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	01/07/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 2 of 4 residents (Residents 1 and 2) reviewed for resident-to-resident altercations. Resident 1 sustained skin injuries (a skin tear & bruises) when their arm was grabbed by another resident in the facility (Resident 3). The facility also failed to ensure Resident 2 was free from physical abuse when their hair was pulled by another resident in the facility (Resident 3). These failures had the potential to cause more than minimal physical harm, psychological harm, mental anguish and fear. Findings included. Review of the facility's Freedom from Abuse Policy, dated September 2022, documented that each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including but not limited to other residents. The abuse policy also showed that willful is defined in the definition of abuse and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. <RESIDENT 1> Review of Resident 1's quarterly Minimum Data Set (MDS-a required assessment) assessment dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 1 had intact thinking and memory. Review of the facility incident investigation dated 11/28/2025 showed Resident 1 was talking in the hallway with a resident (Resident 2) when another resident (Resident 3) grabbed their left arm. Resident 1 sustained a skin tear on the left arm when the other resident grabbed their left arm, the skin tear measured 3.5 centimeters (cm-a unit of measurement) by 3.0 cm and had two bruises on the side of the left arm that measured 2.0 cm by 2.5 cm and another bruise on the left side of the arm that measured 4.0 cm by 4.0 cm. In an interview on 12/22/2025 at 2:25 PM Resident 1 stated, I was in my wheelchair in the hallway, talking with a resident [Resident 2] that lives nearby, when another resident [Resident 3] came up to me and grabbed my left arm. I don't know why they did this; I was not talking to them and had not noticed them until I felt them grab my left arm. It all happened so fast. They pulled really hard on my left arm and tore my skin open; it bled a lot at first. My arm bruised up right away, I had bruising all around my arm. It is all healed now.Review of the December 2025 Treatment Administration Record (TAR) with an order dated 11/29/2025 showed, left arm skin tear, cleanse with normal saline, pat dry. Apply dry dressing daily [every evening shift] for wound healing. The treatment stopped being applied on 12/21/2025. Further review of the December 2025 TAR with an order dated 12/01/2025 showed, monitor bruises to left arm until resolved, every evening shift [every Wednesday]. Discontinue date 12/21/2025.Review of the facility's incident investigation dated 11/28/2025 showed that physical abuse was substantiated when Resident 3 grabbed Resident 1's left arm which caused a skin tear that measured 3.5 cm by 3.0 cm and two bruises on the side of the left arm that measured 2.0 cm by 2.5 cm and another bruise on the left side of the arm that measured 4.0 cm by 4.0 cm.<RESIDENT 2> Review of Resident 2's admission MDS dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 2 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had severely impaired thinking and memory. Review of the facility incident investigation dated 11/28/2025 showed a resident [Resident 3] used both of their hands and grabbed Resident 2 by the hair shaking hardly. Further review of the facility incident investigation showed the Resident Care Manager (RCM) was present at the time of the incident, separated the residents and then asked Resident 3 why they grabbed Resident 2 by the hair, Resident 3 responded they [Resident 2] stole my phone. The investigation determined this was not true, when Resident 3 dropped their phone during an activity in the dining room, staff picked up the phone and returned the phone to Resident 3 shortly after it was dropped. Further review of the incident investigation dated 11/28/2025 showed Resident 2 was assessed for injuries from their hair being pulled and none were found. The investigation also showed Resident 2 had no recollection of the incident. Review of the facility's incident investigation dated 11/28/2025 showed that physical abuse was substantiated when Resident 3 grabbed Resident 2 by the hair shaking hardly.<RESIDENT 3> Review of Resident 3's admission MDS dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 3 had severely impaired thinking and memory. Review of the care plan dated 09/25/2025 showed, the resident was on antipsychotic (used to manage disorganized thinking) medication related to behavior management, delirium (sudden, severe and rapid change in brain function).Review of the November 2025 Medication Administration Record (MAR) showed Venlafaxine (medication used to treat depression) Extended Release 150 milligrams (mg-a unit of measurement) give one tablet one time a day for depression with a start date of 09/23/2025. The MAR also showed Resident 3 refused to take the medication on 11/25/2025, 11/26/2025 and 11/27/2025.Further review of the November 2025 MAR showed Aripiprazole (medication used to treat mental and mood disorders) 10 mg one time a day for AMS (altered mental status) related to delirium, with a start date of 09/23/2025, and discontinue date of 11/19/2025. Aripiprazole 10 mg one time a day for delusions/delirium was restarted on 11/20/2025. The MAR also showed Resident 3 refused to take the medication on 11/25/2025, 11/26/2025 and 11/27/2025. In an interview on 12/23/2025 at 3:11 PM Staff D, Licensed Practical Nurse said the first incident occurred at 3:20 PM on 11/28/2025 when Resident 3 pulled Resident 2's hair, and the second incident occurred at 4:00 PM, 40 minutes after the first incident on 11/28/2025 when Resident 3 reached out and grabbed Resident 1's left arm which caused a skin tear and bruising. Staff D stated that the RCM was present and witnessed Resident 3 grab Resident 1's left arm before Resident 3 could be stopped. Staff D also said Resident 3 was transferred to the hospital after the incidents that occurred on 11/28/2025 for evaluation of their behavior. In an interview on 12/23/2025 at 3:58 PM Staff E, RCM said Resident 3 had a prior history of agitated behaviors but had been very quiet since they were readmitted to the facility.In an interview on 12/23/2025 at 4:05 PM Staff F, Certified Nursing Assistant said, Resident 3 had a temper and could get angry very easily. Staff F also said Resident 3 had mood swings from happy to angry, but if they wanted something they would get angry very quickly.In an interview on 12/23/2025 at 4:28 PM Staff E said they were present when Resident 3 pulled Resident 2's hair, separated the two residents, remained with Resident 3 and monitored their behavior when Resident 3 reached out and grabbed Resident 1's left arm which caused a skin tear and bruising. Staff E also said it was possible that the refusals of the medications on 11/25/2025, 11/26/2027 and 11/27/2025 could have caused Resident 3's aggressive behavior on 11/28/2025.In an interview on 12/23/2025 at 4:55 PM Staff A, Administrator said the incidents on 11/28/2025 when Resident 3 grabbed Resident 1's left arm and caused a skin tear was substantiated as physical abuse and when Resident 3 pulled Resident 2's hair was also substantiated as physical abuse. Reference WAC 388-97-0640 (1)(2)(a) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASARR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions (RC) are not inappropriately placed in nursing homes for long-term care) screening form was completed, for an exempted hospital discharge resident who remained in the facility for more than 30 days for 1 of 3 residents (Resident 3) reviewed for PASARR screening. This failure placed the residents at risk of not receiving the appropriate care and services for their needs and/or lacking access to specialized services for individuals with identified mental health diagnoses or disabilities. Findings included .Review of the admission Minimum Data Set assessment (MDS-a required assessment) dated 09/24/2025 documented Resident 3 was admitted to the facility on [DATE]. Review of the Level I PASRR assessment form dated 09/22/2025 showed Resident 3 had Serious Mental Illness Indicators, known or suspected mood disorders, and had evidence that they exhibited functional limitations related to a known or suspected behavioral health disorder. Further review of the Level I PASRR assessment form dated 09/22/2025 showed Resident 3 was admitted to the facility on [DATE] and was discharged from the hospital as an Exempted Hospital Discharge, the form showed Section II.A. Exempted Hospital Discharge, the individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services. Review of the Level I PASRR assessment form dated 09/22/2025 also showed, no Level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur. Review of the discharge MDS assessment dated [DATE] showed Resident 3 was discharged from the facility on 11/28/2025. Review of the Electronic Health Record did not show that a Level 2 PASRR evaluation was completed. In an interview on 12/23/2025 at 2:24 PM Staff C, Social Services Director (SSD) said when a resident admits to the facility with an exempted hospital discharge Level I PASRR, the resident must discharge from the facility within 30 days or a Level 2 PASRR form must be completed and sent out to the PASRR office for evaluation within 30 days if the resident does not discharge. Staff C also said Resident 3 did not have a Level 2 PASRR evaluation completed within 30 days, and was in the facility from 09/22/2025 to 11/28/2025, which was past 30 days. Staff C stated, I did not know that Resident 3 admitted to the facility on [DATE] with an exempted hospital discharge Level I PASRR. In an interview on 12/23/2025 at 2:41 PM Staff A, Administrator stated, the Level 2 PASRR form should have been completed within 30 days for Resident 3. Reference WAC 388-97-1975(5)

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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** Based on interview and record review, the facility failed to ensure adequate supervision and interventions were implemented to manage aggressive behaviors for 1 of 3 residents (Resident 3) reviewed for resident-to-resident altercations. This failure had the potential to cause substantial injuries to residents, fear and a diminished quality of life. Findings included .<RESIDENT 3>Review of Resident 3's admission Minimum Data Set (MDS-a required assessment) assessment dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 3 had severely impaired thinking and memory. Review of the facility incident investigation dated 11/28/2025 showed Resident 3 grabbed a residents [Resident 1] left arm who was talking in the hallway with another resident [Resident 2] in the facility. The resident [Resident 1] sustained a skin tear when Resident 3 grabbed their left arm. The skin tear measured 3.5 centimeters (cm-a unit of measurement) by 3.0 cm and had two bruises on the side of the left arm that measured 2.0 cm by 2.5 cm and another bruise on the left side of the arm that measured 4.0 cm by 4.0 cm. Basic First Aid was initiated to assist in healing of the skin tear.Further Review of the facility incident investigation dated 11/28/2025 showed Resident 3 used both of their hands and grabbed Resident 2 by the hair shaking hardly. The facility incident investigation showed the Resident Care Manager (RCM) was present at the time of the incident, separated the residents and then asked Resident 3 why they grabbed Resident 2 by the hair, Resident 3 responded they [Resident 2] stole my phone. The investigation determined this was not true, when Resident 3 dropped their phone during an activity in the dining room, staff picked up the phone and returned the phone to Resident 3 shortly after it was dropped. <RESIDENT 1>Review of Resident 1's quarterly MDS dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 1 had intact thinking and memory. In an interview on 12/22/2025 at 2:25 PM Resident 1 stated, I was in my wheelchair in the hallway, talking with a resident [Resident 2] that lives nearby, when another resident [Resident 3] came up to me and grabbed my left arm. I don't know why they did this; I was not talking to them and had not noticed them until I felt them grab my left arm. It all happened so fast. They pulled really hard on my left arm and tore my skin open; it bled a lot at first. My arm bruised up right away, I had bruising all around my arm. It is all healed now.<RESIDENT 2>Review of Resident 2's admission MDS dated [DATE] showed the resident was admitted to the facility on [DATE]. The MDS assessment also showed Resident 2 had severely impaired thinking and memory.Review of the incident investigation dated 11/28/2025 showed Resident 2 was assessed for injuries from their hair being pulled and none were found. The investigation also showed Resident 2 had no recollection of the incident.In an interview on 12/23/2025 at 3:11 PM Staff D, Licensed Practical Nurse stated the first incident occurred at 3:20 PM on 11/28/2025 when Resident 3 pulled Resident 2's hair, and the second incident occurred at 4:00 PM, 40 minutes after the first incident on 11/28/2025 when Resident 3 reached out and grabbed Resident 1's left arm which caused a skin tear and bruising. Staff D stated that the RCM was present and witnessed Resident 3 grab Resident 1's left arm before Resident 3 could be stopped. Staff D also stated Resident 3 was transferred to the hospital after the incidents that occurred on 11/28/2025 for evaluation of their behavior.In an interview on 12/23/2025 at 3:58 PM Staff E, RCM stated Resident 3 had been a resident of the facility previously, had shown agitated/aggressive behaviors during that time, had been discharged from the facility for a few months and since they readmitted to the facility on [DATE] they had been very quiet and had not shown any agitated/aggressive behaviors.In an interview on 12/23/2025 at 4:05 PM Staff F, Certified Nursing Assistant stated, Resident 3 had a temper and could get angry very easily. Staff F also (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 3 had mood swings from happy to angry, but if they wanted something they would get angry very quickly if they did not get whatever they wanted.In an interview on 12/23/2025 at 4:28 PM Staff E stated they were present when Resident 3 pulled Resident 2's hair, separated the two residents, remained with Resident 3, monitoring their behavior when Resident 3 reached out and grabbed Resident 1's left arm which caused a skin tear and bruising. Staff E also stated they could not stop Resident 3. Staff E stated Resident 3 had not shown any agitated/aggressive behaviors since they readmitted to the facility on [DATE] but did have a history of agitated/aggressive behaviors previously. Staff E stated the staff intervention that was implemented to prevent additional resident to resident altercations after Resident 3 pulled Resident 1s hair was close staff supervision of Resident 3. Staff E also stated staff closely supervised Resident 3 after they readmitted to the facility on [DATE] in case they had any aggressive behaviors.In an interview on 12/23/2025 at 4:55 PM Staff A, Administrator stated staff were present and provided supervision after Resident 3 grabbed Resident 2's hair, but Resident 3 acted quickly and staff could not stop Resident 3 from grabbing Resident 1's left arm. Reference WAC 388-97-1060(3)(g)