

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Shoreline		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the State Agency within the required timeframe for 3 of 7 residents (Residents 1, 2 & 3), reviewed for abuse reporting. This failure placed the residents at risk for potential unidentified mistreatment and lack of protection due to unrecognized abuse. Findings included. Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2025, showed Nursing Home responsibilities included: -Report all suspected incidents of abuse, neglect, financial exploitation, or misappropriation of property. -Notify the State Hotline of allegations immediately or as soon as resident is protected. -Log in state reporting log abuse and neglect. RESIDENT 1 Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnoses that included need for assistance with personal care and unspecified dementia (a condition that affects the brain and makes it harder for a person to remember things, think clearly, make decisions, or take care of daily tasks). In an interview on 03/05/2026 at 2:19 PM, Resident 1 stated, [Resident 2] comes in and takes my nice clothes from here, that's [that is] why I brought a suitcase to put my nice clothes. I told them [Facility staff] she [Resident 2] comes in, I told them if I slap [Resident 2] it's their [Facility staff] fault because they [Facility staff] don't [do not] watch [Resident 2]. Resident 1 further stated, She came in here just today again. When asked about Resident 1's missing clothes, Resident 1 stated, Some clothes go to the laundry and never come back. RESIDENT 2 Review of a face sheet showed Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance (acting in ways that are unusual for them and that may be hard for others to manage) and psychosis (a person's brain has trouble telling what is real from what is not). Review of Resident 2's care plan, revised on 12/02/2025, showed, Problematic behavior in which [Resident 2] acts characterized by ineffective coping: verbally or physical aggression. wandering to other residents' rooms, self-propelling around the facility, being agitated when [Resident 2] knows that she is being monitored related to diagnosis of dementia. Review of the facility's incident logs for December 2025, January 2026, and February 2026 did not show documentation of incidents involving Resident 1 and/or Resident 2. Further review of the incident log through 03/05/2026, did not show entries related to Resident 1 and/or Resident 2. In an interview on 03/05/2026 at 2:40 PM, Staff A, Administrator, was informed of Resident 1's allegation that Resident 2 entered her room and that some of her property was missing. In a follow-up interview on 03/13/2026 at 1:28 PM, Resident 1 stated that [Resident 2] came into the room when I was asleep, around four AM, she came and took the pillow from the other bed. I called the nurse to let them know and they came and took [Resident 2]. When asked when the incident occurred, Resident 1 stated, It was the night before last night, I think. In an interview and joint record review on 03/13/2026 at 1:38 PM with Staff B, Interim Director of Nursing, and Staff C, Interim Administrator, stated that they followed the Purple Book guidelines for reporting allegations of abuse. A joint record review of the facility's March 2026 incident log through 03/13/2026 did not show documentation of incidents involving Resident 1 and/or Resident 2. Staff C stated, We followed up with both residents [Resident 1 & 2] on 03/12/2026 and on 03/13/2026, and that the allegation was not reported to the State (continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Agency when the allegation was reported to Staff A on 03/05/2026. Staff B and Staff C stated that they expected reported allegations would be reported timely. RESIDENT 3 Review of a face sheet showed Resident 3 admitted to the facility on [DATE] with diagnoses that included need for assistance with personal care, abnormalities of gait (the way a person walks) and mobility, and dementia. Review of a document titled, Resident Interviews, dated 02/12/2026, showed documentation that Resident 3 reported that Care is a little rough from the men [male staff]. It further showed that the interview was completed by Staff D, Social Services Coordinator/Assistant. In an interview and joint record review on 03/13/2026 at 1:32 PM, Staff D stated that she was trained on abuse and neglect by the facility. A joint record review of a document titled, Resident Interviews, dated 02/12/2026, showed, Resident 3 was documented to report Care is a little rough from the men. Staff D stated that they interviewed Resident 3 and that [Resident 3] mentioned that men are a little rough getting him out of bed. When asked what follow-up actions were taken after Resident 3 reported rough care from men, Staff D stated that an investigation of the allegation was not completed and that I did the interviews and sent them [completed resident interview forms] to the Social Services Director. Staff D further stated that she should have reported Resident 3's allegation to the nurse and that would start the investigation into the allegation. A joint record review and interview on 03/13/2026 at 1:38 PM with Staff B and Staff C, showed the facility's incident log for February 2026 did not show documentation of Resident 3's reported allegation on 02/12/2026. Staff B stated, I do not see [Resident 3's] name on here, I don't [do not] see an investigation completed for that resident. I would expect staff to have followed up on that. Staff B further stated, The interview form should have been reviewed, and [Resident 3] should have been re-interviewed. Staff C stated that they expected reported allegations would be reported timely to the State Agency. Reference: (WAC) 388-97-0640 (2)(b).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated for 3 of 7 residents (Residents 1, 2 & 3), reviewed for abuse investigation. This failure placed the residents at risk for repeated incidents, unidentified abuse and/or neglect, and a diminished quality of life. Findings included. Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2025, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. RESIDENT 1 Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnoses that included need for assistance with personal care and unspecified dementia (a condition that affects the brain and makes it harder for a person to remember things, think clearly, make decisions, or take care of daily tasks). In an interview on 03/05/2026 at 2:19 PM, Resident 1 stated, [Resident 2] comes in and takes my nice clothes from here, that's [that is] why I brought a suitcase to put my nice clothes. I told them [Facility staff] she [Resident 2] comes in, I told them if I slap [Resident 2] it's their [Facility staff] fault because they [Facility staff] don't [do not] watch [Resident 2]. Resident 1 further stated, She came in here just today again. When asked about Resident 1's missing clothes, Resident 1 stated, Some clothes go to the laundry and never come back. RESIDENT 2 Review of a face sheet showed Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance (acting in ways that are unusual for them and that may be hard for others to manage) and psychosis (a person's brain has trouble telling what is real from what is not). Review of Resident 2's care plan, revised on 12/02/2025, showed, Problematic behavior in which [Resident 2] acts characterized by ineffective coping: verbally or physical aggression. wandering to other residents' rooms, self-propelling around the facility, being agitated when [Resident 2] knows that she is being monitored related to diagnosis of dementia. Review of the facility's incident logs for December 2025, January 2026, and February 2026 did not show documentation of incidents involving Resident 1 and/or Resident 2. Further review of the incident log through 03/05/2026, did not show entries related to Resident 1 and/or Resident 2. In an interview on 03/05/2026 at 2:40 PM, Staff A, Administrator, was informed of Resident 1's allegation that Resident 2 entered her room and that some of her property was missing. In a follow-up interview on 03/13/2026 at 1:28 PM, Resident 1 stated that [Resident 2] came into the room when I was asleep, around four AM, she came and took the pillow from the other bed. I called the nurse to let them know and they came and took [Resident 2]. When asked when the incident occurred, Resident 1 stated, It was the night before last night, I think. In an interview and joint record review on 03/13/2026 at 1:38 PM with Staff B, Interim Director of Nursing, and Staff C, Interim Administrator, stated that they followed the Purple Book guidelines for reporting allegations of abuse. A joint record review of the facility's March 2026 incident log through 03/13/2026 did not show documentation of incidents involving Resident 1 and/or Resident 2. Staff C stated, We followed up with both residents [Resident 1 & 2] on 03/12/2026 and on 03/13/2026, and that the allegation was not reported to the State Agency when the allegation was reported to Staff A on 03/05/2026. Staff B and Staff C stated that they expected reported allegations would be investigated timely. RESIDENT 3 Review of a face sheet showed Resident 3 admitted to the facility on [DATE] with diagnoses that included need for assistance with personal care, abnormalities of gait (the way a person walks) and mobility, and dementia. Review of a document titled, Resident Interviews, dated 02/12/2026, showed documentation that Resident 3 reported that Care is a little rough from the men [male staff]. It further showed that the interview was completed by Staff D, Social Services Coordinator/Assistant. In an interview and joint record review on 03/13/2026 at 1:32 (continued on next page)</p>		

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