STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON HEALTH & REHABILITATION CENTER - PASCO	**2004 N 22ND AVENUE PASCO, WA 99301**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to report an incident involving a missing resident in a timely manner to local law enforcement as required for one of one resident (#1) reviewed for missing persons. This failure disallowed an opportunity for law enforcement to assist in the search of Resident #1. Findings included: Resident #1. Review of the resident's medical record showed he was admitted to the facility from the hospital on [DATE] with [DIAGNOSES REDACTED]. Review of Progress Notes, dated 08/27/2020 at 3:39 PM, showed the resident was found to be missing from the facility that morning, and had not reported to any staff his desire to leave the facility. A search was conducted but was unsuccessful in locating the resident. There was no documentation the local law enforcement agency had been notified. Staff B, Social Services Director, stated per telephone interview on 08/29/2020 at 10:15 AM, that staff was still unable to locate the missing resident. She stated the police had not been notified as the resident was not vulnerable, as he was directing all care and services. Reference (WAC) 388-97-0640(6)(c) This is a repeat citation from the survey dated 07/10/2019. .

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

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.