

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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)		
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** Based on interview and record review, the facility failed to report a missing resident within the required reporting timeframe for 1 of 4 residents (Resident 2), reviewed for abuse reporting. The failure to notify law enforcement, the state agency and the failure to follow its policy requirement of immediate notification of the Administrator, Director of Nursing Services, the resident's legal representative, and the attending physician when a resident is missing placed the resident at risk for unidentified abuse and/or neglect. Findings included .Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, .are reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).Review of the facility's policy titled, Freedom from Abuse, Neglect, Exploitation and Misappropriation of Resident Property, approved on 05/2026, showed Mandated reporters are to immediately report all alleged violations to the Administrator, state agency, and all other required agencies (e.g.[example] law enforcement when applicable) within specified timeframes when they have reasonable suspicion of abuse, neglect, exploitation and misappropriation of resident property has occurred or reasonable suspicion that a crime has occurred. It showed, The Administrator and Director of Nursing Services shall be immediately notified of all allegations of abuse and neglect. The policy further showed, Any incidents of abuse or injuries of unknown origin will be reported to State officials and or/ law enforcements per the State regulations/requirements.Review of the facility's policy titled Wandering and Elopements, showed that if a resident is missing, staff are to initiate the elopement/missing resident emergency procedure and if the resident is not located, the policy directs staff to notify the Administrator, Director of Nursing Services, the resident's legal representative, and the attending physician.Review of the admission record printed on 06/15/2026 showed that Resident 2 was admitted to the facility on [DATE].Review of the October 2025 incident log showed that Resident 2 had a concern documented on 10/30/2025, with the nature of the occurrence logged as AMA [Against Medical Advice]. The review further showed that an incident for Resident 2 occurred on 10/25/2026 and had not been reported to the state agency and law enforcement until 10/27/2025.Review of the Electronic Health Record (EHR) showed that Resident 2 left the facility on [DATE] to visit family and did not return to the facility. The review further showed that Resident 2 did not knowingly leave the facility AMA.Review of the investigation report dated 10/28/2025, showed Resident [Resident 2] was noted to be gone from the facility on 10/25[10/25/2025] in the afternoon hours. Her assigned nurse attempted to reach out to the resident consistently over the weekend but were not able to get a hold of her. On 10/27 [10/27/2026] transcribing nurse attempted to get a hold of Resident 2 by the cellphone but was unable to get a hold of her. Calls were made to her brother.with no success as well. Per char review, resident [Resident 2] had listed grandparent whose contact was called as well with no success. Transcriber then met with IDT [Inter Disciplinary Team] and it was agreed to contact the police department and social services director submitted an APS [Adult Protective Services] report.Review of the facility provided Sign Out/Sign In Sheet (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation for October 2025 did not show whether Resident 2 signed out or signed in on 10/25/2025. Review of Resident 2's EHR did not show documentation that the facility Administrator, Director of Nursing Services and / or the attending physician were notified about the incident immediately. In an interview on 06/16/2026 at 1:12 PM, Staff C, Resident Care Manager, stated that when a resident leaves the facility, We have to notify the provider, and assess the resident's mental and physical status to make sure the resident is safe to go out. Staff C stated they did not know whether Resident 2 was safe or unsafe to leave the facility on that specific date. Staff C stated the incident occurred over the weekend, and law enforcement and state agencies were notified two days after the incident, on 10/27/2025. In an interview on 06/16/2026 at 12:03 PM, Staff E, Social Services Director, stated that when a resident leaves the facility, they would check the sign-out log, attempt to contact the resident, and notify the family if the resident cannot be reached. Staff E added that they would report the situation to APS and law enforcement as soon as they realized a resident was missing and would not wait two days to report it. In an interview on 06/16/2026 at 2:22 PM, Staff B, Director of Nursing, stated that it was their expectation that staff report Resident 2's incident to all required parties immediately once it was determined the resident was missing. In an interview on 06/16/2026 at 2:48 PM, Staff A, Administrator, stated, My expectation is to be informed of the incident immediately. I will speak with the appropriate individuals and then report it to law enforcement within few hours. Reference: (WAC) 388-97-0640 (5)(a).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary services to maintain personal hygiene for 1 of 3 residents (Resident 1) reviewed for Activities of Daily Living (ADLs). The failure to provide bathing care for a resident who was dependent on staff for assistance placed the resident at risk for poor hygiene, unmet care needs, and a diminished quality of life. Findings included .Review of the facility's policy titled Activities of Daily Living, reviewed in June 2026, showed, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The policy further stated, Appropriate care and services are provided for residents who are unable to carry out ADLs independently.in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, and oral care).Review of the admission record printed on 06/15/2026 showed that Resident 1 was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness.Review of the admission minimum data set (a required assessment tool) dated 03/11/2026 showed that Resident 1 required two person assistance for bathing.Review of the shower schedule showed that Resident 1's bathing was scheduled twice weekly, on Tuesdays and Thursdays.Review of the ADL care plan revised on 06/09/2025 showed that Resident 1 had a self care performance deficit related to impaired mobility and blindness. The care plan further showed that Resident 1 was dependent on care and required two staff to assist with bathing.In an interview on 06/15/2026 at 10:37 AM, Resident 1 stated they had not been receiving their bathing care consistently for the past six months. Resident 1 stated that staff did not come to their room to offer a bed bath and hair washing. Resident 1 stated, Staff only document that I refused the bath, without including my explanations, and although there were a few days I postponed due to pain and the small Hoyer sling causing discomfort, this does not accurately reflect what actually occurred. When informed that the facility had multiple entries indicating refusals, Resident 1 stated, They must be marking me as refusing, even when the bath was never offered.In an interview on 06/16/2026 at 10:13 AM, Staff D, Certified Nursing Assistant, stated that Resident 1 required two female caregivers for bathing and that they were previously one of the shower aides assigned to the resident. Staff D reported that in April 2026, Resident 1 fired them and no longer wanted them to provide care. Staff D stated they had not provided bathing care to Resident 1 since that time. Staff C stated the facility currently had only two shower aides (one male and one female) and that they did not know who had been providing bathing care for Resident 1.A joint record review of Resident 1's January 2026 Kardex (care guide) and interview on 06/16/2026 at 1:12 PM with Staff C, Resident Care Manager, showed that Resident 1 was scheduled for eight showers, received two (on 01/06/2026 and 01/23/2026), and had three refusals on 01/09/2026, 01/13/2026, and 01/2026. The review of February 2026 Kardex showed that Resident 1 received a bath on 02/27/2026 and had refusals on 02/04/2026, 02/06/2026, 02/13/2026, 02/16/2026, 02/18/2026, 02/20/2026, 02/24/2026, 02/25/2026, and 02/26/2026. The review of March 2026 Kardex showed Resident 1 received no bath and had refusals on 03/03/2026, 03/06/2026, 03/16/2026, 03/20/2026, and 03/27/2026. The review of April 2026 Kardex showed Resident 1 received no bath and had refusals on 04/07/2026, 04/10/2026, 04/16/2026, 04/17/2026, 04/21/2026, and 04/24/2026.The review of May 2026 Kardex showed Resident 1 received no bath and had refusals on 05/05/2026, 05/08/2026, 05/12/2026, 05/19/2026, and 05/26/2026. The review of June 2026 Kardex showed that Resident 1 had not received bath and no documentation for refusal. The record further showed that Resident 1 received no bathing care in April, May, or June 2026. When asked whether an assessment had been completed to identify the root cause of Resident 1's consistent refusals of bathing care, Staff C stated that no assessment had been completed and that they did not know the reason for the resident's ongoing refusal behavior. A joint record review of Resident 1's Electronic Health Record (EHR) did not show that the facility consistently discussed the risks and benefits of bathing care with (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1. Staff C stated they would expect the facility to offer and re-offer all scheduled bathing care, to have consistent discussions with Resident 1 regarding the risks and benefits of bathing, to update the care plan and to complete an assessment to identify the root causes of the resident's refusals. In an interview on 06/16/2026 at 2:22 PM, Staff B, Director of Nursing, stated that the facility became aware of the shower issues the previous week and was working on addressing the concerns. Staff B stated they would expect Resident 1 to be offered all scheduled baths, for staff to re-offer the care if a refusal occurred, for the care plan to be updated, and for the risks and benefits to be discussed with Resident 1 and/or their representative. Staff B further stated they would expect Resident 1's assessment to be completed to identify the root cause of their refusals. Reference: (WAC) 388-97-1060 (2)(c).		