STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505009	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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** 48298 Based on interview and record review, the facility failed to ensure allegation of abuse was reported to the State Agency within the required timeframe for 1 of 1 resident (Resident 1), reviewed for abuse allegation. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised in September 2022, showed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations). The policy further showed, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Resident 1 admitted to the facility on [DATE]. Review of admission Minimum Data Set-an assessment tool dated 04/11/2024, showed Resident 1 was cognitively intact. Review of the facility's investigative report dated 05/15/2024, revealed a handwritten note on 05/14/2024 by Staff C, Registered Nurse. Staff C documented that an unknown male individual affectionately touched Resident 1's hand during dinner time and kissed their right shoulder after tucking them in bed. Further review of the investigative report showed the facility reported Resident 1's allegation on 05/22/2024. Review of the May 2024 incident log report did not show Resident 1's allegation was logged. On 06/13/2024 at 1:32 PM, Resident 1 stated that a male individual affectionately touched their hand during dinner time and kissed their right shoulder after tucking them in bed. Resident 1 stated that the incident happened the night before Mother's Day. Resident 1 further stated that they did not tell anyone except their collateral contact and that they reported the incident to Staff B, Certified Nurse Assistant, who was my aide on Monday [05/13/2024]. (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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(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	On 06/24/2024 at 12:47 PM, Staff C, stated that they worked double [evening and night shift] on 05/13/2024. Staff C stated that they received report from the outgoing staff regarding Resident 1's allegation. Staff C further stated that they interviewed Resident 1 and placed their written interview notes on the DNS's (Director of Nursing Services [Staff A]) inbox located outside Staff A's office door on 05/14/2024. On 06/24/2024 at 1:51 PM, Staff A stated that they received Staff C's written report on 05/15/2024 from their inbox. Staff A stated, I initially did not report the allegation to the State and reported it on the 22nd [05/22/2024] and that they ruled out the abuse but should have reported Resident 1's allegation as soon as they received it. Reference: (WAC) 388-97-0640 (5)(a)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to ensure allegation of abuse was thoroughly investigated and/or completed/documented on the incident report log within five days for 1 of 1 resident (Resident 1), reviewed for abuse investigation. This failure placed the resident at risk for unidentified abuse and a diminished quality of life. Findings included . Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised in September 2022, showed that all allegations are thoroughly investigated. The policy further showed, The individual conducting the investigation as a minimum interviews staff members (on all shifts) who had contact with the resident during the period of alleged incident, reviews all events leading up to the alleged incident and documents the investigation completely and thoroughly. Upon conclusion of the investigation, the investigator records the findings of the investigation. Resident 1 admitted to the facility on [DATE]. Review of the May 2024 incident log report did not show Resident 1's allegation was logged. Review of the facility's investigative report dated 05/15/2024, revealed a handwritten note on 05/14/2024 by Staff C, Registered Nurse. Staff C documented that an unknown male individual affectionately touched Resident 1's hand during dinner time and kissed their right shoulder after tucking them in bed. The investigative report showed the facility submitted Resident 1's allegation on 05/22/2024. Further review of the investigative report did not show minimum staff interviews were conducted and/or the conclusion of the investigation to rule out abuse was documented. On 06/13/2024 at 1:32 PM, Resident 1 stated that a male individual affectionately touched their hand during dinner time and kissed their right shoulder after tucking them in bed. Resident 1 stated that the incident happened the night before Mother's Day. Resident 1 further stated that they did not tell anyone except their collateral contact and that they reported the incident to Staff B, Certified Nurse Assistant, who was my aide on Monday [05/13/2024]. On 06/24/2024 at 12:47 PM, Staff C, stated that they worked double [evening and night shift] on 05/13/2024. Staff C stated that they received report from the outgoing staff regarding Resident 1's allegation. Staff C further stated that they interviewed Resident 1 and placed their written interview notes on the DNS's (Director of Nursing Services [Staff A]) inbox located outside Staff A's office door on 05/14/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint record review and interview on 06/24/2024 at 1:51 PM with Staff A, showed Resident 1's allegation was not logged on the May 2024 incident log report and the investigative report did not show minimum staff interviews were conducted and/or the conclusion of the investigation to rule out abuse was documented. Staff A stated that they received Staff C's written notes for Resident 1's abuse allegation and started the investigation on 05/15/2024. Staff A stated that they had interviewed the identified resident's collateral contact, residents, and some staff but not everyone [other staff] who may have been involved. Staff A stated that they ruled out abuse but did not complete or thoroughly investigate the abuse allegation. Staff A further stated that there was no conclusive summary in the investigation report to rule out Resident 1's allegation of abuse. Reference: (WAC) 388-97-0640 (6)(a)