted to be invited to group activities and would join in social activities. Resident 7 identified their hobbies as working puzzles, using their iPad, doing crafts, and reading. Spiritual/religious habits were very important to Resident 7. The activity summary showed Resident 7 .has little interest in group programs and prefers to schedule their own activities .likes to watch television, watching videos, puzzles, crafts outdoors .visiting with other residents. During an interview on 05/20/2025 at 10:50 AM, Resident 7 stated there was not much to do for activities. They stated they would like to go out on the bus and would participate in a lady's craft group and would enjoy doing cross stitch work. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required set-up/moderate assistance of one staff member with ADLs and was cognitively intact. Record review of an activities assessment dated [DATE], showed Resident 13 did not want to participate in group activities and preferred to be alone. The assessment showed they did like to gamble. The activity summary showed Resident 13 .liked to watch television, reading, relaxing, and napping . During an interview on 05/20/2025 at 10:51 AM, Resident 13 stated they liked to watch television. They stated the television in their room had no sound and channels were missing or frozen (the screen was unresponsive and showing the same image). Resident 13 stated they loved to watch the news and playing cards. They stated they would like to play cards and games with other residents. <Resident 19> Review of the medical record showed Resident 19 was admitted to the facility with diagnoses including diabetes, kidney disease and weakness. The 03/10/2025 comprehensive assessment showed Resident 19 required substantial/dependent assistance of one to two staff members for ADLs and had an intact cognition. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 19's care plan showed they preferred watching television, reading, electronics, word search, and visiting with family and friends. The care plan also showed Resident 19 had no interest in group programs and preferred to engage in self-directed activities. During an interview on 05/19/2025 at 1:25 PM, Resident 19 stated they wished the facility had different options and more stimulating activities for them. Resident 19 stated they enjoyed pet therapy visits. Resident 19 stated the visits lasted a few minutes and wished they were longer. During an interview on 05/23/2025 at 4:31 PM, Resident 19 stated activities they enjoyed were card games, country music and reading. Resident 19 stated these activities were not offered for individuals or small groups of people that did not like large groups and did not know if the facility had any books available to read. Resident 19 also stated there was nowhere else to go in the facility outside of their room, unless they participated in a group activity. <Resident 34> Review of the medical record showed Resident 34 was admitted with diagnoses including abdominal aortic aneurysm (a bulge or weakness in the wall of the aorta, the main artery carrying blood from the heart), schizophrenia (a serious mental health condition, that affects how people think, feel and behave) and weakness. The 04/22/2025 comprehensive assessment showed Resident 34 required substantial/dependent assistance of one to two staff for ADLs and a moderately impaired cognition. Record review of Resident 34's care plan showed they had little interest in group activities and preferred self-directed activities. The care plan also showed the resident enjoyed watching television, the facility daily chronicle (a flyer that contains historical facts and the daily activities) and napping. Record review of Resident 34's activity log dated 04/25/2025 to 05/24/2025 showed Resident 34 was observed to have watched television as their activity performed each day. During an observation and interview on 05/23/2025 at 3:55 PM, Resident 34 was lying in their bed, room lights off and privacy curtains on both sides of the residents' bed were extended to the length of their bed and a blank wall in front of their bed. Resident 34 stated they stay in their bed most of the day and did not do anything. Resident 34 stated they would like to watch television if they had one. During an observation and interview on 05/27/2025 at 9:42 AM, Resident 34 was sitting on the edge of the bed, room was dark, privacy curtains on both sides of resident's bed were extended to the length of their bed, and a wheelchair next to the bed. Resident 34 stated they did nothing all weekend. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/27/2025 at 8:06 AM, Staff D, Activity Coordinator, stated they completed an initial activity's interview and created a care plan based on the interview. They stated residents were provided with the monthly activities calendar and were encouraged to attend the group activities. Staff D stated they provided one on one in room visits to the residents if the resident was unable or unwilling to attend the group activities. They stated they passed the Daily Chronicle and wrote the activities for that day on the back of the paper. Staff D stated they were aware that residents wanted a sewing machine and needle crafts (crochet, knitting, and needlepoint). They stated they were not aware that residents wanted to play cards and/or games. Staff D stated most residents spend their time on their phone or iPad. They stated the residents did not have access to a newspaper but could watch the news on their television. Staff D stated the facility did not have a puzzle/game room available for resident use. Record review of the May 2025 activities calendar showed two days with arts and crafts, no religious services, no card games, no news groups, and no sewing/needle craft groups. During an interview on 05/27/2025 at 11:07 AM, Staff A, Administrator, stated they had met with Staff D and reviewed the activities provided to the residents. Staff A stated they expected the activities department to provide activities to all residents of the facility, despite any cognitive impairments. Staff A stated the facility had room to grow with activities for residents. Reference WAC: 388-97-0940(1)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 of 3 residents (Resident 4 and 46) reviewed for quality of care. 1.) Resident 4 was not assessed and evaluated for their mobility needs to ensure an appropriate wheelchair was provided for safety and comfort. 2.) Resident 46 was not provided their long-term use medications upon admission for chronic pain and depression. These failures placed the residents at risk for pain, isolation, and worsening of their medical conditions. Findings included . <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including heart disease, muscle weakness, and lack of coordination. The 02/28/2025 comprehensive assessment showed Resident 4 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 4 was cognitively intact. During a concurrent observation and interview on 05/19/2025 at 10:37 AM, showed Resident 4 lying in bed. There was a wheelchair located at the end of the bed against the wall that had a flattened cushion on the seat. Resident 4 stated they did not get out of bed because their wheelchair was terrible and not comfortable. They stated they would like to go outside, to the dining room, and bingo. Resident 4 stated they went shopping to the mall, once every three months and would like to go more often. They stated they were not able to tolerate the wheelchair for more than a short trip. Resident 4 stated when they came back from shopping, they were in pain due to their back and legs hurting. During an interview on 05/21/2025 at 2:38 PM, Staff Q, Nursing Assistant (NA), stated Resident 4 only got out of bed when they went shopping. They stated Resident 4 complained that their wheelchair was uncomfortable and was in pain when they returned from shopping. Staff Q stated they let the nurse know that Resident 4 was uncomfortable and in pain when sitting in their wheelchair. During an interview on 05/21/2025 at 2:41 PM, Staff E, Resident Care Manager (RCM), stated the process for wheelchair evaluations included obtaining a referral for therapy to assess the resident. They stated they had not received any concerns regarding Resident 4' s wheelchair. Staff E stated the nursing assistants should be reporting these concerns to the nurses. During a follow up interview on 05/22/2025 at 11:30 AM, Resident 4 stated staff changed the cushion on their wheelchair on 05/21/2025. They stated the cushion was not the problem, it was the back of the chair that was stiff and did not allow them to recline. Resident 4 stated they did not want to be in bed all day. They stated their wheelchair was uncomfortable and they could not sit in it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/22/2025 at 11:47 AM, showed Staff R, NA, assisting Resident 4 into their wheelchair. Resident 4 was sitting at a 90-degree angle and had three inches on either side of their hips. There legs were dangling four inches off the floor. Staff R stated they tried to get Resident 4 out of bed every day because they had not been out of bed for a long time. Staff R stated Resident 4 was very uncomfortable in their wheelchair. They stated they reported that to the nursing staff and was told that it was okay for Resident 4 to stay in bed. Resident 4, smiling, stated they liked being up, they could see out their window and maybe even go outside. During an interview on 05/23/2025 at 8:06 AM, Staff G, Therapy Director, stated the first step for wheelchair concerns would be to modify the current wheelchair and replace the cushions if they were past life expectancy. They stated they would look at strengthening for repositioning and educate staff for proper positioning. Staff G stated they would monitor to see if the modifications and education was successful. The last effort would be to purchase a new wheelchair. They stated concerns were brought to them the previous day regarding positioning for Resident 4. Staff G stated the cushion in the wheelchair was not appropriate and they had reached out to their wheelchair supplier that morning to address the wheelchair concerns. Staff G stated the facility did not have a process for wheelchair evaluations. During an interview on 05/27/2025 at 9:33 AM, Staff B, Director of Nursing, stated the therapy department worked with nursing to ensure wheelchairs were properly fitted to the residents. They stated staff should have reported the concerns with Resident 4's wheelchair to management to ensure therapy followed up with an evaluation. During an interview on 05/27/2025 at 11:18 AM, Staff A, Administrator, stated the process for wheelchair evaluations and positioning included a referral to therapy for an assessment, evaluating the current wheelchair and positioning, and making changes as necessary. Staff A stated they would have expected the staff to act on Resident 4's concerns sooner. <Resident 46> Review of the medical record showed Resident 46 was admitted to the facility on [DATE], with diagnoses including fracture of the left patella (knee), a right lower leg amputation, depression, chronic pain, and insomnia (difficulty, falling and/or staying asleep). The 03/12/2025 comprehensive assessment showed Resident 46 required assistance of one to two staff members for mobility and transfers, had moderate to severe depressive symptoms and was cognitively intact. During an interview on 05/20/2025 at 8:43 AM, Resident 46 stated they had a terrible time getting their medications as ordered on admission which had caused both pain and withdrawal symptoms. They stated the first few days in the facility were hell and they couldn't figure out what was wrong with them. Resident 46 stated they could not think clearly, was crying all the time, was nauseated, had stomach pains and diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview Resident 46 stated they found out after questioning the medication nurses, their pain medication that was supposed to be given every six hours was not given as it was not available until two days after admission. Resident 46 stated they had been taking the narcotic pain medication oxycodone 15 milligrams (mg) every day, every four hours for multiple chronic pain disorders for the past 15 years. In addition, Resident 46 stated they had been on the medication Seroquel (a prescription antipsychotic medication used for mental illness) 50 mg for depression and a sleep disorder for the past four months and unknown to them, it was discontinued on admission by the admitting physician and replaced with the over-the-counter supplement Melatonin (a naturally occurring hormone in the body that regulates wake-sleep cycles). Resident 46 stated no one in the facility had informed them that these medications were not being given as ordered on discharge from the hospital and the sudden stopping of these medications caused them a lot of distress, increased pain and inability to sleep. Further, during the same interview Resident 46 stated their oxycodone had not been reordered in May 2025 causing them to be without again for a whole day and stated the nurses told them it had not been reordered, and they had none in the facility to give them. In addition, Resident 46 stated the Seroquel and been stopped and restarted two more times since admission. Resident 46 stated they had been informed by their previous physicians that neither oxycodone or Seroquel should be stopped suddenly and needed to be tapered off or serious symptoms of withdrawal could occur and believed to have been in withdrawal each time these medications were suddenly stopped as they had felt miserable and with increased pain, anxiety and depressive symptoms. Review of the medication Seroquel in Medscape (a leading online resource for healthcare professionals and provides detailed information on drugs, diseases and procedures) showed Seroquel was the brand name for the medication quetiapine and was primarily prescribed to improve mood, thoughts and behaviors in mental health disorders. Caution warnings for the medication showed potential for withdrawal symptoms after abrupt discontinuance can lead to withdrawal symptoms like nausea, vomiting, dizziness and difficulty sleeping and should be tapered off gradually. Review of the medication Oxycodone in Medscape showed it was a narcotic opioid medication (a class of drugs that are used for pain relief but also have the potential for abuse and addiction) used for moderate to severe pain and caution warnings include, do not discontinue the medication with a patient physically dependent on opioids abruptly, withdrawal symptoms include increased pain, irritability, agitation, trouble concentrating, nausea, vomiting, diarrhea, muscle and stomach cramping, and difficulty sleeping. Review of Resident 46's admission assessment and physician orders dated 03/10/2025 showed the resident was admitted to the facility at 3:00 PM with orders from the hospital discharge reading oxycodone 15 mg. every six hours as needed and Seroquel 50 mg one to two tablets every evening. The admission order further showed the Seroquel was discontinued on admission by the facility admitting physician and Melatonin was started at 6 mg every evening. Review of Resident 46's medication administration records (MARS) for March 2025 showed oxycodone 15 mg every six hours as needed was ordered on 03/10/2025 on admission and the first dose given was on 03/12/2025 at 2:43 AM, almost 36 hours after admission to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition to the medication Seroquel being discontinued on 03/10/2025, review of Resident 46's MARS for April 2025 and May 2025 showed the medication was restarted on 04/04/2025 and discontinued on 04/11/2025 and again restarted on 05/01/2025 and discontinued on 05/06/2025. Further review of Resident 46's MARS from 03/12/2025 through 05/21/2025 showed they requested oxycodone 15 mg every day from two to four times daily. Review of Resident 46's MARS for May 2025 showed the resident received Oxycodone 15 mg on 05/18/2025 at 2:04 PM and not again until 05/19/2025 at 10:00 PM, 20 hours after their last dose. Review of Resident 46's provider notes showed in part on the 03/11/2025 visit the provider stated, on my arrival to the building today I was notified the patient was leaving against medical advice (AMA) due to people screaming all night, the food was terrible, and she did not receive her proper pain medication. On a 04/04/2025 provider visit it stated in part, Patient requested to be seen because they were having insomnia and was requesting Seroquel. They stated they had been taking 50 mg and was on the medication for four months which was effective only to be discontinued when they came to this facility. We discussed restarting it at 25 mg for two weeks then we will reevaluate. They agreed to this plan. On a 05/01/2025 provider visit it stated in part, Patient is tearful and in distress, we did complete a depression scale test, it was greater than 15 indicating moderate to severe depression. Discussed adding Seroquel as an adjunct therapy to their deep depression 25 mg nightly and they were agreeable with this plan of care. On a 05/07/2025 provider visit it stated in part Patient has complaints that their Seroquel has been taken away and that they did get a couple of good night's sleep with it and had been feeling better. There was concern for heart issues with other medications they were on, and the Seroquel and they did ultimately agree with the orders that were placed to discontinue the Seroquel. On a 05/19/2025 provider visit it stated in part, Patient has multiple questions about their psychotropic medications [Resident 46] continues to feel that [Resident 46] needs the Seroquel for their adjunct to depression. During an interview on 05/21/2025 at 11:10 AM, Staff F, RCM, stated they had only recently been hired and taken the RCM position and knew there had been some problems with getting medications ordered and reordered timely in the past. Staff F stated the new facility administration was working on making this a seamless process and could not speak to missed medications or standards of practice in tapering medications prior to their employment in the facility. During an interview on 05/27/2025 at 11:15 AM, Staff BB, Medical Director, stated the decision to taper a medication was dependent on several factors and would need to review the record and discuss the issues with the resident before making a determination. Reference: WAC 388-97-1060(1)

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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, including staff training, to prevent an avoidable fall for 1 of 2 residents (Resident 3) 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. Staff would be trained on the use of assistive devices and transfer equipment. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including respiratory failure, diabetes (a group of diseases that result in too much sugar in the blood), anxiety, and depression. The 02/25/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for activities of daily living (ADLs) and required set up for eating/oral cares. The assessment also showed Resident 3 had an intact cognition. Record review of a facility investigation dated 02/08/2025, showed Resident 3 was sitting on a shower chair with a mechanical lift tipped over, a nursing assistant (NA) and shower aide were present. The investigation showed the NA was preparing to give Resident 3 a shower and was lifted with the mechanical lift. The mechanical lift tilted due to the resident's weight; staff assisted the resident safely back preventing fall. During an interview on 05/19/2025 at 11:06 AM, Resident 3 stated staff had dropped them from the mechanical lift about a month ago. They stated the mechanical lift tipped over during a transfer from their bed to a shower chair. Resident 3 stated there were two NAs using the mechanical lift. They stated one NA was running the remote while the other was behind them, pulling back on the sling. Resident 3 stated, as they were being pulled back into the chair, the mechanical lift tipped over and they fell onto the shower chair, breaking the wheel off the chair. Resident 3 stated their lower hips and shoulder were half off the shower chair and their head was pinned against the armrest of the chair. They stated they had right shoulder and neck pain after the fall. During an interview on 05/21/2025 at 10:16 AM, Staff S, NA, stated they were transferring Resident 3 on the mechanical lift with assistance from a shower aide. They stated during the transfer, the mechanical lift went to one side, tipped over, and the resident was dumped into the shower chair. Staff S stated the shower aide was behind the resident and pulled them hard to position them over the shower chair and pulled us over. They stated the facility removed the lift from the floor after the fall because it was defective (broken). Staff S stated they had received training on use of the mechanical lift. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/2025 at 10:27 AM, Staff T, Registered Nurse, stated Resident 3 was being transferred to a shower chair and the mechanical lift tipped over on the resident. They stated the lift malfunctioned, but did not know what was not working properly. Staff T stated they assessed Resident 3 who complained of right shoulder pain. An x-ray was taken and showed no new injury. They stated Resident 3 had chronic shoulder pain and the fall had made the pain more intense. Staff T stated the mechanical lift was removed from the floor and a maintenance request was completed to repair the mechanical lift. During an interview on 05/21/2025 at 11:14 AM, Staff U, Maintenance Director, stated all mechanical lifts received preventative maintenance monthly. They stated after the incident; they inspected the mechanical lift and found no defects. They stated the only way a mechanical lift would tip over would be if the stabilizing legs were not properly extended. Staff U stated the resident ' s weight (greater than 400 pounds), along with the improper extension of the legs would cause the center of gravity to shift and the mechanical lift would tip over. Staff U stated that was most likely the cause of the fall. During an interview on 05/27/2025 at 3:13 PM, Staff L, Regional Nurse Consultant, stated they were unable to locate a mechanical lift competency/training for Staff S, so as of now, they don't have it (training). Reference: WAC 388-97-1060(3)(g)

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	505126	A. Building B. Wing	05/27/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. The facility failed to develop and implement a scheduled toileting program (a process of taking a person to the bathroom at pre-determined intervals to facilitate bowel and bladder emptying) for 1 of 3 residents (Resident 4) reviewed for bowel and bladder incontinence. This failure placed the resident at risk for skin break down, feelings of frustration and embarrassment. Findings included . Review of a policy titled, Quality of Care - Incontinence, Fecal Incontinence, dated 11/2017, showed a resident that was admitted to the facility that was incontinent upon admission would receive care and services to restore as much normal bowel function as possible. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility with diagnoses including heart disease, depression, and macular degeneration (an eye disease that causes blurriness in their central vision or trouble seeing in low lighting). The 02/28/2025 comprehensive assessment showed Resident 4 was dependent on one to two staff members for transfers and toileting hygiene. The assessment showed Resident 4 was frequently incontinent of bowel and was not on a toileting program. Resident 4 was cognitively intact and able to make their needs known. Review of a nursing assessment titled NSG [nursing] Bowel and Bladder Screener dated 11/18/2024, showed Resident 4 was assessed for and was a candidate for a scheduled toileting (timed voiding) program. During an interview on 05/20/2025 at 8:37 AM, Resident 4 stated they did not always feel the sensation to have a bowel movement. They stated the nursing assistants told them when they had a small bowel movement in their brief, but when they got up in the shower chair, they always had a large bowel movement. Resident 4 stated they were unable to get into the bathroom to use the toilet, and they did not have a bedside commode. Resident 4 stated no one had discussed a scheduled toileting program with them and they would be interested in trying one. Resident 4 stated they did not like having to use a brief. During an interview on 05/23/2025 at 10:58 AM, Staff E, Resident Care Manager, stated the process for establishing a toileting schedule included completing a bowel assessment on admission, quarterly, and as needed. They stated the assessment had a scoring system and the facility used that to identify those residents that would be eligible for a toileting program. They stated once the resident has been identified as a candidate, they would do tracking of bowel movements to establish a pattern and formulate a schedule off that pattern. They stated Resident 4 had not been identified as a candidate for a scheduled toileting program. During an interview on 05/27/2025 at 9:48 AM, Staff B, Director of Nursing, stated the process for developing and implementing a toileting schedule included completing a thorough assessment, reviewing the history of the toileting problem, and determine what has worked for the resident in the past. Staff B stated Resident 4's bowel assessment should have been followed up, especially because they had an identifying pattern such as having large bowel movements when on the shower chair. (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/2025 at 9:53 AM, Staff A, Administrator, stated improvements could be made regarding the facility's toileting programs. Reference: WAC 388-97-1060(3)(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure vaccines were discarded when expired for 1 of 2 medication storage refrigerators (East/West Medication Storage room). The facility also failed to follow Centers for Disease Control (CDC) guidance for temperature monitor of vaccines in 1 of 1 medication storage refrigerator located in the medication storage room. This failures placed the residents at risk for receiving compromised or ineffective medications and vaccines and negative health outcomes. Findings inlcuded . Review of the policy titled Pharmacy Services, Labeling and Storage of Drugs and Biologicals, dated 11/2017, showed the facility would store drugs and biologicals under proper temperature controls. Review of the CDC guidance titled, Vaccine Storage and Handling, dated [DATE], showed to ensure safety of vaccines, the refrigerator must have a reliable temperature monitoring device with the recommended use of a recording device called a digital date logger (DDL-a device that records temperatures at least every 30 minutes). The guidance further showed when a DDL was not used, then the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. <Medication Room Storage Refrigerator> During an observation and interview on [DATE] at 10:07 AM, with Staff H, Infection Prevention Nurse, showed the medication storage room refrigerator contained the following: 12 boxes of influenza vaccines Four vials of Apisol (solution used for tuberculosis sensitivity test) One vial of Alteplase (medication used to dissolve blood clots) Seven insulin pens (medication sued to control high blood sugar) Two boxes and four individual influenza vaccines, total 24 vaccines, expired 04/2025. Additionally, the medication storage refrigerator thermometer had a temperature red line with interruptions on the line. Staff H stated the thermometer read 66 degrees Fahrenheit (unit of measure for temperature) and they were not sure if the temperature was an accurate reading. Staff H stated the night shift nurses were responsible for reading and recording the medication refrigerator temperatures. Review of the medication storage refrigerator temperature logs showed the temperatures were to be monitored and recorded twice daily, at the beginning and end of each workday. Review of the temperature logs showed: (continued on next page)

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	505126	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health & Rehabilitation Center - Pasco	2004 N 22nd Avenue Pasco, WA 99301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]; eight days in a row with missed temperature documentation, and two additional missed temperature opportunities, February 2025; five missed temperature documentation, [DATE]; 12 days without any temperature documentation and 12 additional missed temperature documentation. [DATE]; 10 days without any temperature documentation and 13 additional missed temperature documentation, [DATE]; one day without any temperature documentation and one additional missed temperature documentation. During a concurrent interview on [DATE] at 10:33 AM, Staff B, Director of Nursing, stated they were unaware of the expired vaccines. Staff B stated the process was the unit manager was to monitor for outdates and medication refrigerator temperatures were documented and accurate. Staff B stated the monitoring was to be done daily. Staff L, Regional Nurse Consultant, stated medication refrigerators with vaccines were to be completed twice daily. Staff B stated they were disappointed the staff had not been completing the temperature logs accurately. Staff B stated they were unsure if the vaccines and medications would be as effective as they should and should be replaced. Reference: WAC 388-97-1300(2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dental services were provided in a timely manner to 1 of 2 residents (Resident 13) reviewed for dental care. This failure placed the resident at risk for nutritional decline, embarrassment, and unmet dental needs. Findings included . Review of a policy titled, Dental Services, dated 11/2017, showed the facility would assist residents with routine dental care. The facility would assist the resident in making dental appointments and arranging transportation. The facility would assist with a referral for dental services, promptly within three business days of receiving the information, for residents with lost or damaged dentures. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required partial/maximal assistance of one staff member for activities of daily living. The assessment also showed Resident 13 had broken/loosely fitting dentures. Resident 13 had an intact cognition. Record review of an admission assessment dated [DATE], showed Resident 13 had full upper and partial lower dentures. The assessment showed the dentures were broken/fit loosely. Record review of Resident 13 ' s care plan revised 03/03/2025, showed a focus area has oral/dental health problems .dentures don ' t fit well, with interventions coordinate arrangements for dental care, transportation as needed/as ordered. A concurrent observation and interview on 05/24/2025 at 11:36 AM, showed Resident 13 sitting in their wheelchair in their room. They stated their dentures were loose and needed relined. As Resident 13 spoke, their dentures were visibly slipping. The resident was slurring their words and drooling. Resident 13 had a tissue in their left hand. They reached up to their mouth and wiped the excessive saliva from their chin. Resident 13 pushed their dentures back in place and stated, I ' m sorry, they are so loose, they need relined. During an interview on 05/27/2025 at 8:42 AM, Staff C, Social Services Director, stated they were responsible for arranging dental appointments. Staff C stated the process included nursing staff identifying the need and reporting that to social services. Staff C would ensure there was an order for the dental appointment and notify medical records to schedule the dental appointment. Staff C stated they used to receive dental concerns from the nurse that completed the comprehensive assessments, but that process was not being followed. Staff C stated they were not aware Resident 13 had concerns with their dentures as it was not reported to them from the admission assessment, comprehensive assessment, or nursing staff. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/27/2025 at 9:56 AM, Staff B, Director of Nursing, stated when the facility was aware a resident had a dental need, the in-house dental provider would see them. They stated the process should include an assessment on admission and a discussion with the interdisciplinary team (a group of healthcare professionals from different disciplines to help people receive the care they need) to discuss the concern and ensure appropriate services were received. Staff B stated they would have expected Resident 13 to have a referral for their denture needs within the first few weeks of admission. During an interview on 05/27/2025 at 11:31 AM, Staff A, Administrator, stated the facility should have been actively working towards scheduling an appointment for the resident and there should have been follow up to ensure Resident 13 had been seen by a dental provider. Reference: WAC 388-97-1060(3)(j)(vii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide meals that were palatable and at an appetizing temperature for 7 of 11 residents (Resident 19, 10, 36, 2, 3, 33 and 27) reviewed for food. These failures resulted in residents experiencing dissatisfaction with the food and placed residents at risk for inadequate nutritional intake and weight loss. Findings included . Review of a policy titled, Food and Nutrition Services, Food and Drink, dated 07/2018, showed the facility will have food and drink prepared that would be palatable, appealing, and at a safe and appetizing temperature. The policy also showed food would be in a form that met individual needs, including intolerances and preferences. Review of the facility Food Committee Meetings showed: January 2025; the squash was very hard, and food was cold, including, soups, coffee and hot cocoa. April 2025; the hashbrowns were not cooked well, toast was soggy and white meat was hard. <Resident 19> Review of the medical record showed Resident 19 was admitted with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), kidney disease and weakness. The 03/10/2025 comprehensive assessment showed Resident 19 required substantial/dependent assistance of one to two staff members for activities of daily living (ADLs) and had an intact cognition. During an interview on 05/19/2025 at 1:08 PM, Resident 19 stated the facility food was horrible. Resident 19 stated the process for meal selection was they were provided a weekly menu each Sunday and they were to circle the food items they wanted to eat. Resident 19 stated they had requested a salad, and they received a pile of noodles with an inedible sauce. Resident 19 stated for this day's meal they requested a cheeseburger, baked beans and a salad, from the alternative menu options. They received their meal and the food preference card on their food tray showed the cheeseburger crossed off and the word sorry written and they received a fried pork sandwich instead. Resident 19 stated they were unable to eat pork as they would become ill, and they had told the facility during their initial intake interview. Resident 19 also stated they did not receive the caprese salad either. Resident 19 stated the food was not hot and usually cold when they received their meals. <Resident 10> Review of the medical record showed Resident 10 was admitted with diagnoses including stroke (a medical emergency that occurs when blood flow the brain is disrupted and deprives the brain of oxygen, leading to brain damage, disability or death), diabetes, and heart disease. The 03/04/2025 comprehensive assessment showed Resident 10 was dependent of one to two staff members for ADLs and required set up for eating. The assessment also showed Resident 10 had an intact cognition. During an interview on 05/19/2025 at 2:02 PM, Resident 10 stated they did not like the facility food. Resident 10 stated the food was the same food most of the time and served cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 36> Review of the medical record showed Resident 36 was admitted with diagnoses including high blood pressure, depression and anxiety. The 03/18/2025 comprehensive assessment showed Resident 36 required moderate/dependent assistance of one to two staff members for ADLs and set-up assistance for eating. The assessment also showed Resident 36 had an intact cognition. During an interview on 05/19/2025 at 2:28 PM, Resident 36 stated the facility food was sometimes gross. Resident 36 stated the food would be 'unidentifiable and the meat did not look like meat and would be tough. <Resident 2> Review of the medical record showed Resident 2 was admitted with diagnoses including asthma (a lung disease that causes inflammation around the airways making it hard to breathe), heart failure and depression. The 03/28/2025 comprehensive showed Resident 2 was dependent on one to two staff members for ADLs and had an intact cognition. During an interview on 05/19/2025 at 4:10 PM, Resident 2 stated they did not eat pork, tomatoes and zucchini, and would cross it off the menu and the facility would continue to serve it to them. Resident 2 stated when they were provided a meal, the meal was not warm. <Resident 3> Review of the medical record showed Resident 3 was admitted with diagnoses including diabetes, respiratory failure and major depressive disorder (a serious mental illness that causes a persistent low mood, loss of interest in activities, changes in sleep, appetite, energy, and concentration). The 02/25/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for ADLs and required set up for eating/oral cares and had an intact cognition. During and interview on 05/20/2025 at 8:52 AM, Resident 3 stated their breakfast that morning was gross as usual, and the hashbrowns were half cooked and cold. <Resident 33> Review of the medical record showed Resident 33 was admitted with diagnoses including high blood pressure, diabetes and depression. The 02/13/2025 comprehensive assessment showed Resident 33 required substantial/dependent assistance of one to two staff members for ADLs and had an intact cognition. During an interview on 05/20/2025 at 9:09 AM, Resident 33 stated the eggs they receive were cold, hashbrowns were soggy when they asked for them to be crispy and the bacon was very thin and tasted bad. <Resident 27> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 27 was admitted with diagnoses including quadriplegia (damage to the brain or spinal cord resulting in loss of movement of the body below the neck), pain and depression. The 03/22/2025 comprehensive assessment showed Resident 27 was dependent on one to two staff members for ADLs and an intact cognition. During an interview on 05/20/2025 at 10:46 AM, Resident 27 stated they were assisted by a staff member to eat their meals, and the food would be cold when they ate. During an interview on 05/20/2025 at 2:39 PM, Staff AA, Dietary Manager, stated residents were provided menus on Sundays and residents could select their meal choices from the menus. Staff AA stated they had heard of complaints of cold food months ago and was not aware of any further complaints regarding food temperatures or any regarding residents not being provided with their meal choices. <Test Tray> On 05/22/2025 at 12:21 PM, two lunch meal test trays were requested by surveyor and was checked for temperatures by Staff AA, with the following results: Chicken 150.3 degrees Fahrenheit (F-unit of measure for temperature) Cooked carrots 133.2 F Rice 154.3 F Frittata (a baked egg dish with vegetables) 129 F Small whole potatoes 132.6 F Milk 42.7 F Pudding 49.8 F The lunch meals were lukewarm, bland, and the rice, chicken, gravy and roll were similar in a pale color served on a white plate. The chicken was extremely dry, difficult to chew, pale in color and tasteless. The potatoes and carrots were dark in color and unappetizing. During an interview on 05/27/2025 at 12:26 PM, Staff A, Administrator, stated they expected residents to have their food preferences honored and served at palatable temperature and when there was a concern regarding their meals, the Dietary Manager should follow up with the residents. Reference WAC: 388-97-1100(1)(2)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to explain the arbitration agreement (a legal document that required the use of a third party to resolve a dispute) in its entirety, including the right to rescind (cancel) the agreement within 30 calendar days, in a manner and language that the resident understood for 4 of 4 residents (Resident 2, 6, 7, and 13) reviewed for binding arbitration. This failure placed the residents at risk for losing legal protection, lack of understanding of the legal document, and the right to a jury or court hearing. Findings included . Review of a policy titled, Resident Arbitration Agreements - Entering into Binding Arbitration Agreements, dated 10/11/2022, showed the facility would not require any resident or their representative to sign an arbitration agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at the facility. The agreement would grant the resident and/or their representative the right to rescind the agreement within 30 calendar days of signing it. The facility would ensure the agreement was explained in a form and manner that included language that the resident and/or their representative understood. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including heart failure, depression, and bacterial infections. The 03/28/2025 comprehensive assessment showed Resident 2 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 2 had an intact cognition. The medical record showed Resident 2 signed an arbitration agreement on 05/07/2024. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility with diagnoses including chronic pain, anxiety, and muscle weakness. The 02/26/2025 comprehensive assessment showed Resident 6 was dependent on one to two staff members for ADLs. The assessment also showed Resident 6 had an intact cognition. Further review of the medical record showed Resident 6 signed an arbitration agreement on 05/07/2025. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including spina bifida (a condition that occurs when the spine and spinal cord don't form properly), takotsubo syndrome (a temporary heart condition caused by intense emotional or physical stress), and weakness. The 04/22/2025 comprehensive assessment showed Resident 7 required maximal/dependent assistance of one to two staff members for ADLs. The assessment also showed Resident 7 was cognitively intact. The medical record showed Resident 7 signed an arbitration agreement on 03/07/2025. <Resident 13> (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including heart failure, weakness, and depression. The 03/03/2025 comprehensive assessment showed Resident 13 required partial/maximal assistance of one staff member for ADLs. The assessment also showed Resident 13 had an intact cognition. Further review of the medical record showed Resident 13 signed an arbitration agreement on 03/07/2025. During a Resident Council (a group of residents that meet regularly to improve the quality of life and care in the nursing home) meeting on 05/20/2025 at 10:30 AM, Resident 2, Resident 6, and Resident 7 stated they were not informed that the binding arbitration agreement was an optional form. Resident 13 stated they knew what binding arbitration was but did not recall signing any document for binding arbitration. Resident 2, Resident 6, Resident 7, and Resident 13 stated they were not informed of their right to rescind their signed arbitration within 30 calendar days. During an interview on 05/21/2025 at 12:49 PM, Staff K, Nursing Assistant, stated they reviewed and completed the admission paperwork with new admissions. They stated they were trained by the previous admissions coordinator. Staff K stated when they explained the arbitration agreement to the new admits, they informed the residents the agreement required the resident to talk out disagreements to avoid making a lawsuit. They stated residents were not required to sign the agreement. Staff K stated they did not know if residents were able to rescind the agreement. During an interview on 05/27/2025 at 7:47 AM, Staff O, Health Information Director, stated they assisted the admissions coordinator with completion of the admission paperwork. They stated they were trained to explain to residents that the arbitration agreement would prevent them from going to court and settle disputes amongst the facility. When asked if a resident that signed the agreement could cancel (rescind) the agreement, Staff O stated, that is a good question, I don ' t know that answer. During an interview on 05/27/2025 at 11:34 AM, Staff A, Administrator, stated the person that was responsible for the admission agreements was trained on the process for arbitration by Staff P, Regional Director of Business Development. Reference: WAC 388-97-1620(2)(b)(i)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system in place that ensured effective consistent communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 2 residents (Resident 209) reviewed for hospice services. This failure placed residents at risk for not receiving necessary care and services. Findings included . Review of the facility policy titled, Administration, Hospice, dated 07/2018, showed the facility would identify a designated staff member to work with hospice and coordinate care to the resident. The facility would establish a plan of care with hospice that identified specific services each provider was responsible for. <Resident 209> Review of the medical record showed Resident 209 was admitted to the facility on [DATE] with diagnoses including, emphysema (a progressive disease that caused damage to the airways and lungs, making it hard to breathe, shortness of breath) and chronic obstructive pulmonary disease with exacerbation (COPD- a sudden worsening group of lung diseases that block airflow and make it difficult to breathe). The 05/16/2025 nursing admission assessment showed Resident 209 required setup/partial assistance of one staff member for activities of daily living (ADLs) and had an intact cognition. Review of Resident 209's facility care plan dated 05/16/2025, showed no focus, goals, intervention or coordination of cares related to hospice. During an interview on 05/21/2025 at 9:39 AM, Staff N, Nursing Assistant, Staff N stated the process for receiving information for residents was from their care plan or nursing staff. Staff N stated they were not informed Resident 209 was on hospice. During an interview on 05/21/2025 at 1:34 AM, Staff F, Resident Care Manager, stated the process for admitting a hospice resident was they would be notified by the Admissions Coordinator. Staff F stated when Resident 209 was admitted , the facility provided standard care, medications, monitored pain, health status and updated hospice nurse as needed. Staff F stated there would not be hospice orders in the chart as the facility would not do anything different for hospice residents than any other of the facility residents. Staff F stated they performed the admission assessment, and the care plan was created from that assessment. Staff F stated the initial care plans were to include pain, risk of falls, activities of daily living, and nutrition status. Staff F stated they were not aware of what was required for care plans for residents receiving hospice services. Staff F stated they would have identified Resident 209 as a hospice resident under their care profile and included a hospice phone number but had failed to. Staff F also stated they did not document any conversations with hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/2025 at 2:23 PM, Staff B, Director of Nursing, stated Resident 209 was a hospice resident. Staff B stated when residents had hospice services, the process included contacting hospice, receive standing orders, provided the medications, and hospice would maintain oversight and communication with family. The facility was responsible for ADLs, acute changes, meals and followed standard orders. Staff B stated NAs should have been notified Resident 209 was on hospice from the nursing staff. Staff B stated Resident 209's care plan did not include the required elements for hospice. During an interview on 05/21/2025 at 4:10 PM, Staff L, Regional Nurse Consultant, stated Resident 209's care plan should have included hospice information, the hospice company name, contact information, phone numbers and who to contact at hospice. Staff L stated the care plan also should have included which cares hospice would provided and what cares the facility would perform. Reference WAC: 388-97-1060(1)