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	07/18/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation and to take appropriate corrective action for 1 of 3 residents (Resident 3), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions.Findings included .Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events .Federal law requires the nursing home to do a thorough investigation of the incident. In order for a facility to provide evidence of the thoroughness of the investigation the information must be recorded. It showed that a thorough investigation may require two phases of fact gathering which included phase one, initial investigation (within the first 24 hours) and phase two, extended investigation (after the first 24 hours). It further showed that interview of witnesses, including caregivers in the immediate area and from work shifts prior to the incident discovery was included in phase one and that interviews of expanded sample of witnesses were included in phase two. Review of the facility's policy titled Abuse and Neglect - Clinical Protocol, revised in March 2018, showed that neglect meant, The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. It further showed that the staff will investigate alleged abuse and neglect to clarify what happened and identify possible causes and that the facility management and that staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. Review of electronic health record showed Resident 3 admitted to the facility on [DATE]. Review of the facility's document titled, Online Incident Report Facility/Agency Information, dated 07/08/2025, showed that Staff B, Director of Nursing, received a verbal report via phone call from Resident 3's Collateral Contact 1 regarding an incident on 07/07/2025. The document further showed action taken to prevent a recurrence of the incident was that Staff F, Registered Nurse, was suspended pending investigation.Review of the 07/07/2025 incident investigation summary report provided by Staff B showed that the involved caregivers present during the incident were interviewed. The incident investigation report did not show other potential caregiver witnesses were interviewed. Review of staff time cards showed that Staff F worked in the facility on the following dates:-On 07/09/2025, Staff F worked 1.25 hours.-On 07/10/2025, Staff F worked 10.0 hours.-On 07/11/2025, Staff F worked 9.0 hours. In an interview and joint record review on 07/18/2025 at 1:43 PM, Staff B stated that their process for interviewing witnesses while conducting an incident investigation included interviewing people who are assigned to the resident and if there are any witnesses. Joint record review of the 07/07/2025 incident investigation summary report did not show documentation that caregiver witnesses interviews were conducted. Staff B stated that they interviewed other residents and involved staff only. When asked if they would expect to interview potential witnesses of the incident, Staff B stated that they would check the purple book. Staff B further stated that they completed the investigation on 07/12/2025. Staff B stated that during an investigation, staff suspended for allegations of abuse and neglect would remain suspended until the investigation was completed. Joint record review of Staff F's clock-in/out records on 07/09/2025, on 07/10/2025 and on 07/11/2025 showed that Staff F worked in the facility prior to the completion of the investigation. Staff B stated that Staff F worked at the facility during the data collection phase and prior to the investigation conclusion. Reference: (WAC) 388-97-0640 (6)(a)(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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of practice to ensure a clinical assessment was completed timely for a change of condition (a sign that something might be wrong and needs attention) for 1 of 3 residents (Resident 3), reviewed for assessment of care services. This failure placed the resident at risk of receiving delayed care and for potential negative outcomes.Review of the facility's policy titled, admission Assessment and Follow Up: Role of the Nurse, revised in September 2012, showed that The following information should be recorded in the resident's medical record: 1. The date and time of the assessment was performed and showed that reporting included report other information in accordance with facility policy and professional standards of practice.Review of a electronic health record showed Resident 3 admitted to the facility on [DATE]. Review of the facility's document titled, Online Incident Report Facility/Agency Information, dated 07/08/2025, showed that Staff B, Director of Nursing, received a verbal report via phone call from Resident 3's Collateral Contact 1 (CC1) regarding an incident on 07/07/2025. It showed that CC1 alleged that Resident 3 was not assessed for a change of condition and that CC1 reported, I don't think [Staff F, Registered Nurse] assessed [Resident 3]. She said [Resident 3's] oxygen was 92% [pulse oximetry - measurement of oxygen carried in the blood] but yet the EMTs [Emergency Medical Technician - trained professional who show up in ambulances when someone calls 911 for a medical emergency] said [Resident 3's] oxygen was 74%. Review of the facility's document titled Exhibit 359 Follow-Up Investigation Report, submitted on 07/08/2025, showed that the 07/07/2025 incident occurred in the evening hours shortly after dinner. It further showed that at the time of the incident Staff F was called to tend to another resident and that Staff F left a NAC [Nursing Assistant Certified] with [Resident 3].Review of the facility document titled, SBAR [Situation/Background/Appearance/Review] Communication Form, dated 07/07/2025, showed Resident 3's recorded vital signs (basic body measurements that help providers quickly check how healthy someone is) for blood pressure and pulse rate were assessed on 07/07/2025 at 8:38 AM. It further showed that Resident 3's recorded pulse oximetry was assessed on 07/07/2025 at 11:22 PM. It did not show that Resident 3 was assessed for their vital signs at the time of the incident. In an interview on 07/15/2025 at 2:00 PM, Staff C, NAC, stated that on 07/07/2025 after dinner, after 8:00 PM and before 8:30 PM, they were called by Staff F to help interpret for Resident 3 who was non-English speaking. Staff C stated that at the time of the incident, Resident 3 was not able to be understood and that [Resident 3] wasn't [was not] talking, it was so slow, [Resident 3] tried to talk but [Resident 3] could not speak the words. Staff C then stated that they told Staff F that Resident 3 was not responding good at the time and that Staff F should call CC1. Staff C further stated that CC1 arrived at the facility around 8:30 PM or 9 PM. When asked if prior to the incident, Resident 3 could be understood verbally, Staff C stated, Yes, we speak the same language.In an interview on 07/15/2025 at 2:06 PM, Staff D, Licensed Practical Nurse, stated that if a resident had a change of condition, they would assess the resident and then check vital signs to see what's going on. Staff D then stated that they would document an assessment performed using the facility's SBAR Communication Form. Staff D further stated that all licensed nurses could assess a resident having a change of condition.In an interview on 07/15/2025 at 2:11 PM, Staff E, Resident Care Manager, stated that they expected an assessment, including checking the vital signs, would be performed in the event a resident had a change of condition. Staff E stated that they expected a resident would be assessed immediately for a change in condition and that their vital signs will be changed [differ from usual vital signs]. When asked if license nurses could delegate assessment of a resident to another staff member, Staff E stated, Yes, if a nurse is busy with another resident, and anytime there's [there is] a change of condition. Staff E stated that, It's the duty of all nurses to do something and that nurses should not walk away until another nurse takes over. In an interview and joint record review on 07/18/2025 at 1:43 PM, Staff B, Director of Nursing, stated that they expected nursing staff would assess a resident for a change of condition, including checking the vital signs. Staff B stated that they considered a change in level of alertness and in the ability to communicate as a change of condition. Staff B then stated that they expected documentation of an assessment performed would be recorded in the facility's SBAR Communication Form and that nurses had the ability to manually enter data onto the form. When asked when the 07/07/2025 incident occur, Staff B stated, It happened in the evening shift between 8:00 PM and 9:00 PM and that they suspected Resident 3 was transferred to the hospital from the facility on 07/07/2025 between 8:00 PM and 9:00 PM. Joint record review of the 07/07/2025 SBAR

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a therapeutic diet was provided as ordered for 2 of 3 residents (Residents 1 & 2), reviewed for therapeutic diets. This failure had the potential to cause unwanted weight gain, a decline in medical conditions, and a diminished quality of life. Findings included.Review of the facility's policy titled, Diets Available on the Menu, Revised June 2019 showed, Prescribed diets are provided to deliver nutrition for residents in the facility. In order to define and standardized, diet orders will be interpreted as follows to comply with the [facility name] approved diet manual and/or to enhance choices & quality of life while meeting the current resident nutrition needs. RESIDENT 1Review of Resident 1's Electronic Health Record (EHR) printed on 07/18/2025 showed Resident 1 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes (A disease that occurs when your body cannot use insulin - is a hormone that helps your body use sugar properly). It further showed that Resident 1 was prescribed a Carbohydrate [diabetic] diet and received scheduled insulin.Review of Resident 1's dietary card on their lunch tray dated 07/15/2025 showed Resident 1 was on a diabetic diet. Observation on 07/15/2025 at 12:00 PM showed Resident 1's lunch tray consisted of honey mustard chicken, cheesy broccoli rice floret, cornbread, baked apple with pear slices, and a non-sugary drink. Further observation showed Resident 1 consumed the entire meal.RESIDENT 2Review of EHR showed Resident 2 was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes, and received scheduled insulin.Review of Resident 2's dietary card on their lunch tray dated 07/15/2025 showed a diabetic diet. Observation and interview on 07/15/2025 at 12:23 PM, showed Resident 2's lunch meal tray consisted of honey mustard chicken, cheesy broccoli rice floret, cornbread, baked apple with pear slices, non-sugary drink, and one serving of whole milk. Resident 2 stated that they were diabetic and were supposed to be on a diabetic diet. Observation showed that Resident 2 consumed three quarters of the meal served.In a joint observation and interview on 07/15/2025 at 1:45PM with Staff G, Registered Dietician, Resident 2 had consumed all of their cornbread, and three quarters of their meal served. Staff G stated that they followed the prescribed diet and used a dietary spreadsheet to ensure residents received the right diet. Staff G stated that Resident 2 was not supposed to be served cornbread since they were diabetic.In a joint record review of the dietary spreadsheet on 07/15/2025 at 2:00PM with staff G, showed that cornbread was marked No for residents on a diabetic diet. Staff G further clarified that No meant that resident on a diabetic diet was not supposed be served with Cornbread.A joint record review and interview on 07/18/2025 at 11:06 AM with Staff H, Kitchen Cook, showed Resident 1's dietary card listed a diabetic diet on 07/15/2025. When asked if Resident 1 should have received cornbread for lunch on 07/15/2025 and Staff H said, No. Staff H further stated that they followed the prescribed diet and dietary spreadsheets when serving food. In an interview and joint record review on 07/18/2025 at 1:57PM, Staff B, Director of Nursing, stated that they expected staff would follow the prescribed therapeutic diet. Staff B further stated that Resident 1 and 2 should not have received the cornbread serving since they were on a diabetic diet. Reference (WAC): 388-97-1200(1)