STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Issaquah	805 Front Street Issaquah, WA 98027

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure funds were reimbursed to the resident and/or representative or the state Office of Financial Recovery (OFR), within 30 days of resident discharge or death, for 4 (Residents 234, 235, 237, & 236) of 7 discharged residents reviewed. This failure caused a delay in reconciling residents' accounts within 30 days as required. Findings included . <Facility Policy> According to an undated facility Trust Standards policy, balances in the trust would be disbursed upon discharge according to state regulations. This policy identified trust funds would be disbursed in seven days for discharged residents and 30 days for expired residents. <Resident 234> Review of an [DATE] Discharge Minimum Data Set (MDS - an assessment tool) showed Resident 234 discharged from the facility on [DATE] with their return not anticipated. Review of Resident 234's trust transaction history showed their balance of $6.00 was not closed out and disbursed until [DATE], 64 days after Resident 234 discharged from the facility. <Resident 235> Review of an [DATE] Discharge MDS showed Resident 235 discharged from the facility on [DATE] with their return not anticipated. Review of Resident 235's trust transaction history showed their balance of $28.00 was not closed out and disbursed until [DATE], 59 days after Resident 235 discharged from the facility. <Resident 237> Review of a [DATE] Discharge MDS showed Resident 237 discharged from the facility on [DATE]. Review of Resident 237's trust transaction history showed their balance of $303.66 was not closed out and disbursed until [DATE], 34 days after Resident 237 discharged from the facility. <Resident 236> (continued on next page)

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

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a [DATE] Discharge MDS showed Resident 236 discharged from the facility on [DATE] with their return not anticipated. Review of Resident 236's trust transaction history as of [DATE], showed their balance of $60.00 was still active in the facility trust and was not disbursed yet, 33 days after Resident 236 discharged from the facility. In an interview on [DATE] at 8:52 AM, Staff P (Business Office Manager) stated the facility needed to ensure trust funds were distributed within 30 days of a resident's discharge. Staff P stated Resident 234, 235, 237, and 236 trust accounts should have, but were not disbursed as required. REFERENCE: WAC [DATE](5).

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51791 Based on observation, interview, and record review the facility failed to initiate, log, investigate, and/or resolve grievances identified for 2 (Residents 14 & 56) of 2 sample residents reviewed for grievances. Staff failure to oversee the grievance process and track grievances through to their conclusions, placed residents at risk for unmet care needs. Findings included . <Facility Policy> The facility's May 2000 Grievance Policy showed formal grievances would be submitted in writing by outlining the concern on the grievance communication form. Staff would assist in completion of the form and submit it to the administrator, who would forward it to the appropriate department manager for action within 72 hours of receipt. <Resident 14> According to the 07/22/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 14 had moderate cognitive impairment, loosely fitting dentures, broken teeth, and experienced pain when chewing. Review of the February 2025 Grievance Log showed Resident 14 verbalized in the resident council meeting their dentures did not fit and were returned to the dental provider. This log showed Resident 14 understood that new [dentures] would take about two months, but it's already been six months. Staff I (Activities Director) completed the grievance communication form on 02/20/2025 for Resident 14 and submitted the form to Staff A (Administrator). On 02/20/2025, Staff C (Social Services Coordinator) documented they reached out to the provider for an update. Staff C concluded the investigation by attaching the contracted provider's email response and added they would ask Resident, if they would like extractions. Review of the 03/03/2025 dental evaluation showed the provider noted, patient does not have any upper denture at facility. In a phone interview with the dental provider on 03/27/2025 at 9:25 AM, the provider stated they emailed Staff C to report the dentures were missing on 03/05/2025. In an interview on 03/27/2025 at 11:16 AM, Staff C stated they received an email from the provider regarding Resident 14's missing dentures. Staff C stated they did not complete a grievance communication form addressing Resident 14's missing dentures. Staff C could not recall whether they informed Staff A of the email from the provider. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 12:54 PM, Staff A stated they were unaware Resident 14's dentures were missing. Staff A stated they expected staff to follow the grievance policy, when residents' belongings were reported as missing. Staff A stated it was the residents' right to voice concerns and have those concerns thoroughly investigated and resolved. Staff A stated an important part of the process was to communicate the results of the investigation to the resident and concerned representatives. 45941 <Resident 56> According to the 12/20/2024 Quarterly MDS, Resident 56 had minimal difficulty with hearing and used hearing aids. According to the 03/19/2025 Quarterly MDS, Resident 56 had moderate difficulty with hearing and did not use hearing aids. Observation and interview on 03/20/2025 at 1:44 PM showed Resident 56 had a hearing aid in their left ear only. Resident 56 stated they could not hear well since they lost their right hearing aid. In an interview on 03/21/2025 at 10:43 AM, Resident 56's representative stated Resident 56 went to the hospital on 12/06/2024 and came back to the facility on [DATE] with both hearing aids. A week after Resident 56 came back from the hospital, they lost their right ear hearing aid in the facility and the facility did not resolve the missing hearing aid yet. Observations on 03/21/2025 at 11:34 AM, on 03/24/2025 at 1:01 PM, and on 03/25/2025 at 8:58 AM, showed Resident 56 lying in bed and only had their left ear hearing aid in. Resident 56 stated they could not hear well ever since they lost their hearing aid. Resident 56 stated their daughter talked to the staff about getting new hearing aid. Review of a 09/20/2024 admission assessment showed staff documented Resident 56 had both hearing aids and had difficulty with hearing. Review of the facility's November 2024, December 2024, January 2025, February 2025, and March 2025 grievance logs and investigation logs showed no documentation Resident 56's missing hearing aid was acknowledged or investigated. In an interview on 03/25/2025 at 2:01 PM, Staff C stated the facility process for missing items was to file a grievance form on the resident's behalf and the facility would investigate. Staff C stated if the facility could not find the resident's items, the facility would replace the items. Staff C stated they did not recall anything regarding Resident 56's missing hearing aid. In an interview on 03/25/2025 at 2:15 PM, Staff F (Resident Care Manager) stated they were aware Resident 56 was missing one of their hearing aids. Staff F stated Resident 56 came back from the hospital with both hearing aids and they lost the right ear hearing aid in the facility. Staff F stated they reported to social services that Resident 56 was missing their hearing aid. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/25/2025 at 2:32 PM, Staff U (Charge Nurse) stated they knew about Resident 56 missing hearing aid since Resident 56 came back from hospital in December 2024. Staff U stated they reported Resident 56's missing hearing aid to Staff F and Staff C. Staff U stated they reported the missing items to Staff C, and Staff C was supposed to fill out the grievance form. In an interview on 03/27/2025 at 10:16 AM, Staff F stated the facility's provider notified staff regarding Resident 56's missing hearing aid. In an interview on 03/27/2025 at 11:30 AM, Staff H (Outside Provider) stated Resident 56 lost their hearing aid after they came back from the hospital. Staff H found out about the missing hearing aid from the resident. Staff H provided the documentation showing they notified Staff C in February 2025 regarding Resident 56's missing hearing aid. In an interview on 03/27/2025 at 12:08 PM, Staff A stated they were unaware Resident 56 was missing a hearing aid. Staff A stated they expected staff to follow the grievance policy, when residents' belongings were reported as missing. Staff A stated it was the residents' right to voice concerns and have those concerns thoroughly investigated and resolved. Staff A stated staff should initiate a grievance form when they found out about Resident 56 missing hearing aid and provided an alternate device to the resident for hearing, but they did not. REFERENCE: WAC 388-97-0460.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS -an assessment tool) accurately reflected the status for 2 (Resident 80 & 5) of 19 residents reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 5> According to a 09/25/2024 Annual MDS Resident 5 had multiple medically complex diagnoses including an anxiety disorder and depression, and required the use of psychotropic medications during the assessment period. This MDS showed Resident 5 was not currently considered by the state Level 2 Preadmission Screening and Resident Review (PASRR) process to have a Serious Mental Illness (SMI). Review of a 09/29/2023 Level 1 PASRR showed staff identified Resident 5 had SMI indicators of a mood and anxiety disorder and required a referral for a Level 2 evaluation. Review of a 12/14/2023 PASRR Notice of Determination showed Resident 5 was assessed to have a mental health diagnosis and required specialized behavioral health services. The Level 2 PASRR evaluation was completed on 12/14/2023 with recommendations for Resident 5's specialized plan of care established. In an interview on 03/27/2025 at 9:22 AM, Staff D (MDS Coordinator) stated if Resident 5 had a Level 2 evaluation and was determined to have an SMI, it should be accurately identified on the 09/25/2024 Annual MDS. According to Resident 5's 12/23/2024 Quarterly MDS, staff assessed the resident to have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device during the assessment period. No pressure ulcers were identified as current on this MDS. Review of nursing progress note from 12/23/2024 at 3:02 PM showed staff documented an assessment that Resident 5's skin was intact with no wounds present and no new skin issues noted. A 12/23/2024 weekly skin audit completed at 4:00 PM showed Resident 5 continued to have previously identified chronic discoloration to both lower legs and fading bruises to the left arm. No pressure ulcers, scars over bony prominences, or non-removable dressing/devices were documented as being present during the assessment. In an interview on 03/27/2025 at 9:22 AM, Staff D reviewed Resident 5's records and stated the question about having a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device was marked inaccurately on the 12/23/2024 Quarterly MDS. Staff D stated an accurate MDS was important as it, drives the care plan and helps provide an accurate picture of a resident and what care needs to be provided. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46479 <Resident 80> Review of a 02/10/2025 Discharge MDS showed Resident 80 was discharged on [DATE] to an acute care hospital and their return to the facility was not anticipated. Review of a 02/10/2025 nursing progress note showed Resident 80 discharged home in stable condition with their spouse. In an interview on 03/25/2025 at 8:50 AM, Staff D (MDS Coordinator) reviewed the 02/10/2025 Discharge MDS assessment and stated the MDS was coded incorrectly, that the resident discharged home, not to the hospital. Staff D stated the 02/10/2025 MDS required modification. REFERENCE: WAC 388-97-1000(1)(b).

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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** 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions and/or obtained prior to admission for 4 of 6 (Residents 56, 16, 32, & 8), and 1 supplemental (Resident 61) residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 61> According to a 02/11/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 61 admitted on [DATE] with multiple medically complex diagnoses including a bipolar disorder (a mental illness characterized by extreme mood swings). This MDS showed Resident 61 required the use of an antipsychotic medication during the assessment period. Record review showed Resident 61 was admitted from the hospital with a 10/30/2024 Level 1 PASRR that showed the resident had a Serious Mental Illness (SMI) indicator of a mood disorder. There was no referral or evaluation completed due to Resident 61's identified SMI prior to Resident 61's admission to the facility as required. Review of 01/20/2025 Level 1 PASRR, completed over two months after Resident 61's admission, showed staff identified the resident had a mood disorder, but marked no Level 2 evaluation was indicated due to an exempted hospital discharge. The exempted hospital discharge section was blank on the 01/20/2025 Level 1 PASRR form. Staff documented on the form that Resident 61 did not discharge within 30 days and there was no anticipated discharge at this time. In an interview on 03/27/2025 at 9:22 AM, Staff C (Social Services Coordinator) reviewed Resident 61's records and stated if the Level 1 PASRR completed on 10/30/2024 indicated Resident 61 had a SMI, then a Level 2 evaluation should be completed prior to the resident's admission to the facility as required. Staff C stated the 01/20/2025 Level 1 PASRR should have identified a Level 2 referral was required as Resident 61 had a SMI identified and did not have a pending discharge in progress. <Resident 56> According to a 12/20/2024 Quarterly MDS, Resident 56 admitted on [DATE] with multiple medically complex diagnoses including anxiety and depression, and required the use of antianxiety and antidepressant medications during the assessment period. Record review showed Resident 56 was admitted from the hospital with a 09/20/2024 Level 1 PASRR that showed the resident had SMI indicators of a mood disorder and anxiety. There was no referral or evaluation completed due to Resident 56's identified SMIs prior to Resident 56's admission to the facility as required. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/27/2025 at 9:22 AM, Staff C reviewed Resident 56's records and stated if the 09/20/2024 Level 1 PASRR indicated Resident 56 had a SMI, then a Level 2 evaluation should be completed prior to the resident's admission to the facility as required. <Resident 16> According to a 02/18/2025 Annual MDS, Resident 16 had multiple medically complex diagnoses including a bipolar disorder and depression, and required the use of antipsychotic and antidepressant medications during the assessment period. Review of a 06/17/2024 Level 1 PASRR showed staff identified Resident 16 had a SMI indicator of a mood disorder and required a referral for a Level 2 evaluation. No Level 2 evaluation was found in Resident 16's records. On 01/20/2025, seven months later, staff completed a second Level 1 PASRR with a SMI indicator of a mood disorder and indicated a referral for a Level 2 evaluation was required for a significant change. Record review showed no Level 2 was found in Resident 16's records. In an interview on 03/27/2025 at 9:22 AM, Staff C reviewed Resident 16's records and stated a Level 2 evaluation should be completed as required with the 06/17/2024 and 01/20/2025 referrals. Staff C was unable to locate a Level 2 form that showed a referral was completed and stated the evaluators were behind schedule. When asked to provide documentation the evaluators were behind schedule, Staff C did not provide any further data. <Resident 32> According to a 01/28/2025 Annual MDS, Resident 32 had multiple medically complex diagnoses including dementia and depression, and required the use of an antidepressant medication during the assessment period. Review of a 12/28/2024 Level 1 PASRR showed staff identified Resident 32 with a SMI indicator of a mood disorder and required a Level 2 referral for the SMI. This form was not signed or dated by staff and no Level 2 evaluation was found in Resident 32's records. In an interview on 03/27/2025 at 9:22 AM, Staff C reviewed Resident 32's records and stated their expectation was for the form to be complete, signed, and with a Level 2 evaluation obtained as required. 46479 <Resident 8> Review of Resident 8's 04/26/2024 Significant Change in status MDS showed the resident's most recent entry to the facility was 04/19/2024. This MDS showed Resident 8 had diagnosis of anxiety, depression, bipolar disorder, and post-traumatic stress disorder. This MDS showed Resident 8 experienced inattention, disorganized thinking, suicide attempt, and rejected care during the assessment period. The MDS showed Resident 8 received antipsychotic, antianxiety, and antidepressant medications during the assessment period. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 04/19/2024 Level 1 PASRR showed Resident 8 had SMI indicators including mood disorders, anxiety disorders, and post-traumatic stress disorder. The PASRR showed Resident 8 required a referral for a Level II PASRR due to having a significant change in their health status. Record review showed Resident 8 was not referred for a Level II PASRR until 12/27/2024, eight months after their significant change in health status occurred. In a joint interview on 03/27/2025 at 11:47 AM Staff A (Administrator) and Staff C reviewed Resident 8's records and confirmed the Level II PASRR referral was not sent timely. REFERENCE: WAC 388-97-1915(1)(2)(a-c). 45941 51791

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45941 Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised, as needed for 2 (Residents 16 & 61), and conduct timely care conferences to ensure person-centered care for 1 (Resident 14) of 19 sample residents whose CPs and CCs were reviewed. This failure left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . <Facility Policy> The facility's March 2022 Care Plans, Comprehensive Person-Centered Policy showed the interdisciplinary team (IDT) was to collaboratively review and update a comprehensive, person-centered care plan with each resident and/or their representative when a significant change occurred in the resident's condition, the desired outcome in the prior plan was not met; after a readmission from a hospital stay, and, at least, quarterly. <Resident 16> According to a 02/18/2025 Annual Minimum Data Set (MDS - an assessment tool), Resident 16 was assessed to be dependent on staff for toileting and for transferring from their bed to their wheelchair. The MDS showed Resident 16 was at risk for falls and had a fall on 11/28/2024. Review of a revised 12/04/2024 Fall CP showed Resident 16 was at moderate risk for falls related to the use of pain medications and psychotropic medications. The CP directed staff to keep Resident 16's bed in the lowest position for safety. Observation on 03/21/2025 at 10:35 AM, 03/24/2025 at 9:01 AM, and at 1:12 PM, and on 03/25/2025 at 9:05 AM, showed Resident 16 was lying in bed in their room and their bed was not in the lowest position. Review of a 07/17/2024 revised CP showed Resident 16 had cellulitis on their leg and staff were directed to give antibiotic medication to the resident. Review of Resident 16's March 2025 medication administration record on 03/25/2025 showed no orders for the antibiotic medication. In an interview on 03/25/2025 at 10:02 AM, Staff G (Resident Care Manager) checked the CPs regarding Resident 56's fall and medications. Staff G stated Resident 56's bed should be in lowest position to decrease the risk of injury related to a fall. Staff G stated Resident 56 did not have cellulitis anymore and Resident 56 was not receiving antibiotic medications. Staff G stated the CPs needed to be updated and revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/25/2025 at 11:33 AM, Staff B (Director of Nursing) stated CPs should be revised and staff should follow the CPs. 43642 <Resident 61> According to a 02/11/2025 Quarterly MDS, Resident 61 had multiple medically complex diagnoses including stroke and required the use of a feeding tube (a tube to supply nutrients and fluids to the body). Review of an 11/05/2024 feeding tube CP showed a revised 12/02/2024 intervention for Resident 61 to receive diabetic tube feeding formula four times daily with a total volume of 1320 milliliters (ml) per 24 hours. An 11/05/2024 nutritional problem CP showed a revised 02/10/2025 intervention for a fiber tube feeding formula four times daily with a total volume of 1440 ml per 24 hours. Review of Resident 61's physician orders showed a 01/02/2025 tube feeding order for the fiber formula to be administered four times daily. Observations on 03/21/2025 at 10:21 AM showed a container of the fiber tube feeding formula hanging at Resident 61's bedside. In an interview on 03/27/2025 at 10:44 AM, Staff G stated Resident 61's CP should have, but was not updated and revised to reflect only the current tube feeding formula orders. 51791 <Resident 14> According to the 07/22/2024 Annual MDS, Resident 14 had diagnoses including stroke, heart failure, difficulty swallowing, anxiety, depression, respiratory failure, post-traumatic stress disorder, and obesity. In an interview on 03/20/2025 at 1:40 PM with Resident 14, they stated they were not aware of any meetings with staff regarding their CP or the issues they were having with the fit and function of their upper dentures. Review of Resident 14's records showed two care conference progress notes on 10/13/2023 and 07/11/2024. In an interview on 03/27/2025 at 11:16 AM, Staff C (Social Services Coordinator) acknowledged they did not find more recent care conference progress notes for Resident 14. Staff C stated care conferences should be conducted quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 11:28 AM, Staff B acknowledged care conferences were expected to occur quarterly and as needed with significant changes in resident circumstances. Staff B stated care conferences were essential to maintaining person-centered care by including the resident, their representative, and a member from each discipline of the facility care team in the decision making process. REFERENCE: WAC 388-97-1020(5)(b).

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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. 43642 Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were followed and medications were given within ordered parameters for 5 (Residents 5, 231, 32, 56, & 16), POs were clarified as needed for 1 (Resident 5), and nurses signed only for tasks completed for 1 (Resident 5) of 19 sample residents reviewed. The facility failed to document administered medications for 1 (Resident 239) supplemental resident reviewed for medication pass. These failures left residents at risk for unmet care needs and other negative health outcomes. Findings included . <Facility Policy> The facility's 2007 Medication Administration Policy showed staff were to administer medications in accordance with prescribers' written orders and, if necessary, staff would contact the prescriber for clarification. Staff were to document all interactions and the resulting order clarification in the nursing progress notes and elsewhere in the medical record, as appropriate. <Documenting Administered Medications> <Resident 239> During medication pass observations on 03/24/2025 at 8:55 AM, Staff S (Charge Nurse) prepared and administered a non-narcotic pain medication to Resident 239 due to the resident's complaint of pain. Review of Resident 239's March 2025 Medication Administration Record (MAR) showed a 03/12/2025 order for a non-narcotic pain medication to be administered every eight hours as needed for pain. Record review showed Staff S did not document the medication dose that was administered to Resident 239 on 03/24/2025 at 8:55 AM in the resident's records. In an interview on 03/27/2025 at 3:02 PM, Staff B (Director of Nursing) stated it was their expectation staff document any medications administered to reduce the risk of potential medication errors. <Signing for Tasks not Completed> <Resident 5> Observations on 03/20/2025 at 9:58 AM showed Resident 5 with fingernails on both hands extending past their fingertips. Two fingernails on the left hand were broken and jagged. Review of Resident 5's March 2025 Treatment Administration Records (TAR) showed a 03/07/2025 order for diabetic nail care to be completed every week on Wednesday. This order was signed as completed on 03/19/2025, the evening prior to the 03/20/2025 observations of Resident 5's long fingernails. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 10:44 AM, Staff G (Resident Care Manager) stated they observed Resident 5's long nails on 03/26/2025 and had staff trim them at that time. Staff G stated nursing staff should not sign for tasks they did not complete. <Clarification of Orders> <Resident 5> According to Resident 5's March 2025 TAR, the resident received wound care to the left foot every day until 03/14/2025, at which time the order was discontinued and changed to be completed every other day. Review of Resident 5's March 2025 MAR showed the resident had a 02/15/2025 order for a narcotic medication to be given daily 30 minutes before wound dressings to the left foot. This MAR showed staff documented this medication was being administered daily until 03/24/2025, 10 days after the treatment orders were changed to every other day. In an interview on 03/27/2025 at 10:44 AM, Staff G stated staff should have, but did not clarify the narcotic pain medication when the wound care order was changed and no longer being completed daily. <Resident 51> During medication pass observations on 03/26/2025 at 8:39 AM, Staff T (Charge Nurse) prepared and administered several medications for Resident 51. One of the medications administered was a 100 milligram (mg) tablet of a vitamin. Review of Resident 51's March 2025 MAR showed a 03/21/2023 order for the vitamin with the directions to give one tablet by mouth one time a day as a supplement. There was no dosage indicated to direct nursing staff how much of the vitamin was to be administered. In an interview on 03/27/2025 at 3:02 PM, Staff B stated the vitamin order for Resident 51 should have, but was not clarified to include a dosage to administer. <Medications Outside Parameters> <Resident 5> Review of Resident 5's March 2025 MAR showed the resident had a 12/08/2023 order for a laxative suppository for constipation with directions to staff to administer, if a liquid laxative medication was ineffective. Staff documented they administered the suppository on 03/04/2025. There was no documentation by staff the 12/08/2023 liquid laxative order was administered prior to giving Resident 5 the laxative suppository. In an interview on 03/27/2025 at 10:44 AM, Staff G stated it was their expectation staff follow the physician orders and administer medications as ordered. 45941 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 16> According to a 02/18/2025 Annual MDS, Resident 16 used as needed pain medications. The MDS showed Resident 16 had diagnoses including opioid dependence. The 07/17/2024 PO directed staff to give Resident 16 one tablet of the narcotic pain medication every six hours as needed for pain on scale 1 to 5 out of 10 (1-5/10) and two tablets for pain on scale 6 to 10 out of 10 (6-10/10). The March 2025 MAR showed on 03/22/2025 at 6:30 PM, Resident 16 was given one tablet of the narcotic pain medication for a pain level of 8/10. In an interview on 03/27/2025 at 12:48 PM, Staff G stated as needed pain medications should be administered as ordered but staff did not follow the POs. Staff G stated the medication should not be administered outside of parameters. <Resident 56> According to a 12/20/2024 Medicare 5 Day MDS, Resident 56 used as needed pain medications. The MDS showed Resident 56 had diagnoses including gout and pain. The 12/13/2024 PO directed staff to give Resident 56 one half tablet of a narcotic pain medication every four hours as needed for pain on scale 1 to 5 out of 10 (1-5/10) and one tablet for pain on scale of 6 to 10 out of 10 (6-10/10). The March 2025 MAR showed on 03/18/2025 at 11:35 AM, Resident 56 was given one half tablet of the narcotic pain medication for a pain of 8/10 on pain scale. In an interview on 03/27/2025 at 12:48 PM Staff G stated as needed pain medications should be administered as ordered but staff did not follow the POs. Staff G stated the medication should not be administered outside of parameters. 46479 <Resident 231> Review of Resident 231's 03/11/2025 Admission MDS showed the resident had diagnoses of fracture and other multiple trauma. This MDS showed Resident 231 received as needed pain medications during the assessment period. Review of Resident 231's March 2025 MAR showed the resident had three different orders directing staff to administer an as needed narcotic pain medication. The first order directed staff to administer one tab of the narcotic for numeric pain level of 1 - 3. This MAR showed staff administered this order three times for a pain level of 7 and 6. The second order directed staff to administer two tabs of the narcotic if Resident 231's pain level was a 4 - 6. The MAR showed staff administered the order twice for a pain level of 7. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 10:57 AM, Staff Q (Charge Nurse) confirmed the orders were administered outside of the ordered parameters. Staff Q stated if the resident requested less medication despite a high pain level, the staff should document and notify the provider. 51791 <Resident 32> According to the 01/31/2025 Annual MDS, Resident 32 used as needed pain medications. The MDS showed Resident 32 had diagnoses including back pain. Review of the December 2024 MAR showed a PO directing staff to administer one tablet of a narcotic pain medication every eight hours, as needed, for pain on scale of 6 to 10 out of 10 (6-10/10) to Resident 32. The record showed on 12/01/2024 at 12:30 AM, 12/08/2024 at 2:30 PM, and 12/14/2024 at 2:30 PM, Resident 32 was given one tablet of the narcotic pain medication for a pain score of less than 6/10. Review of the January 2025 MAR showed a PO directing staff to administer one tablet of a narcotic pain medication every eight hours, as needed, for pain on scale of 6 to 10 out of 10 (6-10/10) to Resident 32. The record showed on 01/13/2025 at 8:46 AM and 01/25/2025 at 7:32 AM, Resident 32 was given one tablet of the narcotic pain medication for a pain score of less than 6/10. Review of the February 2025 MAR, the PO directed staff to give Resident 32 one tablet of the narcotic pain medication every eight hours, as needed, for pain on scale of 6 to 10 out of 10 (6-10/10). The record showed that on 02/11/2025 at 8:30 AM, 02/14/2025 at 2:10 PM, and 02/19/2025 at 2:40 PM, Resident 32 was given one tablet of the narcotic pain medication for a pain score of 0/10. In an interview on 03/27/2025 at 12:48 PM Staff G stated as needed pain medications should be administered as ordered but staff did not follow the POs. Staff G stated the medication should not be administered outside of parameters. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46479 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 (Residents 77, 56, & 5) of 19 sample residents who were assessed to be dependent on staff for ADLs. The failure to provide ADL assistance as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes. Findings included . <Facility Policy> Review of the facility's Activities of Daily Living, Supporting policy, dated 03/2018, showed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene. <Resident 77> Review of the 03/10/2025 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 77 had cognitive impairment and diagnoses including heart failure, malnutrition, and muscle weakness. The MDS showed Resident 77 required assistance from staff for personal hygiene including combing hair and shaving. Review of Resident 77's 03/03/2025 Admission Nursing Database assessment showed the resident preferred showers either in the AM or PM. Review of Resident 77's 03/14/2025 revised ADL self-care performance deficit Care Plan (CP) showed the resident was to receive showers twice weekly on Tuesday and Friday evenings. In an observation and interview on 03/21/2025 at 8:49 AM, Resident 77 was lying in bed and had long facial stubble. Resident 77 stated they did not have a shower, they only received sponge baths. Resident 77 stated they were waiting to be shaved and that their friend came to the facility to shave them once before. Resident 77 stated they did not like having long facial hair. Similar observations were made on 03/24/2025 at 8:45 AM and on 03/25/2025 at 11:10 AM. Review of Resident 77's 03/2025 task documentation showed staff documented the resident refused/was unavailable for a shower on 03/07/2025. Staff did not document bathing again until 03/18/2025, 11 days later, and documented Resident 77 refused/was unavailable for a shower. The task report showed Resident 77 received a shower on 03/21/2025 and refused/was unavailable on 03/25/2025. Record review showed there were no progress notes regarding the refusals or documentation showing Resident 77 was offered a shower on the next shift or next day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 10:41 AM, Staff J (Resident Care Manager - RCM) stated when residents received showers or baths, staff were expected to offer to shave the resident and provide nail care if appropriate. Staff J stated staff were expected to reapproach the resident for refusals and offer to provide the care the next shift or next day. Staff J stated staff were expected to document refusals and report to the nurse. Staff J stated they were unaware of Resident 77's bathing refusals. 45941 <Resident 56> According to a 03/19/2025 Quarterly MDS, Resident 56 was dependent on staff for personal hygiene, toileting, and showers, and had no rejection of care during the assessment period. Review of a revised 09/20/2024 self-care deficit CP showed Resident 56 required one person assistance with personal hygiene care. Observations on 03/20/2025 at 1:26 PM and on 03/24/2025 at 9:01 AM showed Resident 56 with long fingernails. In an interview on 03/21/2025 at 11:23 AM, Resident 56 stated staff were supposed to clip their fingernails, but they did not. Observation on 03/25/2025 at 9:33 AM showed Resident 56's fingernails had nail polish on but their nails were still long. In an interview on 03/27/2025 at 8:11 AM, Staff R (Licensed Practical Nurse) stated they were responsible to provide nail care to diabetic residents on their weekly skin check days and nurses aids provided nail care to non-diabetic residents on their shower days. Staff R stated if a resident refused, they would document the refusals in resident's record. In an interview on 03/27/2025 at 10:03 AM, Staff F (RCM) stated staff should provide nail care to all residents weekly and as needed. Staff F stated any refusals of care should be documented in a resident's record. 43642 <Resident 5> According to a 12/23/2024 Quarterly MDS, Resident 5 was dependent on staff for personal hygiene, rolling from side to side, and had no rejection of care during the assessment period. Review of a revised 03/06/2025 self-care deficit CP showed directions to staff that Resident 5 required one person extensive to total assist for personal hygiene, diabetic nail care was to be completed weekly by the nurse, and to document if the resident refused care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 03/20/2025 at 9:58 AM and 03/24/2025 at 8:36 AM showed Resident 5 with long, curly chin hairs and fingernails on both hands extending past their fingertips. Two fingernails on the left hand were broken and jagged. In an interview on 03/27/2025 at 9:57 AM, Staff K (Certified Nursing Assistant) stated they were responsible for assisting residents with bathing and shaving on their shower days. Staff K stated if a resident refused, they would document the refusal and notify their supervisor. Review of Resident 5's March 2025 ADL documentation showed the resident had bathing on 03/20/2025 with no refusals documented for personal hygiene or bathing. Review of Resident 5's March 2025 Treatment Administration Records showed the resident was scheduled for diabetic nail care every week and was signed as completed on 03/19/2025. In an interview on 03/27/2025 at 10:44 AM, Staff G (RCM) stated it was their expectation staff assist with shaving and stated it was a part of the care to provide. Staff G stated shaving should be provided at any time when a resident needed it. Staff G stated nail care should be provided by staff weekly and as needed. Staff G stated they noticed Resident 5's long nails on 03/26/2025 and had staff trim them at that time. Staff G confirmed any refusals of care should be documented. REFERENCE: WAC 388-97-1060(2)(c).

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure the physician's orders and resident records were updated to accurately reflect the resident's wishes for Cardiopulmonary Resuscitation (CPR - the act of performing chest compressions and providing breaths to mimic the heartbeat and breathing) status as directed by the Physician Orders for Life Sustaining Treatment (POLST) form for 2 (Residents 33 & 6) of 5 residents reviewed for CPR. This failure placed residents at risk for not receiving care in accordance with the resident's and/or resident's representative decision-making if their heart stopped beating or breathing stopped. Findings included . <Resident 6> Review of Resident 6's records showed a [DATE] POLST form that showed Resident 6's code status (instructions given to medical professionals about what to do in the event a person's heart or breathing stops) was Do Not Attempt Resuscitation (DNAR). Review of Resident 6's physician orders showed a [DATE] code status order for DNAR/Comfort-focused treatment. Resident 6 had a second physician order for a code status from [DATE] which showed Resident 6 was Full Code (directions to staff to perform CPR), rather than DNAR as directed on the [DATE] POLST form. Review of a revised [DATE] advance directive Care Plan (CP) and Kardex (directions to staff regarding how to provide care) showed Resident 6 was a Full Code (CPR) with full treatment, rather than DNAR as ordered on [DATE]. Review of the facility POLST binder kept at the nurse's station showed Resident 6's [DATE] POLST for DNAR was present. In an interview on [DATE] at 10:44 AM, Staff G (Resident Care Manager) stated the correct code status was important to be accurately reflected in a resident's records, which included the physician orders and the resident's CP, to assure staff knew the resident's wishes in advance if found without a pulse or breathing. Staff G reviewed Resident 6's records and stated they did not reflect the resident's wishes for DNAR and needed to be changed. In an interview on [DATE] at 3:02 PM, Staff B (Director of Nursing) stated it was their expectation staff accurately identity a resident's code status in the resident records. 51791 <Resident 33> (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the [DATE] Minimum Data Set (MDS - an assessment tool) Resident 33 had a significant change in their health status, resulting in their transition from life-prolonging care to hospice care (a comfort-focused approach). Review of the [DATE] Nursing Progress Note showed Resident admitted to hospice today by hospice RN. Hospice RN got verbal consent from resident's [representative] and provider for [their] POLST form: DNAR, selective treatment. Resident 33 was to be changed from life-prolonging care (full code) to comfort-focused care (DNAR). Review of Resident 33's [DATE] Kardex showed their code status as Patient is FULL CODE (CPR). In an interview on [DATE] at 11:16 AM, Staff O (Certified Nursing Assistant - CNA) stated they started their shift by reviewing the Kardex and CP for their residents to understand how to support the resident during their shift. Staff O stated, when a code was initiated, they began CPR immediately for residents documented as Full Code status. After beginning CPR, another CNA would go and get the assigned nurse. In an interview on [DATE] at 12:10 PM, Staff F (Resident Care Manager) stated physician orders for all residents were to be accurately documented throughout the residents' record. REFERENCE: WAC [DATE](1).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 45941 Based on observation, interview, and record review the facility failed to develop and implement individualized activity plans and ensure activity programs met the needs of each resident for 2 of 5 (Residents 40 & 5) residents reviewed for activities. Failure to consistently implement meaningful individual activity plans left residents at risk for boredom, frustration, isolation, and a diminished quality of life. Findings included . <Facility policy> According to the facility's undated Activities policy the facility would provide an Activities program that would address the intellectual, social, spiritual, creative, and physical needs, capabilities, and interest of each resident. The activity program would promote each resident's self-respect by providing activities that support self-expression and choice. <Resident 40> According to the 02/19/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 40 had no speech, poor vision, and was dependent on staff for all daily activities including personal hygiene, toileting, bed mobility, and transfers. The MDS showed Resident 40 preferred to listen to music, being around pets, doing things with a group of people, participating in favorite activities, spending time outdoors, and participate in religious activities or practices. Review of a revised 11/25/2024 Activities Care Plan (CP) showed Resident 40 was dependent on staff for activities related to interests: listening to music, watching TV, pets visits; and needs: one to one visit. The goal for Resident 40 was to maintain involvement in cognitive stimulation and social activities. The CP included interventions showing Resident 40 needed 1:1 bedside/in-room visits and activities if the resident was unable to attend out of the room events. The interventions directed staff to provide an activity calendar and assistance with activity functions. Review of the activity participation records on 03/25/2025 showed staff documented Resident 40 was sleeping on 21 events for 1:1 activities and staff documented Active for four days out of 25 days. Observations on 03/20/2025 at 2:49 PM, on 03/21/2025 at 10:47 AM, on 03/24/2025 at 12:51 PM, and on 03/25/2025 at 9:02 AM and 12:11 PM, showed Resident 40 lying in their bed with closed eyes. No music was playing in their room. No observations showed Resident 40 up in their wheelchair for group activities or religious activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/26/2025 at 1:06 PM Staff I (Activity Director) stated they were responsible for completing the activity assessment and implementing the activity program. Staff I stated 1:1 program meant activity staff went to the resident's room and asked how the resident was doing and sometimes staff provided hand massages. Staff I stated for nonverbal residents, activity staff play music on their TV. When asked why Resident 40's TV was off and no music was playing, Staff I stated, Well, we do not turn music on in that room because Resident 40's roommate will be disturbed. When Staff I was asked if staff offered alternate devices such as headphones to Resident 40, Staff I responded they never thought about that idea. Staff I stated activity staff should offer and assist Resident 40 with activities of their preferences, but they did not. 43642 <Resident 5> According to a 12/23/2024 Quarterly MDS, Resident 5 had severe memory impairment and was assessed by staff to enjoy listening to music, being around animals, keeping up with the news, enjoys their favorite activities, and religious activities. This MDS showed Resident 5 had no rejection of care and was dependent on staff to roll from side to side and transfer from the bed to a chair. Review of a 09/26/2024 psychosocial well-being Care Area Assessment (CAA) showed staff documented to proceed to the CP to provide social interactions that were meaningful and purposeful to reduce isolation and promote friendships, to aid in sharing emotions, to alleviate stress, grieving, and sense of loss. The 09/25/2024 Activities CAA showed staff indicated Resident 5 was in bed all day and did not attend any group activities. This CAA showed staff would offer them snacks and pet visits, encourage them to attend group activities, and work with nursing staff to get Resident 5 up in their chair for group activities. Review of a 10/24/2024 activities CP showed Resident 5 was interested in reading, playing cards, hand massage, socializing, movies, computer, and watching the news. Staff documented Resident 5 needed daily activity materials, assistance to group activities, pet visits, and 1:1 activities. This CP directed staff to provide Resident 5 with assistance/escort to activity functions. Review of a 02/20/2025 mood/behavior CP directed staff to encourage Resident 5 to engage in any activities they seemed to enjoy and to ensure they had the opportunity to engage in faith-based activities if they chose. Review of February 2025 activity documentation records showed Resident 5's only group activity was a movie on 02/12/2025. According to Resident 5's March 2025 activity documentation records, only two group activities were provided, one for sensory stimulation on 03/10/2025 and the other for bingo on 03/19/2025. Record review showed no activity progress notes or quarterly assessments/reviews were completed. In an interview on 03/27/2025 at 10:37 AM, Resident 5 stated they liked music and bingo. The resident was unable to indicate when they went to activities. Observations on 03/20/2025 at 9:58 AM, 03/24/2025 at 1:14 PM, and 03/27/2025 at 10:37 AM showed Resident 5 lying in bed with only the television on. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Avamere Rehabilitation of Issaquah		STREET ADDRESS, CITY, STATE, ZIP CODE: 805 Front Street Issaquah, WA 98027	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 1:26 PM, Staff I stated sometimes the nursing aides brought the residents to activities and sometimes Staff I would go through the hall to remind residents of the activities. Staff I stated if a resident was sleeping, they, do not bother them. When asked how often Staff I assessed a resident's current activity preferences or if their activity needs changed, Staff I stated they did not do quarterly assessments or notes. Staff I stated they only did the CAAs on admission and yearly, and stated, I think I should do that more often and update the resident's activity care plan when things change. REFERENCE: WAC 388-97-0940(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to accurately assess for the safety of and obtain and implement physician's orders to leave the facility independently for 1 (Resident 240) of 1 residents reviewed for safety, failed to ensure appropriate safety measures to prevent a fall were implemented for 1 (Resident 5) of 2 residents reviewed for falls, and, to ensure safe resident smoking and perform quarterly smoking assessments for 1 (Resident 6) of 1 resident reviewed for smoking. These failures placed all residents at risk for injury, harm, and continued falls. Findings included . Review of the facility policy, titled Safety and Supervision of Residents, revised 07/2017, showed the facility would strive to make the environment as free from hazards as possible. The interdisciplinary team would analyze information obtained from assessments and observations to identify specific accident hazards or risks for individual residents. The facility would have interventions to reduce an individual's risks related to hazards in the environment, including adequate supervision and assistive devices. The policy showed the facility would implement and monitor the interventions for effectiveness and modify when necessary. <Resident 240> Review of a Quarterly Minimum Data Set (MDS - an assessment tool), dated 03/24/2025, showed Resident 240 was able to make their own decisions, able to understand, and be understood by others, had behaviors of rejecting care and verbal behaviors directed at others that put the resident at significant risk for injury and interfered with care. The MDS showed Resident 240 had a stimulant (has a direct effect on the nervous system) substance abuse dependence disorder. The MDS showed Resident 240 used a wheelchair for ambulation, required supervision with transfers. Review of an admission nursing assessment, dated 02/12/2025, showed Resident 240 did not currently use illegal drugs or cigarettes, but had a recent history of using illegal drugs and cigarettes. There was no physician order that allowed the resident to smoke or leave the facility independently. Review of a progress note, dated 03/20/2025 at 7:56 AM, showed Staff C (Social Services Assistant) documented Resident 240 wanted to go the store and was offered the option for the activity department to do their shopping due to (the resident) going out and not being safe because the resident could have access to illegal drugs. A progress note, dated 03/20/25 at 3:45 PM, showed Staff C documented the police located Resident 240 outside of a local store and waited with Resident 240 until facility staff picked them up. The documentation showed no indication the physician was informed of Resident 240 leaving the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nursing Progress Note (NPN), dated 03/23/2025, showed Staff U (Charge Nurse) documented Resident 240 was visibly upset, yelling at staff, and was last seen at 4:30 PM in the hallway. A NPN, dated 03/23/2025 10:15 PM, showed Staff W (Registered Nurse - RN) documented that Resident 240 was out to the store, and returned at 9:15 PM. Staff W documented that Resident 240 stated (he/she) had to walk all the way back to the facility because their cab did not show up. The documentation showed no indication the physician was informed of Resident 240 leaving the facility for a second time. Despite the lack of a thorough assessment the facility developed a safety risk Care Plan (CP), that was revised 03/25/2025, and showed Resident 240 was at risk for safety due to leaving the facility and going to the store without assistance. The CP directed staff to ensure Resident 240 signed out and back in when going out to the community, notify Resident 240's representatives, and the physician. The CP directed staff to call, check on, and follow up with Resident 240 when out of the facility. During an observation and interview on 03/26/2025 at 12:47 PM, Resident 240 was observed in bed with multiple blankets covering their head. The Resident refused to be interviewed. In an interview on 03/27/2025 at 1:30 PM, Staff B (Director of Nursing) stated Resident 240 had a history of a illegal drug use. When asked how residents were assessed to be safe to leave the facility independently. Staff B felt the original assessment was accurate. Staff B stated Resident 240 was alert and oriented and able to call their own taxi. Staff B stated the facility did not, but should have obtained a physician's order for the resident to be able to leave the facility independently, especially with Resident 240's history of substance use. Staff B stated they would expect a physician's order to be able to leave the facility and additional orders to direct staff on what to do or what medications to hold if Resident 240 appeared under the influence of drugs. <Resident 5> According to a 12/23/2024 Quarterly MDS, Resident 5 had severe memory and vision impairment, was dependent on staff for chair to bed transfers, and received psychotropic medications during the assessment period. According to a 09/30/2024 fall Care Area Assessment, staff documented Resident 5 continued to be at risk for falls and falls would be addressed on the resident's CP. Review of a revised 09/30/2024 fall CP showed Resident 5 had decreased safety awareness and gave directions to staff to have a floor mat on the right side of the bed, keep the bed in the lowest position except during care, and have the resident wear non-skid footwear at all times. Review of Resident 5's physician orders showed a 02/15/2025 order for the bed to be in the low position when the resident was in bed except for providing personal care and a floor mat on the left side of the bed. Observations on 03/20/2025 at 9:58 AM showed Resident 5 had a fall mat to the left side of the bed, none on the right side, and the bed was not in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 03/24/2025 at 8:36 AM showed Resident 5 only had a fall mat on the left side of the bed and no non-skid footwear on their feet. At 1:14 PM on 03/24/2025, observations showed Resident 5's bed was not in the lowest position, no fall mat was on the right side of the bed, and no non-skid footwear were on. There was a sticker on the resident's footboard that read, keep bed in low position. Observations on 03/25/2025 at 8:34 AM and 03/27/2025 at 8:02 AM and 10:37 AM showed no fall mat to the right side of bed, no non-skid footwear, and the bed was not in the lowest position. In an interview on 03/27/2025 at 10:44 AM, Staff G (Resident Care Manager) stated it was their expectations staff follow a resident's fall interventions to help prevent falls and/or injuries. Staff G stated staff should implement the identified fall interventions for Resident 5 or update and revise the interventions as indicated. <Resident 6> Review of a Quarterly MDS, dated [DATE], showed Resident 6 was able to make their own decisions and needs known, and was able to understand and be understood by others. The MDS showed Resident 6 had diagnoses including a brain injury, impairments to one side of their upper body, seizure disorder, and diabetes. The MDS showed Resident 6 was dependent on staff for transfers and bathing and used a wheelchair for ambulation Review of smoking CP, dated 02/09/2023, showed Resident 6 was able to smoke independently in outside smoking areas and their smoking materials would be kept in the nurses's medication cart. The CP was revised on 01/18/2025 and directed staff to complete a smoking assessment every quarter to evaluate for safety of independent smoking. Review of Resident 6's medical record showed a smoking policy acknowledgement and consent dated, 09/2019, and smoking assessments completed on 03/2024, 02/2025 and 03/2025. During an observation and interview on 03/20/2025 at 10:21 AM, Resident 6 was observed in their power wheelchair and stated they have smoked for [AGE] years, was grandfathered in after the facility went to no smoking, and kept smoking supplies locked in a drawer at their bedside. In an interview on 03/26/2025 at 12:55 PM, Staff G stated the facility would use an assessment to evaluate if a resident was safe to smoke independently. Staff G stated the facility would have the resident sign the smoking policy, offer smoking cessation alternatives, and smoking supplies would be kept at the nurses cart. Staff G stated when a resident was ready to go outside to smoke the nurse would give the resident the smoking supplies and obtain the supplies when the resident was done smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2025 at 2:00 PM, Staff B stated smoking assessments should be done quarterly. Staff B acknowledged Resident 6 was not assessed to safely smoke after 03/2024 until 02/2025. Staff B stated required assessments on 06/2024, 09/2024, and 11/2024 were not completed. Staff B stated Resident 6 was able to safely keep smoking supplies in a secured box at their bedside and that was not included on the CP like they would expect. Staff B stated the facility smoking policy needed to be revised to include keeping smoking supplies at the bedside for independent smoking residents. Staff B stated Resident 6 should have, but did not sign a smoking policy and consent after the facility changed owners and acknowledged Resident 6 signed a smoking policy and consent over six years ago. REFERENCE: WAC 388-97-1060(3)(g).

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Avamere Rehabilitation of Issaquah	805 Front Street Issaquah, WA 98027

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to obtain timely laboratory services to meet the needs of 2 (Residents 5 & 8) of 5 residents reviewed for unnecessary medications. Failure to obtain physician ordered blood tests for residents who were assessed to require this service, placed residents at risk for delayed treatment and services. Findings included . <Resident 5> According to a 12/23/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 had multiple medically complex diagnoses including anemia (lack of healthy blood cells), heart failure, kidney, and lung disease. This MDS showed Resident 5 was at risk for pressure injuries. Review of a 02/06/2025 wound consult progress note showed Resident 5's wound was evaluated by the wound team and recommendations were given to obtain lab work. Review of Resident 5's February 2025 Treatment Administration Record (TAR) showed a 02/07/2025 physician order to obtain the recommended lab work, which included an ESR [Erythrocyte Sedimentation Rate - a test used to detect inflammation in the body], CRP [C-Reactive Protein - a test to detect a protein level in response to inflammation], and WBC [White Blood Count - a test to help detect infections and inflammation]. Review of a 02/14/2025 Lab Results report showed the lab work was collected from Resident 5 on 02/10/2025 and received on 02/11/2025. This report showed the blood specimen was invalid and tests were not performed due to the age of the specimen. The results report showed the invalid test was reported to the facility on [DATE]. According to Resident 5's February 2025 TAR, a new physician's order was initiated on 02/17/2025 to obtain the ESR, CRP, WBC, and a CBC (Complete Blood Count - a comprehensive blood test) lab tests. Review of a 02/24/2025 Lab Results report showed the ordered lab work was collected from Resident 5 on 02/17/2025 and received on 02/20/2025. This report showed the blood tests ordered were completed except for the ESR blood test, which stated the test was not performed due to the age of the specimen. The results report showed the invalid ESR test was reported to the facility on [DATE]. According to Resident 5's March 2025 TAR, a new physician order was initiated on 03/20/2025 for only a CBC and CMP (Comprehensive Metabolic Panel - a comprehensive blood test). These lab orders were drawn on 03/24/2025 and received 03/25/2025. They did not include the ESR test, which was ordered over six weeks previously and was not obtained. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 10:44 PM, Staff G (Resident Care Manager) stated the lab company came to the facility when they had orders Monday through Thursday and the facility also has staff trained to do lab draws as needed. Staff G stated their expectation was for labs to be completed as ordered and if there was an error with results, to obtain a new lab draw promptly to assure the labs were completed as ordered. Staff G stated labs were ordered for a reason in order to manage a resident's care. Staff G reviewed the resident's records and stated Resident 5's labs were not obtained as ordered. Surveyor: [NAME], [NAME] M. <Resident 8> Review of Resident 8's physician order summary showed a 04/20/2024 order directing staff to administer a heart failure medication daily to the resident. This order summary showed a 04/19/2024 order directing staff to have a lab draw every four weeks to check the blood level of the heart failure medication. Review of Resident 8's February 2025 TAR showed the resident was scheduled to have their lab draw on 02/29/2025. This record showed staff documented a 9 indicating other/see nurse notes. Review of Resident 8's February 2025 progress notes show no progress note was made. Review of Resident 8's lab results show no lab was collected on 02/29/2025 as ordered. In an interview on 03/27/2025 at 12:42 PM, Staff B (Director of Nursing) stated they expected staff to reapproach a resident three times if a lab draw was refused. Staff B stated if a lab draw was not completed as ordered, staff were expected to document why the lab was not completed and the physician should be notified. REFERENCE: WAC 388-97-1620(2)(b)(i). 46479

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to ensure staff performed Hand Hygiene (HH) before and after resident care and failed to follow a contact precaution sign for a resident with Transmission Based Precautions. The facility failed to establish a water management program that assessed and monitored measures to prevent the growth of Legionella (bacteria that could cause a serious lung infection), and other opportunistic waterborne pathogens in the facility's water systems. These failures placed residents at risk for the development of contagious, communicable diseases, and an unclean environment. Findings included . <Water Management Program> In an interview on 03/25/2025 at 10:41 AM, Staff L (Maintenance Director) was unable to provide documentation supporting the facility had a water management plan. Staff M (Infection Preventionist) provided a Legionella Water Management Program policy which showed the facility would have water management committee and staff would review the plan quarterly. Staff L stated they were unaware of a committee or a meeting that discussed the water management plan. Staff L stated they thought the facility performed a Legionella test prior to Staff L being hired but Staff L was unable to provide testing documentation. Staff L did not have a facility water flow diagram and was unaware of high-risk areas in the facility's water systems where Legionella had the potential to grow. Staff L stated each week they checked hot water temperatures in random resident rooms, kitchen, laundry, rehab gym, and showers. Staff L confirmed they should have a water management plan to prevent water borne pathogens, but they did not. In an interview on 03/26/2025 at 11:44 AM, Staff A (Administrator) stated the facility should have a water management plan in place to prevent Legionella, but they did not have one at this time. <HH> <Resident 40> According to a 02/19/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 40 received 51% or more calories through tube feeding (tube inserted into the stomach and provided artificial nutrition). The MDS showed Resident 40 was incontinent of bowel and bladder and was dependent on staff for oral care, toileting, transferring, and bathing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/25/2025 at 9:23 AM showed Staff N (Certified Nursing Assistant - CNA) and Staff K (CNA) were providing incontinence care to Resident 40. Staff N and Staff K had a gown and gloves on. Resident 40 had a bowel movement and Staff K cleaned Resident 40 with wipes. Staff K grabbed a clean brief, placed the brief on the resident, grabbed clean linens and placed them under Resident 40 with the same soiled gloves used to clean the bowel movement. Staff K did not remove their gloves or perform HH before touching the resident's clean brief and clean linens. Staff K grabbed a clean pillow and placed it under Resident 40's legs with the same contaminated gloves. Staff N removed the dirty linens from Resident 40's bed, rolled the linens up and put them on top of a bed side table. Staff N removed their personal protective gown with their soiled gloves on. Staff N removed their soiled gloves last and sanitized their hands. In an interview on 03/25/2025 at 9:38 AM, Staff K stated they forgot to change their gloves in between the care from dirty to clean area. Staff K stated they should remove dirty gloves after the incontinence care was provided and stated they should wash their hands, but they did not. In an interview on 03/25/2025 at 9:41 AM, Staff N stated they should change their gloves in between the care from a dirty to clean area. Staff N stated they should not put the dirty linens on the bed side table. Staff N stated they should put the dirty linens in a bag and wash their hands, but they did not. In an interview on 03/25/2025 at 11:28 AM, Staff M (Infection Preventionist) confirmed staff should perform HH and change their gloves when going from dirty to clean. Staff M stated staff should not put the dirty linens on the resident's bed side table and should put dirty linens in a bag. 46479 <Following Transmission Based Precautions> Observation on 03/25/2025 showed resident room [ROOM NUMBER] had a sign on their door showing the resident was on Contact Precautions and instructed staff to perform HH and put on a gown and gloves prior to entering the resident's room. The sign instructed staff to wash their hands prior to leaving the room. At that time, Staff E (Activity Assistant) entered room [ROOM NUMBER] without performing HH, or putting on a gown and gloves. Staff E handed paperwork to the resident and left the room without washing their hands. In an interview at that time, Staff E looked at the contact precautions sign on the door of room [ROOM NUMBER] and acknowledged they did not follow the sign as directed. In an interview on 03/25/2025 at 11:30 AM, Staff M stated staff should follow the instructions on the sign posted on the resident's doors. Staff M stated staff should wear gown and gloves as instructed on the sign before entering the resident's room but they did not. REFERENCE: WAC 388-97-1320 (1)(a)(c), (5)(c).