

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Avalon Health & Rehabilitation Center - Pasco		STREET ADDRESS, CITY, STATE, ZIP CODE 2004 N 22nd Avenue Pasco, WA 99301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the designated Infection Preventionist (IP) met the qualifications for experience, education, and training or certification for the role to assume responsibility for the facility's Infection Prevention Control Program (IPCP). This failure placed residents, family members, and staff at risk of contracting communicable diseases. Findings included .Record review of the facility's policy titled, Infection Prevention and Control Program, revised on 06/08/2022, showed the facility would identify a staff member to be responsible for the infection prevention and control program and trained as the IP to provide on-site management of the IPCP. In an interview on 06/08/2026 at 9:35 AM, Staff B, Director of Nursing (DON), stated they had been handling the infection control program. Staff B stated they had not completed the specialized training in infection prevention and control. Staff B stated they had their regional nurse currently acting as the facility's IP. In an interview on 06/08/2026 at 4:04 PM, Staff C, Regional Clinical Nurse, stated the facility did not currently have an acting IP as the last IP worked in the facility in May 2026 and a new IP was due to start within the next couple of weeks. Staff C stated they had not completed the specialized training in infection prevention and control. In an interview on 06/08/2026 at 4:12 PM Staff H, Regional Clinical Nurse, stated that Staff R, Regional Nurse Consultant (RNC), had been the acting IP until the second week of May 2026. Staff H stated they were not actually acting IP and thought Staff C was going to do the training and then did not. Staff H stated no one had the required Centers for Disease Control and Prevention (CDC) training or had been acting as the current IP for the last three weeks. Review of an email dated 06/09/2026 showed Staff R, RNC, had been the facility's IP and their last day in the facility was on 05/11/2026 (the facility had been without a certified IP for the last 28 days). In an interview on 06/09/2026 at 8:20 AM, Staff A, Administrator, acknowledged Staff B and Staff C did not have the required specialized training in infection prevention and control. Staff A stated the facility had some changes with the facility's IP. Reference: WAC 388-97-1320(1)(a)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review and validate the Preadmission Screening and Resident Review ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were done prior to admission and were corrected on admission, had the required level two referral sent if residents had a positive level one PASARR, as needed for 2 of 5 residents (Resident 65, and 2) reviewed for unnecessary medications. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility policy titled, Resident Assessment Preadmission Screening and Resident Review (PASARR) revised 08/2018, showed a Preadmission Screening and Resident Review (PASARR) screening would be completed for each resident prior to admission. Resident 65 Review of the medical record showed Resident 65 admitted to the facility on [DATE] with diagnoses to include anxiety disorder (a mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), depression (a serious mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities), and Post Traumatic Stress Disorder ([PTSD], a mental health condition triggered by experiencing or witnessing a terrifying or life threatening event). Resident 65's comprehensive assessment dated [DATE], showed the resident's cognition was intact and required moderate assistance of one person for dressing themselves and transfers. Further review of Resident 65's medical record showed there had not been a completed PASARR Level I screening document or evidence of an approved exemption in the resident medical record. Review of Resident 65's PASARR Level I completed by the facility on 06/10/2026, showed under section I, SMI/ID the resident had three mental health diagnoses marked yes to include the diagnoses of mood disorder, depression and a PTSD disorder. A referral for a Level II PASARR was required if any questions in Section 1A (1, 2, and/or 3) was marked yes. There was no evidence of a PASARR Level I or that a referral had been sent for review in the resident's medical record. Resident 2 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses that included anxiety/panic attacks (a sudden, intense surge of overwhelming fear of discomfort that triggers severe physical reactions) and hallucinations (seeing, hearing, feeling something that does not exist in reality). A PASARR Level I was completed on 03/13/2026 from their hospital stay before being admitted to the facility. During an interview on 06/10/2026 at 3:30 PM, Staff A, Administrator stated the hospital sent the PASSAR Level I with request for a Level II assessment but did not send the request to the evaluator. Staff A stated the facility failed to send the recommended Level II request. During a continued interview on 06/10/2026 at 3:30 PM, Staff A, confirmed that the facility had not received a PASARR screening for Resident 65 from the hospital. Staff A stated the PASARR (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation required had not been completed for Resident 65 upon admission. Reference: WAC 388-97-1915(1)(2)(a)-(c)		

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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 perform timely and thorough assessments and monitoring of 1 of 3 residents (Resident 56), reviewed for a change in condition. Additionally, the facility failed to identify and provide needed care and services for 1 of 3 residents (Resident 70) reviewed for wheelchair positioning. This failure placed the residents at risk for delayed care, health complications, skin breakdown, and poor clinical outcomes. Findings included. Review of a policy titled, Quality of Care, revised 08/2018, showed the facility would identify and provide resident centered care and services in accordance with the resident's preferences, goals for care, and professional standards of practice that meet the resident's physical, mental, and psychosocial needs. Resident 56 Review of the medical record showed Resident 56 was admitted to the facility on [DATE] with a full code directive (a medical order for healthcare providers to use every available medical intervention to attempt to save a life during a life-threatening crisis) with diagnoses including significant respiratory failure, heart failure with continuous oxygen use, and GI bleeding with blood loss. The 05/29/2026 comprehensive assessment showed Resident 56 was alert, oriented, and able to direct their care. Resident 56 required assistance of two staff members and a mechanical lift for transfers and assistance with toileting and dressing. During an observation and concurrent interview on 06/08/2026 at 10:50 AM, Resident 56 was lying on their bed with the head of the bed elevated to 75 degrees (an upright, seated position that uses gravity to relieve breathing difficulties). Resident 56 was wearing an oxygen nasal cannula (thin plastic tube with two prongs used to provide oxygen directly into the nose) that was attached to a supplemental oxygen device. The resident's face was pale with a yellowish/gray color and significant edema (swelling) to their left arm and fingers. The top of their left forearm showed large areas of dry, brown, flakey skin. During the same interview, Resident 56 stated they felt weak and were unable to stand and bear weight (supporting one's own body weight). The resident stated they could not successfully participate with physical therapy. Resident 56 stated they had informed the nursing staff on 06/04/2026 and 06/05/2026 that they needed to be seen by a doctor to run a blood test and a chest x-ray because they had similar symptoms in the past that led to hospitalization for pneumonia (a lung infection) and a GI bleed. During the 06/08/2026 conversation, the resident was short of breath and only able to speak in short sentences. Resident 56 stated that there was no communication from the staff as to when the physician would see them. Review of Resident 56's June 2026 Medication Administration Record (MAR), showed the Resident 56 was taking an anticoagulant (a medication that thins the blood). The MAR showed staff were to monitor adverse reactions to the anticoagulant medication that included no adverse reaction, occult stools (obtaining a stool sample and testing it for blood) and other monitoring examples. Nursing documentation on the MAR showed no adverse reactions to the anticoagulation medication. During an interview on 06/08/2026 at 11:00 AM, Staff L, Registered Nurse (RN), stated the resident's left arm had been swollen. Staff L stated the resident had low blood pressure and pulse measurements. Staff L stated they were not aware of Resident 56's shortness of breath and the physician had not ordered any recent laboratory work. During an interview on 06/08/2026 at 12:45 PM, Staff P, RN, stated Resident 56 had previously been hospitalized with (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pneumonia and a GI bleed. The surveyor asked Staff P if they could assess Resident 56 due to pallor (extreme paleness of the skin and mucous membranes) and shortness of breath. Staff P stated that Staff I, RN Unit Manager, was Resident 56's care manager. During an interview on 06/08/2026 at 1:30 PM, the surveyor informed Staff B, Director of Nursing, that they were concerned about Resident 56's condition and requested them to assess the resident. Staff B verified that Resident 56 was pale and edematous. Staff I was asked by Staff B to assess Resident 56's lung sounds and notify the physician of Resident 56's diminished lung sounds and increased edema, especially in the left arm. During an interview on 06/09/2026 at 9:30 AM, Staff B stated that Resident 56's physician would examine the resident in the facility that afternoon. Review of a nursing progress note (PN) dated 06/09/2026 at 6:38 PM, showed the physician decreased Resident 56's blood pressure medication due to their low blood pressure readings and increased their diuretic (a medication used to remove extra fluid from the body) medication due to the increased edema in the resident's body. Resident 56 was placed on alert monitoring (additional assessments and charting used when a resident experiences a change in condition) to be assessed by nursing staff. Review of a nursing PN dated 06/09/2026 at 8:59 PM, showed the physician assessed Resident 56 for pursed lip breathing (a technique used to help move oxygen into the lungs and carbon dioxide out of the lungs) and diminished lung sounds at all bases. Resident 56 was to be weighed three times weekly and weights were to be reported to the physician. During an observation on 06/10/2026 at 8:40 AM, Resident 56 showed difficulty speaking, was short of breath, confused, and shaking. During an interview on 06/10/2026 at 9:00 AM, Staff B stated Resident 56 appeared worse, referring to their level of consciousness, breathing, edema, and pale color. During an observation and concurrent interview on 06/10/2026 at 10:00 AM, Staff I spoke to the surveyor about sending Resident 56 to the hospital. Staff I called the physician and an ambulance for transfer to the hospital. Review of the 06/10/2026 History and Physical from the hospital showed that Resident 56 was short of breath, had an increased heart rate of 105 beats per minute (normal is 60-100 beats per minute), anemia [lack of healthy red blood cells with deficient (Hemoglobin (Hb) a protein in red blood cells that carry oxygen)], their blood level was critically low at 6.1 g/dl (unit of measure- normal is 13.4-15.2 g/dl). Resident 56 required a blood infusion (a medical procedure in which donated blood or blood components are delivered directly into the blood stream) to replace their blood loss. Additionally, Resident 56 had pulmonary edema (too much fluid in the lungs making it hard to breathe). Resident 70Review of the medical record showed Resident 70 was admitted to the facility with diagnoses including right sided hemiplegia and hemiparesis (weakness and/or paralysis on one the right side of the body), dementia (a progressive disease that destroys memory and other important mental functions), and polyneuropathy (damage to nerves that can cause problems with sensation, coordination, or other body functions). The 03/15/2026 comprehensive assessment showed Resident 70 was dependent on one to two staff members for activities of daily living. The assessment also showed Resident 70 had a severely impaired cognition. An observation on 06/08/2026 at 11:08 AM, showed Resident 70 in their tilt-in-space wheelchair (a specialized wheelchair designed to maintain proper positioning and redistribute pressure by maintaining a seated position while tilting the entire seating system backwards) outside of the activities room watching television. The supportive armrest tray (a flat board covered with (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	foam/material that clamps to the wheelchair, that is used to position a weak/paralyzed arm) was attached to the right side of the wheelchair and tilted away from Resident 70's body, causing their arm to fall off the tray. Resident 70 was observed to pick up their right arm with their left hand and place it across their abdomen for support. Resident 70 had both feet on the right foot pedal of the wheelchair, and their hips were shifted to the left in their seat. Their head was resting on the far left of the head support (a curved shaped device that attaches to a wheelchair, used to support the head and neck). During a concurrent observation and interview on 06/10/2026 at 1:23 PM, Resident 70 was observed in their wheelchair, watching television outside of the activities room. Resident 70 was observed in the same position as the observation on 06/08/2026. They stated they were not comfortable and their legs were sore. During an interview on 06/11/2026 at 8:56 AM, Staff E, Registered Nurse, stated the nursing assistants would report concerns with a resident's wheelchair positioning to them, and they would inform the therapy department of the need for a wheelchair evaluation. Staff E stated they had not received any reports or concerns. During an interview on 06/11/2026 at 11:52 AM, Staff G, Director of Rehabilitation, stated they received notification of positioning concerns during their daily interdisciplinary team meeting. They stated there was no formal process to inform therapy of positioning concerns and they had not received any concerns regarding Resident 70 until that same day. During an interview on 06/11/2026 at 4:00 PM, Staff B, Director of Nursing, stated the nursing assistants should inform the licensed nurses if a resident complained of pain while in their wheelchair. They stated they would check the residents' seating, assess the resident, and refer them to therapy for an evaluation. During an interview on 06/12/2026 at 8:23 AM, Staff A, Administrator, stated the nursing assistants should report concerns to nursing staff so they could evaluate the resident. Staff A stated the process was not followed for Resident 70. Reference: WAC 388-97-1060(1)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure care and services were provided for 2 of 4 residents (Resident 4 and 31) reviewed for restorative nursing for Range of Motion (ROM) services to prevent decrease in range of motion and mobility. This failure placed the residents at risk for a decrease in mobility, and inability to maintain their current level of functioning. Findings included .Review of the facility policy titled, Restorative Nursing Programs revised 06/2018, showed to assist residents in obtaining and maintaining their highest practicable functional levels, prevent unnecessary declines, and provide an active and healthy living environment.Resident 4Review of Resident 4's medical record showed the resident had been admitted to the facility on [DATE] with diagnoses including left hemiplegia (paralysis that affects one side of the body), muscle weakness, difficulty walking and reduced mobility. The comprehensive assessment dated [DATE] showed Resident 4's cognition was intact and was dependent on staff for care and mobility.In an interview on 06/09/2026 at 12:40 PM, Resident 4 stated they were told that their insurance stopped in March 2026 and had not received any type of therapy since then. During an observation and concurrent interview on 06/11/2026 at 2:44 PM, Resident 4 was lying in bed, stated they had a good morning. Resident 4 stated they had not received any therapy and it had been since March 2026 since they had walked with staff.Review of Resident 4's care plan dated 03/22/2026, showed the resident had limited physical mobility related to weakness and deconditioning. The care plan further showed the resident required supervision or touching assist by one staff member to walk.Resident 31Review of Resident 31's medical record showed the resident had been admitted to the facility on [DATE] with diagnoses including kidney failure, vision loss and a knee amputation on the left with a left leg prosthesis. The comprehensive assessment dated [DATE] showed Resident 31's cognition was moderately impaired and was dependent on staff for care and mobility.In an interview on 06/08/2026 at 3:02 PM, Resident 31 stated it had been six weeks since their last therapy session. Resident 31 stated they had lost strength in their legs and feeling like they did when they first arrived at the facility. During an observation and concurrent interview on 06/10/2026 at 9:17 AM, Resident 31 was sitting in their wheelchair in the hallway, stated they were doing upper body stretching and exercises. Resident 31 stated that since they had no therapy, they do the exercises to keep themselves going.In an interview on 06/11/2026 at 9:20 AM, Staff K, Nursing Assistant (NA), stated they were aware that some residents' care plans had a restorative program, and for those residents' they utilized dressing the residents for their ROM. Staff K stated nursing assistants did not have time to do a real restorative program with residents. Staff K stated they tried to do the best they could for their residents.In an interview on 06/11/2026 at 9:27 AM, Staff G, Director of Rehabilitation (DOR), stated they were aware that the restorative nursing program had not been consistently provided to residents. Staff G stated that the program had been inactive for approximately one month. Staff G indicated that the facility was in the process of restarting the restorative program, but that the process was moving slowly.In an interview on 6/12/26 at 9:22 AM, Staff A, Administrator, acknowledged that there had been inconsistency with the facility's restorative program. Staff A stated that Staff G was working on strengthening their program to ensure residents were offered and received the service.Reference: WAC 388-97-1060(3)(d)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were trauma survivors received trauma-informed care (an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma), in accordance with professional standards of practice, for 2 of 3 residents (Resident 7 and 65), reviewed for trauma-informed care. This failure placed the residents at risk for unidentified triggers and re-traumatization. Findings included. Review of a policy titled, Trauma-Informed Care, dated 09/20/2022, showed the facility would provide residents who were trauma survivors with culturally competent care that accounts for the residents' experiences and preferences, to eliminate or mitigate triggers that may cause re-traumatization. Residents would be screened upon admission to assist in the identification of residents who may be trauma survivors. The facility would collaborate with the resident/resident representative and members of the interdisciplinary team (a group of healthcare professionals from different disciplines to help people receive the care they need) to identify potential re-traumatization triggers. Resident centered care plans would be developed to reflect resident needs and preferences related to trauma. Resident 7 Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including major depressive disorder (ongoing sadness, hopelessness, and loss of interest that lasts at least two weeks), post-traumatic stress disorder [(PTSD) a mental health condition that's caused by an extremely stressful or terrifying event], and psychophysiologic insomnia (the inability to sleep due to excessive worry and anxiety about sleep). The 03/18/2026 comprehensive assessment showed Resident 7 was dependent on one to two staff members for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 7 had a moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). Record review of a document titled, Post-Traumatic Checklist dated 03/21/2023, showed Resident 7 avoided activities or situations because they reminded them of a stressful experience from the past. The form showed watching specific shows on television were stressful and/or overwhelming that reminded them of negative experiences from their past. The form showed the resident had identified interventions that were helpful to them during stressful/whelming situations. Record review of the care plan dated 03/12/2026, showed the resident had a potential mood problem due to their diagnoses of major depressive disorder and PTSD. There were no triggers or interventions listed on the care plan related to PTSD, despite Resident 7 identifying them on the Post-Traumatic Checklist form. During an interview on 06/08/2026 at 10:03 AM, Resident 7 stated they were sexually assaulted in the past. They stated they had received counseling and therapy related to that event, but watching a movie or television show with scenes related to the event would trigger memories related to the traumatic event, causing them to be stressed and overwhelmed. Resident 7 stated they colored pictures to distract themselves from the triggering events. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 65 Review of the medical record showed Resident 65 was admitted to the facility on [DATE], with diagnoses that included mood disorder (a mental condition that primarily affects your emotional state), depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities once enjoyed), and PTSD. The comprehensive assessment dated [DATE] showed Resident 65's cognition was intact and required assistance with ADLs. During an interview on 06/09/2026 at 8:57 AM, Resident 65 stated they were a trauma survivor. The resident stated their trauma started at age two and continued until their adolescence. Resident 65 stated they had triggers (sensory experiences, emotions, or situations that activate the trauma response such as bring back intense memories, physical reactions that make it feel as if the trauma is happening again) were things like clowns, or women with lots of make-up on their face. Review of Resident 65's care plan dated 5/20/2026, showed the resident had signs, symptoms, and concerns with mood related to PTSD. Further review of the resident's care plan showed there were no triggers or person-centered interventions that could help guide caregivers on how to help Resident 65 when they experienced triggers. During an interview on 06/11/2026 at 9:20 AM, Staff K, Nursing Assistant, stated they were unaware of residents who were trauma survivors. Staff K stated information like that (resident triggers) would be helpful for the residents' care. During an interview on 06/11/2026 at 11:04 AM, Staff H, Regional Nurse Consultant, stated the process for trauma-informed care included completing an evaluation on admission, readmission, and quarterly to identify past trauma. Depending on the results of the evaluation, another assessment would be completed to assist with care planning. The care plan would show a brief synopsis of the trauma, triggers, and interventions. Staff H stated Resident 7's diagnosis of PTSD would have triggered the trauma-informed care evaluation. They stated the process was not followed. During an interview on 06/12/2026 at 8:23 AM, Staff A, Administrator, stated the process for trauma-informed care would be to follow the facility policy. Reference: WAC 388-97-1620(2)(b)(i)(ii)		

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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. Based on observation, interview, and record review, the facility failed to follow the Centers for Disease Control [(CDC) a public agency that protects the public's health and well-being] guidance for temperature monitoring of vaccines and medications in 1 of 2 medication storage refrigerators (Refrigerator 1) reviewed for medication storage. This failure placed the residents at risk of receiving compromised or ineffective vaccines and/or medications. Findings included .Review of the CDC guidance titled, Vaccine Storage and Handling, dated 04/03/2024, 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, the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. Review of a policy titled, Pharmacy Services, Labeling and Storage of Drugs and Biologicals, dated 11/2017, showed the facility stored drugs and biologicals in locked compartments under proper temperature controls. An observation and record review on 06/11/2026 at 1:58 PM, accompanied by Staff B, Director of Nursing, showed Refrigerator 1, located in the medication storage room, had a temperature log taped to the front of the refrigerator. The log was titled Food Refrigerator Temperature Log, and was dated 05/2026. The log showed temperatures were to be taken and recorded daily on the night shift. The temperature log had one column for daily temperature readings, despite the requirement for twice daily temperature readings. The log showed temperatures were not documented on 05/01/2026, 05/02/2026, 05/03/2026, 05/04/2026, and 05/05/2026. Additionally, there was no log for the month of 06/2026. The refrigerator contained 61 doses of influenza (a highly contagious viral infection that attacks the respiratory system) vaccines, four Respiratory Syncytial Virus (a highly contagious virus that infects the lungs and breathing passages) vaccines, eight shingles (a viral infection that causes a painful rash and nerve damage) vaccines, and 29 pneumococcal vaccines. Additionally, the refrigerator contained the following medications that required refrigeration: four insulin (a medication that turns food into energy and manages the blood sugar) pens, one vial of insulin, one calcitonin nasal spray (a medication used to treat bone loss), and two bottles of prescription eye drops. Staff B stated they had provided the 06/2026 temperature log to Staff I, Unit Manager Registered Nurse, to post on Refrigerator 1 for refrigerator temperature monitoring. Staff B stated they were unsure where the new log was and it was their responsibility to make sure the staff posted it. During an interview on 06/11/2026 at 2:45 PM, Staff I stated the refrigerator temperature log was posted for the night shift nurses to complete. They stated the Infection Preventionist was responsible for posting it but since there was no one in that position, Staff B was posting it. During a follow up interview on 06/11/2026 at 4:06 PM, Staff B stated the facility should have been checking Refrigerator 1 temperatures twice daily for vaccine storage; once daily for the medications. Staff B stated the process for medication storage was not followed. During an interview on 06/12/2026 at 9:14 AM, Staff A, Administrator, stated the Infection Preventionist was responsible for monitoring the medication refrigerator temperatures. Since the facility did not currently have anyone in that position, the monitoring didn't get followed through. Reference: WAC 388-97-1300(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Avalon Health & Rehabilitation Center - Pasco		STREET ADDRESS, CITY, STATE, ZIP CODE 2004 N 22nd Avenue Pasco, WA 99301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to maintain an accurate facility assessment [(FA) an evaluation that determines the resources required to meet each resident's care and services needs]. The assessment contained inaccuracies regarding resident demographics, the involvement of a qualified Infection Preventionist, and lacked active involvement of the Medical Director and Director of Nursing. This failure placed the residents at risk for inadequate care, potential infections, and poor health outcomes. Findings included. Review of a policy titled, Administration Facility Assessment, dated 11/2017, showed the FA was reviewed and updated at least annually or when the facility planned for any change that would require a substantial modification to the assessment. The FA may include the current number of residents and resident capacity, care required by the resident population, staff competencies for the resident population, and considerations for ethnic, cultural, or religious factors that may impact the care of the population. Record review of the FA, dated 06/01/2026, showed the demographics of the resident population within the facility included residents that had a socio-economic status of poor and sexual orientation of straight (attracted to the opposite sex/gender), despite the facility accepting residents of all socio-economic backgrounds and sexual orientation as evidenced by private pay residents and housing of a same sex couple. Additional review of the FA showed the facility would employ a Registered Nurse or Licensed Practical Nurse with certification in Infection Prevention and Control, at a minimum of part time basis. The assessment showed the facility did not employ Medication Aides (a nursing assistant that is authorized to administer medications in a long-term care facility under the supervision of a registered nurse. Further review of the FA showed the persons involved in completing/reviewing the FA included the Director of Nursing and the Medical Director. Record review of the facility staff list, provided to the surveyors on 06/08/2026, showed no staff identified as the Infection Preventionist. The staff list also showed the facility employed one medication aide. During an interview on 06/12/2026 at 9:14 AM, Staff B, Director of Nursing, stated they had not seen the FA and were not involved in reviewing it. During an interview on 06/12/2026 at 8:53 AM, Staff A, Administrator, stated the facility did not currently have an Infection Preventionist. They stated the facility did employ one Medication Assistant. They stated the Medical Director, Director of Nursing, and Administrator were involved in reviewing the 06/01/2026 FA. During a follow-up interview at 9:41 AM, Staff A stated with the inaccuracies in demographics and staffing, the FA was inaccurate and needed to be re-done from the start. During an interview on 06/12/2026 at 11:48 AM, Staff J, Medical Director, stated they did not know what a FA was and were not involved in reviewing the current FA completed on 06/01/2026. During an interview on 06/12/2026 at 11:53 AM, Staff H, Regional Nurse Consultant, stated the FA was inaccurate and both Staff B and Staff J should have been involved in reviewing the FA. Reference: WAC 388-97-1620(1)(2)(b)(i)(ii)		