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	11/14/2025

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 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)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to follow physician's orders and failed to ensure staff documented treatments in accordance with professional standards for 1 of 1 resident (Resident 1), reviewed for treatment administration. These failures placed the residents at risk for unmet care needs, negative outcomes, and a diminished quality of life.Findings included .Review of the facility's policy titled, Administering Medications, dated April 2019, showed that Medications are administered in a safe and timely manner, and as prescribed. The policy showed, The individual administering the medication initials the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones. The policy further showed, Topical medications used in treatments are recorded on the resident's treatment record (TAR [Treatment Administration Record]).On 11/13/2025 at 1:17 PM, Staff D, Registered Nurse, stated nursing staff were responsible for following medication/treatment orders. Staff D stated if a resident refused, they would document it and report it to the provider.In a joint observation and interview on 11/13/2025 at 2:34 PM, with Staff D showed Resident 1 had two unlabeled dressings covered with kerlix (a brand name for a type of wound dressing made from 100% cotton gauze) on each lower leg. Staff D stated that Resident 1 had venous ulcers (slow healing sores caused by poor blood flow in the veins) on both lower legs and that their order was to have dressing changes every other day. When asked if Staff D had changed Resident 1's dressings on 11/13/2025, Staff D stated no. Staff D stated that Resident 1 had pitting edema (swelling) in their lower legs and did not wear compression stockings/ted hose. Staff D stated that when a dressing was changed, they expected it to be labeled with the initials of the nurse and the date it was completed.In another joint record review and interview on 11/13/2025 at 2:40 PM, with Staff D, showed Resident 1's TAR had the following orders that were administered on 11/13/2025 by Staff D:-An order dated 07/17/2025 for After applying Aquaphor [a healing ointment] in morning, apply compression stockings [used to improve circulation] or TED hose [used to prevent blood clots]. Remove at bedtime. In the morning for lymphedema [chronic condition that causes swelling in the arms or legs due to a blockage or damage that prevents fluid from draining properly] place stockings.-An order dated 10/31/2025 for left lower leg to, Cleanse with Dakins solution [used for wound cleansing and management] and pat dry. Apply A&D [skin protectant] ointment, Calcium alginate [wound dressing that absorbs fluids and promotes healing] to the wound bed ONLY, cover with SUPER ABSORBANT PAD or ABD [abdominal pad], and wrap with kerlix DAILY. every day shift for wound healing.-An order dated 10/31/2025 for right lower leg to, Cleanse with Dakins solution and pat dry. Apply A&D ointment, Calcium alginate to the wound bed ONLY, cover with SUPER ABORBANT PAD OR ABD, and wrap with kerlix DAILY. every day shift for wound healing. Staff D stated they documented the treatment orders were done on 11/13/2025 at 8:52 AM and that they had not done the treatment orders for Resident 1. Staff D stated that they had never seen Resident 1 wear compression stockings/ted hose. Staff D further stated they should have completed Resident 1's treatment first and then documented it in the TAR.On 11/13/2025 at 4:02 PM, Staff C, Resident Care Manager, stated nursing staff should check the physician's orders and have correct documentation after administration of medications. Staff C stated a treatment dressing should be labeled with the nurse's initials and date and time it was done. Staff C stated Staff D was not supposed to document Resident 1's treatment administration until it was done.On 11/13/2025 at 4:24 PM, Staff B, Director of Nursing Services, stated they expected nursing staff to follow physician orders, and if something did not seem right to get clarification. Staff B further stated they expected staff to document after treatment was completed.In a follow-up interview on 11/14/2025 at 11:50 AM, Staff B stated that Staff D should have followed the physician's orders for Resident 1 and checked it off after completing the tasks.Reference: (WAC) 388-97-1620(2)(b)(i)(ii).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 ensure a Licensed Practical Nurse (LPN) had the appropriate competencies, skills set and proficiencies to assess/evaluate wound care for 1 of 1 nursing staff (Staff E), reviewed for competent nurse staffing. This failure placed the residents at risk for unmet care needs, inaccurate wound assessments, and adverse outcomes.Findings included .Review of facility's policy titled, Skin and Wound Monitoring and Management, dated August 2024, showed A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to:1) Measuring the skin injury2) Staging the skin injury (when the cause is pressure)3) Describing the nature of the injury (e.g./ pressure, stasis, surgical incision)4) Describing the location of the skin alteration5) Describing the characteristics of the skin alteration6) Describing the progress with healing, and any barriers to healing which may exist7) Identifying any possible complications or signs/symptoms consistent with the possibility of infection. The policy further showed, Assessment of the pressure injury for tunneling [a passageway that forms beneath the skin and extends from the surface of a wound into deeper tissues] and undermining [condition where tissue destruction occurs beneath the intact skin at the edges of the wound, creating a pocket like space] is an important part of the complete pressure injury [damage to the skin and underlying tissue that occurs from prolonged or intense pressure and/or shear] assessment.Resident 2 was admitted to the facility on [DATE].Review of Resident 2's wound care notes provided by the facility showed the following:-Resident 2 was seen by a Nurse Practitioner Wound Care Specialist on 06/19/2025, 07/03/2025, and 07/10/2025. -The initial wound care note dated 06/19/2025, showed an Assessment/Wound description w/[with] size/undermining, for a Stage 4 pressure wound (most severe type of pressure sore, characterized by a deep, open wound exposing muscle, tendons, or bone) to Resident 1's right ischial (the lower and back part of the right hip bone) area. The assessment included staging, measurement, debridement (medical procedure that removes dead, damaged, or infected tissue from wound to promote wound healing), tissue type, exudate (fluid that leaks from a wound as part of the normal healing process), odor/infected/pain, peri-wound (skin surrounding the wound), and plan.-Resident 2 was seen by Staff E, LPN, on 07/14/2025, 07/18/2025, 07/25/2025, 08/04/2025, 08/07/2025, 08/28/2025, 09/02/2025, 09/11/2025, and 09/18/2025. An AvaWound Evaluation [the facility's wound assessment/evaluation] #1-V 2, was completed for these visits. The AvaWound Evaluation #1-V 2, showed an assessment/evaluation for Resident 2's wound location, date it was first observed, type of wound, pressure stage, whether non-pressure, acquisition (whether wound was facility acquired, upon admission, or recurring) , measurement, tunneling, undermining, exudate amount/type/color, wound odor, debridement type, wound bed description, wound edges, surrounding skin/periwound, pain, and treatment plan/recommendations. Further review of the wound care AvaWound Evaluation #1-V 2, for Resident 2 dated 07/14/2025, 07/18/2025, 07/25/2025, 08/04/2025, 08/07/2025, 08/28/2025, 09/02/2025, 09/11/2025, and 09/18/2025 did not show a co-signature of a Registered Nurse (RN) or Wound Care Specialist.In a phone interview on 11/14/2025 at 4:14 PM, Staff E stated that they helped out with wounds and no longer did as of last week as the facility got a third party wound staff. Staff E stated they were with the wound provider for a few weeks, and then they kept doing what the wound care provider did when they were no longer there. Staff E stated they cleaned the wounds, completed measurements, and put dressings on. Staff E stated the wound provider assessed the wounds. When asked if Staff E assessed the wounds, Staff E stated, I wouldn't [would not] call it assessment, and that they did not stage any wounds. Staff E stated that they put their documentation into the wound evaluations. When asked about the evaluations completed for Resident 2, Staff E stated that they did not stage the wounds, that they followed the previous wound care provider's assessment, and if it basically looked the same then that is what they would document. Staff E stated they were not wound care certified. When asked if assessing/evaluating was under an LPN's scope of practice, Staff E stated, I never really thought of that, I am not sure. I will have to get back to you.On 11/14/2025 at 5:00 PM, Staff B, Director of Nursing, stated Staff E had been the facility's wound nurse and that they were not wound care certified. When asked if Staff E could complete wound assessments, Staff B stated, the company calls them evaluations. When asked what an evaluation meant, Staff B stated, I don't [do not] know if I have an answer to that, and stated they were aware their software system classified the evaluation as a