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	05/17/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents on urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) were provided with privacy for 2 of 6 residents (Residents 30 & 8), reviewed for dignity. This failure placed the residents at risk for decreased self-worth and a diminished quality of life Findings included . Review of the facility's policy titled, Dignity, revised in February 2021, showed that each resident would be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The document further showed that residents were to be treated with dignity and respect. Review of the facility's policy titled, [Urinary] Catheter Care, revised in August 2022, showed that the purpose of this procedure is to prevent urinary catheter-associated complications, including bladder infections. The document further showed that catheter tubing and drainage bag were to be kept off the floor. RESIDENT 30 Observation on 05/13/2025 at 4:25 PM and on 05/14/2025 at 1:30 PM showed Resident 30's urinary catheter bag was not covered by a privacy bag and visible from the hallway. A joint observation and interview on 05/14/2025 at 1:55 PM with Staff M, Licensed Practical Nurse, showed Resident 30's urinary catheter bag was not covered with a privacy bag. Staff M stated that Resident 30's catheter bag should have been inside the privacy bag. In an interview on 05/17/2025 at 1:17 PM, Staff E, Resident Care Manager, stated that Resident 30's urinary catheter should have been covered with a privacy bag. In an interview on 05/17/2025 at 4:15 PM, Staff B, Director of Nursing, stated they expected urinary catheter bags to be covered, and that Resident 30's urinary catheter bag should have been covered with a privacy bag. RESDIENT 8 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's urinary care plan revised on 12/05/2024, showed, Drainage bag to remain covered. Observations on 05/13/2025 at 11:58 AM and on 05/15/2025 at 7:52 AM, showed Resident 8's urinary catheter bag was not covered with a privacy bag, and it was visible from the hallway. In an interview and joint observation on 05/15/2025 at 8:02 AM, Staff H, Certified Nursing Assistant, stated that catheter drainage bags should be covered with a privacy bag. A joint observation showed Resident 8's urinary catheter drainage bag was not covered with a privacy bag. Staff H stated that Resident 8's catheter bag could be seen from the hallway and should be covered with privacy bag for dignity. In an interview on 05/16/2025 at 11:54 AM, Staff E stated that Resident 8's catheter drainage bags should be covered. In an interview on 05/17/2025 at 10:42 AM, Staff B stated they expected catheter drainage bags to be covered with a privacy bag. Reference: WAC 388-97-0180 (2) .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 34 Review of Resident 34's Electronic Health Record (EHR- evaluation tab, miscellaneous tab, nursing progress notes from 05/12/2024 to 05/13/2025, and May 2025 physician orders), showed no documentation that Resident 34 had an assessment for self-administration of medication. Observation on 05/14/2025 at 10:22 AM, showed three bottles of multi-collagen [a supplement to provide structure, strength and support throughout the body] supplements on Resident 34's bedside table. Observation on 05/14/2025 at 12:41 PM, showed three bottles of multi-collagen supplements on Resident 34's bedside table. Resident 34 stated, I take [them] every day. A joint record review and interview on 05/14/2025 at 1:38 PM with Staff V, Licensed Practical Nurse (LPN), showed no documentation or assessment for self-administration of medications for Resident 34. Staff V stated there should be an order to self-administer medications. A joint observation and interview on 05/14/2025 at 2:07 PM with Staff V, showed three bottles of multi-collagen on Resident 34's bedside table. Resident 34 also showed that they had another bottle of multi-collagen and a bottle of probiotics [microorganisms that provide health benefits] in the drawer of their nightstand. Resident 34 stated that they were taking both medications every day. Staff V stated, I'll take these [medications] until I get an order from the doctor to keep at the bedside and to self-administer [the medications]. RESIDENT 38 Review of Resident 38's physician orders, printed on 05/12/2025, showed an order for Albuterol Sulfate with the instructions, two puffs inhale orally every four hours as needed for shortness of breath. It showed no documentation for self-administration of medication. Review of Resident 38's EHR (nursing progress notes from 05/14/2024 to 05/15/2025), showed no documentation that Resident 38 had an assessment for self-administration of medication. Observation on 05/13/2025 at 8:55 AM, showed Resident 38 took out an inhaler from the top drawer of their nightstand and inhaled two puffs. Resident 38 stated they [the facility] know I have it. Resident 38 stated they had not been assessed for self-administration of medications and I've been using it [the inhaler] for years. Additional observation on 05/14/2025 at 1:01 PM, showed one albuterol sulfate inhaler stored in Resident 38's nightstand drawer. Resident 38 stated, it's my rescue one [inhaler] that came from my doctor. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 05/14/2025 at 1:38 PM, Staff V stated that residents may not have medications at their bedside and may not self-administer medications unless they have an order. Staff V stated that Resident 38 had not had an assessment done for self-administration of medications. A joint record review of Resident 38's physician orders showed no documentation for self-administration of medication. Staff V stated, I don't see anything [an order]. A joint observation of Resident 38's room showed Staff V asked Resident 38 if they had any medications in their nightstand table. Resident 38 stated, yes, my albuterol inhaler and showed Staff V their inhaler. Staff V stated it should not be there. In an interview on 05/14/2025 at 1:57 PM, Staff D, RCM, stated that Resident 38 should have an order for self-administration of medications and he doesn't have one. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that medications should not be at the bedside unless there is a self-administration assessment. Staff B stated that they expected a doctor's order and a self-administration assessment to be done prior to a resident being able to self-administer medications. When asked if they expected Resident 38's inhaler or Resident 34's medications to be at the bedside without a self-administration assessment, Staff B stated, no that's not the practice and no, would not expect that. Based on observation, interview, and record review, the facility failed to ensure the residents were evaluated and assessed, and/or physician orders were obtained for safe administration of medication for 5 of 19 residents (Residents 30, 34, 38, 10 & 5), reviewed for self-medication administration. This failure placed the residents at risk for inaccurate and unsafe medication administration, adverse side effects, medical complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Self-Administration of Medications, revised in September 2004, showed that the facility would allow residents to self-administer medications if they choose. If the resident wishes to self-administer their medications, the Resident Care Manager (RCM) will evaluate potential by using the self-medication review form. If the RCM determines the resident can carry out this task in a safe and prudent manner, the physician will be notified, an order obtained, and the resident will be placed in a self-administration program. The RCM must establish a care plan. Drugs may be kept in a locked drawer at the bedside or if the resident desires, the medication may also be stored by the nursing staff. Residents who self-administer medications will be reviewed at least quarterly and with any significant change. The residents may continue the self-administration of medication programs as long as the residents remain competent and accountable. RESIDENT 30 Review of Resident 30's self-administration of medication evaluation assessment dated [DATE] showed it was incomplete, no answers were filled in the form, it was blank. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician orders printed on 05/12/2025 showed Resident 30 had orders for Flonase (medication that treats nasal congestion) nasal (into the nose) spray, two sprays in both nostrils (nasal passages) one time a day, Incruse Ellipta (Umeclidinium Bromide - brand name) inhaler [portable device for administering a drug which is to be breathed in] one puff inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD - an ongoing lung condition caused by damage to lungs); and Albuterol Sulfate (an inhaler used to open the airways to increase air flow to the lungs) inhaler - two puffs orally every six hours as needed for COPD. Further review of the physician orders did not indicate that Resident 30 would self-administer and/or would keep the medications at bedside. Observation on 05/12/2025 at 2:05 PM, showed that Resident 30 had an albuterol inhaler, a bottle of Flonase nasal spray, and an Arnuity Ellipta (fluticasone furoate- [brand name], a steroid [anti-inflammatory drugs that help treat breathing disorders]) inhaler on their bedside table. Resident 30 stated they administered the medications themselves. Resident 30 further stated that they get the albuterol inhaler once at night, the nasal spray once a day and the Arnuity Ellipta inhaler twice a day after breakfast and after lunch. Observation on 05/13/2025 at 3:23 PM, showed that Resident 30 had an albuterol inhaler, a bottle of fluticasone nasal spray, and an Arnuity Ellipta inhaler on top of the side table within Resident 30's reach. In an interview and joint observation on 05/13/2025 at 4:16 PM, Staff E, RCM, stated that when residents request to self-administer their medications, staff would complete a self-administration medication assessment and orders would be obtained. A joint observation and interview with Staff E showed Resident 30 had one albuterol inhaler, one bottle of fluticasone nasal spray, and one Arnuity Ellipta inhaler on top of their side table. Resident 30 stated that they kept their medications at bedside and that they use their medication every day. Staff E stated that Resident 30's medications should have been kept in a locked box. A joint record review and interview on 05/13/2025 at 4:31 PM with Staff E, showed Resident 30's May 2025 physician orders showed they had orders for Flonase nasal, albuterol inhaler, and Incruse Ellipta inhaler. Further review of Resident 30's physician orders did not show documentation for self-administration of medication. Staff E stated that Resident 30 should have had orders for self-administration of the three medications that were in Resident 30's room. A joint record review of the self-administration of medication evaluation dated 07/09/2024 showed it was incomplete. Staff E stated that the self-administration of medication evaluation should have been completed, and that Resident 30's medications should have been stored in a locked box. In an interview on 05/17/2025 at 3:55 PM, Staff B, Director of Nursing Services, stated that Resident 30 should have had a self-administration of medication evaluation for the three medications they were self-administering, orders for self-administering of medications, a care plan in place, and that Resident 30's medications should have been kept in a locked box. RESIDENT 10 Review of Resident 10's face sheet printed on 05/12/2025, showed they were admitted to the facility on [DATE] with a diagnosis that included COPD and dyspnea (difficulty breathing). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's physician orders printed on 05/12/2025, showed Resident 10 was prescribed Albuterol Sulfate inhaler as needed. The physician orders further showed no documentation for self-administration of medication. Review of Resident 10's EHR under assessment tab and miscellaneous tab from January 2025 to May 2025, showed no documentation that Resident 10 had an assessment for self-administration of medication. Observations on 05/12/2025 at 2:09 PM and on 05/13/2025 at 8:00 AM, showed Resident 10 had one Albuterol Sulfate inhaler lying on top of their bedside table. Resident 10 stated they used the inhaler when they feel short of breath, especially at night. In an interview and joint observation on 05/13/2025 at 8:08 AM, Staff J, LPN, stated that Resident 10 did not have an order for self-administration and did not have a self-administration assessment. A joint observation showed Resident 10 had an Albuterol Sulfate inhaler lying on top of their bedside table. Staff J stated the inhaler should not be on Resident 10's bedside table and that they should have had a self-administration order. In an interview and joint record review on 05/16/2025 at 5:50 PM, Staff E stated that when a resident wishes to self-administer their medications, they would do an assessment, verify with the physician and get an order, then update their care plan. A joint record review of Resident 10's EHR showed no assessment or documentation for self-administration of medication, Staff E stated Resident 10 did not have an order or an assessment for self-administration of medications and that there should have been. In an interview on 05/17/2025 at 1:10 PM, Staff B stated they expected that there should have been a self-administration of medications assessment and order for Resident 10. RESIDENT 5 Review of the face sheet printed on 05/13/2025 showed Resident 5 was admitted to the facility on [DATE]. Observations on 05/12/2025 at 9:35 AM and on 05/13/2025 at 8:20 AM showed Resident 5 had one bottle of Centrum (brand name) vitamins and one bottle of Fish oil on top of the nightstand. Review of Resident 5's physician orders printed on 05/13/2025, did not show documentation for self-administration of medication. Review of Resident 5's April 2025 and May 2025 EHR under the assessment tab and miscellaneous tab, did not show an assessment for self-administration of medication was done. Review of Resident 5's comprehensive care plan printed on 05/13/2025, did not show documentation that Resident 5 could safely self-administer or independently store medication. A joint observation and interview on 05/13/2025 at 8:25 AM with Staff J, showed that Resident 5 had two bottles of supplement on top of their nightstand. Staff J stated that they [Resident 5] should not have medication on the bedside. Staff J further stated that Resident 5 was not on self-administration of medication program. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/16/2025 at 11:54 AM, Staff E stated medications should not be kept by the bedside before self-administration of medication assessment was completed. In an interview on 05/17/2025 at 10:42 AM, Staff B stated they expected staff to have been assessed Resident 5 to be able to safely self-administer medication and complete the documentation. Reference: (WAC) 388-97-0440, 1060(3)(l) .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an updated guardianship letter was readily available in medical records and accessible to staff for 1 of 4 residents (Resident 29), reviewed for Advanced Directives (a written instruction, such as a living will or durable power of attorney for health care). This failure placed the resident and/or their representative at risk of losing their right to have their preferences honored to receive care according to their choice. Findings included . Review of Resident 29's guardianship letter signed/dated on [DATE] showed it was effective until [DATE]. Further review showed no documentation that the facility attempted to have an updated guardianship letter in Resident 29's Electronic Health Record (EHR). In an interview and joint record review on [DATE] at 2:36 PM, Staff A, Administrator, stated that if a resident had a guardianship, the facility would ask for documentation and it would be uploaded into the resident's EHR. Staff A stated that guardianships expired, and they would need to contact the guardian if it needed to be renewed. A joint record review of Resident 29's guardianship letter showed that it was signed on [DATE] and expired on [DATE]. Staff A stated, it should not be expired. A joint record review of Resident 29's EHR showed no discussion of guardianship. Staff A stated, I need to reach out to the guardian for new paperwork and there should be new paperwork in the chart [EHR] for [Resident 29]. Reference: (WAC) 388-97-0280 (3)(a)(d) .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue Notification of Medicare Non-Coverage (NOMNC- a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) at least two calendar days before the Medicare coverage ended for 1 of 3 residents (Resident 56), reviewed for beneficiary notification. This failure placed the resident and/or their representative at risk for not being fully informed and losing their right to an appeals process. Findings included . Review of the facility's policy titled, NOMNC Policy, revised on 09/12/2024, showed that A NOMNC will be issued at least 2 days, but not greater than 4 days, prior to the last covered day, to beneficiaries where it has been determined that Medicare A, B, or C covered services are no longer required. Review of Resident 56's NOMNC showed a last day of Medicare A coverage of 04/11/2025 and signed on 04/10/2025, one day before the end of Medicare A coverage. In an interview and joint record review on 05/16/2025 at 3:23 PM, Staff G, Social Services Director, stated that the NOMNC must be provided no less than 2 days prior to last coverage day of their skilled stay. A joint record review of Resident 56's NOMNC showed that Resident 56's last coverage day was 04/11/2025 and the NOMNC was provided on 04/10/2025. Staff G stated, it was not given two days before the last coverage day and it should have been given on 04/09/2025. In an interview on 05/17/2025 at 11:50 AM, Staff A, Administrator, stated that the NOMNC should be given to residents two days prior to the last day of Medicare A coverage. Reference: (WAC) 388-97-0300 (1)(e) .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure resident rooms were maintained for 4 of 19 residents (Residents 29, 13, 269 & 31), reviewed for environment. The failure to ensure resident rooms were free from broken light switches and soiled privacy curtains placed residents at risk for a less than homelike environment and a diminished quality of life. Findings included . RESIDENT 29 Observations on 05/13/2025 at 2:57 PM and on 05/15/2025 at 11:01 AM, showed the privacy curtains for Resident 29's room were dirty with a brown material on them. It further showed a broken pull cord above Resident 29's bed and plastic bags tied together being used as the pullcord. In an interview and joint observation on 05/15/2025 at 11:16 AM, Staff BB, Certified Nursing Assistant, stated that if they noticed something in disrepair in a resident's room, they would report to the nurse first, tell maintenance. A joint observation of Resident 29's room showed a broken pull cord above Resident 29's bed and plastic bags tied together being used as the pull cord. Staff BB stated, I don't know why it's like that. It further showed brown material on Resident 29's privacy curtains and Staff BB stated, looks dirty. In an interview and joint observation on 05/15/2025 at 11:24 AM, Staff I, Maintenance Director, stated that they checked resident rooms every single day, I have an assistant who helps. Staff I stated that housekeeping lets us know if privacy curtains needed to be cleaned and we also check them when we check the rooms. A joint observation of Resident 29's room showed plastic bags tied together for the pullcord for the light above Resident 29's bed. Staff I stated, that needs to be taken down, plastic shouldn't be there. I have something else that we can use. It further showed that the privacy curtain had a brown material on it. Staff I stated, it's not clean, I have clean ones downstairs. In an interview on 05/17/2025 at 11:55 AM, Staff A, Administrator, stated that they expected staff to report any maintenance issues, and they were not expecting the plastic bags to be used as a pullcord for the light above resident's beds. Staff A further stated that they expected the privacy curtains in resident rooms to be in good repair and clean. RESIDENT 13 Observations on 05/12/2025 at 10:18 AM and on 05/15/2025 at 11:22 AM showed Resident 13's overhead lighting pull cord was extended by plastic bags. RESDIENT 269 Observations on 05/13/2025 at 9:21 AM and on 05/15/2025 at 11:20 AM showed Resident 269's overhead lighting pull cord was extended by a green piece of fabric strip. RESIDENT 31 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 05/13/2025 at 9:21 AM and on 05/15/2025 at 11:20 AM showed Resident 31's overhead lighting pull cord was extended by a night gown strip. A joint observation and interview on 05/15/2025 at 11:24 AM with Staff I showed Resident 13, Resident 269, and Resident 31's overhead lighting pull cord were not home like. Staff I stated, I don't [do not] know [why] it looks like this, it should not look like this. In an interview on 05/17/2025 at 10:42 AM, Staff B stated resident's rooms should provide a home like environment. Reference: WAC 388-97-0880 (1) .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure non-pharmacological interventions were in place for psychotropic (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) medication management for 2 of 5 residents (Residents 64 & 57), reviewed for unnecessary medications. This failure placed the residents at risk for unmet care needs, adverse side effects, and a diminished quality of life. Findings included . Review of the facility policy titled, Psychotropic Medication Use, revised in July 2022, showed, A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior . non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. RESIDENT 64 Review of a face sheet printed on 05/13/2025 showed Resident 64 admitted to the facility on [DATE] with diagnosis that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Review of physician's orders printed on 05/14/2025 showed that Resident 64 had an order for quetiapine (an antipsychotic-medication that treats psychosis [mental disorder caused by abnormal thinking and perception]) 50 milligrams (mg- a unit of measurement) at bedtime and quetiapine 50 mg as needed per day. Further review of Resident 64's physician's orders did not show documentation for non-pharmacological interventions related to quetiapine use. RESIDENT 57 Review of a face sheet printed on 05/13/2025 showed Resident 57 admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Alzheimer's disease (a brain condition that slowly damages your memory, thinking, learning and organizing skills). Review of physician's orders printed on 05/14/2025 showed Resident 57 had an order for quetiapine 25 mg at bedtime. Further review of Resident 57's physician's orders did not show documentation for non-pharmacological interventions related to quetiapine use. In an interview and joint record review on 05/16/2025 at 11:54 AM, Staff E, Resident Care Manager, stated that psychotropic medications should have non-pharmacologic interventions in place. A joint record review of Resident 64 and Resident 57 physician's orders showed they had orders for psychotropic medication. It further showed that non-pharmacological interventions related to the use of psychotropic medication were not in place for Resident 64 and Resident 57. Staff E stated that they expected non-pharmacological interventions would be in place when residents were started on psychotropic medication. (continued on next page)

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	505009	A. Building B. Wing	05/17/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 05/17/2025 at 10:42 AM, Staff B, Director of Nursing, stated that they expected residents who were prescribed psychotropic medication would have an order for non-pharmacological interventions. A joint record review of physician orders for Resident 64 and Resident 57 did not show non-pharmacological interventions related to quetiapine use. Staff B further stated that Resident 64 and Resident 57 should have had an order for non-pharmacological interventions related to psychotropic medication use. Reference: (WAC) 388-97-1060 (3)(k)(i) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed timely for 1 of 2 residents (Resident 2), reviewed for SCSA. This failure placed the resident at risk for delayed care planning, unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed that a SCSA is required to be performed when a terminally ill resident enrolls in a hospice (compassionate care provided to individuals who are in the final stages of a terminal illness) program or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). Review of a document titled, Hospice Plan of Care, dated 03/02/2025, showed that Resident 2 started hospice services on 03/02/2025. Review of the SCSA MDS dated [DATE] showed it was completed on 03/26/2025, 10 days late. In an interview and joint record review on 05/16/2025 at 5:35 PM, Staff F, MDS Coordinator, stated that they followed the RAI manual for completion of MDS assessments. A joint record review of the hospice plan of care showed Resident 2 admitted to hospice on 03/02/2025. A joint record review of Resident 2's SCSA MDS dated [DATE] showed it was completed on 03/26/2025. Staff F stated that Resident 2 was admitted to hospice on 03/02/2025 and that they opened an SCSA MDS for 03/12/2025. Staff F stated that Resident 2's MDS was completed 14 days after the ARD. Staff F further stated that Resident 2's MDS was completed late and that it should have been completed by 03/16/2025. On 05/17/2025 at 3:15 PM, Staff B, Director of Nursing, stated they expected that MDS assessments were completed timely. Staff B further stated that Resident 2's MDS should have been completed by 03/16/2025. Reference: (WAC) 388-97-1000 (3)(b) .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit the resident Minimum Data Set (MDS - an assessment tool) to the Centers for Medicare & Medicaid Service (CMS) within the required timeframe for 4 of 6 residents (Residents 53, 25, 42 & 59), reviewed for transmitting MDS assessments. This failure placed the residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.11, revised in October 2024, showed all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. RESIDENT 53 Review of the face sheet printed on 05/13/2025, showed Resident 53 admitted to the facility on [DATE] and discharged on 02/19/2025. Review of Resident 53's discharge MDS dated [DATE] showed it was completed on 04/09/2025, 35 days late. Further review of the MDS showed it was not transmitted/submitted to CMS' iQIES. In an interview and record review on 05/16/2025 at 5:35 PM, Staff F, MDS Coordinator, stated they followed the RAI manual for completion of MDSs, that discharge MDS would be completed no later than 14 days from the ARD, and then transmitted to CMS. A joint record review showed Resident 53's MDS dated [DATE] was completed on 04/09/2025. Staff F stated, it was completed late. Further review of the MDS showed it was not transmitted/submitted to CMS. Staff F stated that Resident 53's MDS should have been transmitted to CMS. On 05/17/2025 at 3:59 PM, Staff B, Director of Nursing, stated they expected MDS to be completed and transmitted in a timely manner. Staff B further stated that Resident 53's MDS should have been transmitted after it was completed. RESIDENT 25 Review of Resident 25's discharge MDS dated [DATE] showed it was completed on 05/08/2025, 26 days late. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 05/16/2025 at 5:52 PM with Staff F showed that Resident 25's discharge MDS dated [DATE] was completed on 05/08/2025. Staff F stated that Resident 25's MDS was late and that it should have been completed within the required timeframe. On 05/17/2025 at 4:04 PM, Staff B stated that Resident 25's MDS should have been completed and transmitted in a timely manner. RESIDENT 42 Review of the discharge MDS dated [DATE] showed Resident 42 admitted to the facility on [DATE] and discharged on 04/01/2025. Further review of the MDS showed it was completed on 04/09/2025 and it was not transmitted/submitted to CMS. A joint record review and interview on 05/16/2025 at 5:54 PM with Staff F showed Resident 42's discharge MDS dated [DATE] was completed and it was not transmitted/submitted to CMS. Staff F stated that Resident 42's MDS was not transmitted to CMS, and it should have been. On 05/17/2025 at 4:07 PM, Staff B stated that Resident 42's MDS should have been completed and submitted to CMS timely. RESIDENT 59 Review of Resident 59's discharge MDS dated [DATE] showed it was completed on 04/08/2025 and it was not transmitted/submitted to CMS. A joint record review and interview on 05/16/2025 at 5:55 PM with Staff F showed Resident 59's MDS dated [DATE] was completed on 04/08/2025 and it was not submitted to CMS. Staff F stated that Resident 59's MDS should have been completed timely and submitted/transmitted to CMS. On 05/17/2025 at 3:59 PM, Staff B stated that Resident 59's discharge MDS should have been completed and submitted to CMS in a timely manner. Reference: (WAC) 388-97-1000(5)(a)(e) (i-iii) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 8 of 21 residents (Residents 26, 65, 51, 30, 21, 2, 48 & 39), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were coded on the MDS regarding Preadmission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], intellectual/developmental disabilities [ID/DD]), discharge status, bowel (gut) continence, oxygen, medication, urinary catheter (a flexible tube inserted into the bladder to drain urine), and bowel patterns, placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. It further showed that always incontinent of bowel would be coded if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements. Constipation was defined as If the resident has two or fewer bowel movements during the 7-day look-back period. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). PASARR RESIDENT 26 Review of the Level II PASARR Initial Evaluation Summary, dated 04/09/2019, showed Resident 26 had a Level II PASARR with diagnosis of conversion disorder (a mental health condition that disrupts how the brain works causing real, physical symptoms that a person cannot control), schizophrenia (a chronic mental disorder with symptoms such as hallucinations [experience involving the apparent perception of something not present], delusions [a false belief, judgment, or perception], and cognitive challenges [affects the ability to think, learn, and process information), and anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations). Review of the annual MDS dated [DATE] showed that Resident 26 was admitted to the facility on [DATE]. Further review of the MDS showed Section A1500 (PASARR) was coded 0. [No conditions related to SMI/ID/DD status]. Section A1500 should have been coded 1. [Yes, as the Resident 26 had SMI]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 05/16/2025 at 4:53 PM with Staff F, MDS Coordinator, stated they followed the RAI manual for completion of MDSs. A joint record review showed Resident 26 had a PASARR Level II dated 04/09/2019 that included diagnoses of conversion disorder, schizophrenia, and anxiety. Staff F stated that Resident 26 had a PASARR Level II and had SMIs. A joint record review showed Resident 26's annual MDS dated [DATE] was not marked for Level II PASARR and/or SMI in Section A. Staff F stated that Resident 26's MDS should have been coded for PASARR Level II and for Level II SMI. In an interview on 05/17/2025 at 3:33 PM, Staff B, Director of Nursing, stated that Resident 26's annual MDS should have been accurate. DISCHARGE STATUS RESIDENT 65 Review of a face sheet printed on 05/14/2025 showed Resident 65 was readmitted to the facility on [DATE] and was discharged on 02/19/2025. Review of the progress notes printed on 05/14/2025 showed Resident 65 was discharged to home on [DATE]. Review of the discharge MDS dated [DATE] showed Resident 65 was marked discharged to the hospital in Section A2105 (Discharge Status). Section A2105 should be marked discharge to community/home. A joint record review and interview on 05/16/2025 at 5:40 PM with Staff F showed that Resident 65's MDS dated [DATE] was marked discharged to the hospital. Staff F stated that Resident 65 was discharged to the hospital. A joint record review of Resident 65's progress notes dated 02/19/2025, showed Resident 65 was discharged home. Staff F stated that Resident 65 discharged home and that their MDS was inaccurate. In an interview on 05/17/2025 at 3:36 PM, Staff B stated that Resident 65's MDS should have been coded to have discharged home and that their MDS was inaccurate. BOWEL CONTINENCE RESIDENT 51 Review of the April 2025 task for bowel documentation showed Resident 51 was incontinent of bowel every day during the look-back-period (04/16/2025 to 04/22/2025). Review of the quarterly MDS dated [DATE] showed Resident 51 was coded as always continent of bowel in H0400 (Bowel Continence). Section H0400 should be marked always incontinent, as the bowel task documentation showed Resident 51 was incontinent during the look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 05/16/2025 at 6:14 PM with Staff F showed Resident 51's MDS dated [DATE] was coded for always continent. Staff F stated, it was coded that [Resident 51] was always continent. A joint record review of the April 2025 task for bowel function showed Resident 51 was incontinent of bowel every day during the look-back-period. Staff F stated that Resident 51 was incontinent of bowel, that their MDS should have been coded as always incontinent, and that Resident 51's MDS was inaccurate. In an interview on 05/17/2025 at 3:36 PM, Staff B stated they expected Resident 51's MDS to be completed accurately. OXYGEN USE RESIDENT 30 Review of Resident 30's annual MDS dated [DATE] did not show oxygen was marked in Section O (Special Treatments). Review of the nursing progress notes dated 04/23/2025 showed that Resident 30 was on continuous oxygen at two liters (unit of measurement) per minute. A joint record review and interview on 05/16/2025 at 6:11 PM with Staff F, showed that Resident 30's MDS dated [DATE] was not marked for oxygen use. Staff F stated that oxygen was not marked. A joint record review of the progress notes dated 04/23/2025 showed that Resident 30 was on continuous oxygen at two liters per minute. Staff F stated that Resident 30 received oxygen during the look-back-period and that their MDS was inaccurate. In an interview on 05/17/2025 at 3:50 PM, Staff B stated that Resident 30's MDS should have been accurate. MEDICATION USE RESIDENT 21 Review of Resident 21's quarterly MDS dated [DATE] showed, 7 [seven] injections (N0300) and 7 insulin (a medication to manage blood sugar) injections (N0350A) were marked in Section N (Medications). Review of the April 2025 and March 2025 Medication Administration Record (MAR) did not show Resident 21 received injections and/or insulin injections during the look-back-period (03/26/2025 to 04/01/2025). A joint record review and interview on 05/16/2025 at 5:46 PM with Staff F showed Resident 21's MDS dated [DATE] was marked for seven injections and seven insulin injections in Section N. Staff F stated that Resident 21's MDS was coded for injections and insulin injections. A joint record review of Resident 21's March 2025 MAR and April 2025 MAR showed Resident 21 did not receive insulin injections during the look-back-period. Staff F stated that Resident 21's MDS should not have been coded for injections and/or insulin injections and that their MDS was inaccurate. In an interview on 05/17/2025 at 4:02 PM, Staff B stated that Resident 21's MDS was inaccurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 2 Review of Resident 2's Significant Change in Status Assessment (SCSA) MDS dated [DATE] showed Section N0415F (1. Is taking an antibiotic [medication that treats infection] and 2. Indication noted) were marked. Further review of the MDS showed Section N0415H (opioid [narcotic pain medication]) use was not marked. Review of the March 2025 MAR showed Resident 2 was not receiving antibiotics during the look-back-period (03/06/2025 to 03/12/2025). Further review of the MAR showed Resident 2 received oxycodone (an opioid pain medication) on 03/07/2025 and 03/10/2025. A joint record review and interview on 05/16/2025 at 5:58 PM with Staff F showed that Resident 2's MDS dated [DATE] was marked for antibiotic use in Section N. Staff F stated that Resident 2 received antibiotics according to the MDS. A joint record review of the March 2025 MAR did not show Resident 2 received antibiotics during the look-back-period and that Resident 2 received opioids on 03/07/2025 and 03/10/2025. Staff F stated that Resident 2's MDS should have not been marked for antibiotics as they did not receive any antibiotics, and that opioids should have been coded in the MDS. Staff F further stated that Resident 2's MDS was inaccurate. In an interview on 05/17/2025 at 3:49 PM, Staff B stated they expected MDS to be accurate and that Resident 2's MDS was inaccurate. RESIDENT 48 Review of Resident 48's quarterly MDS dated [DATE] showed Section N0415B (use of antianxiety [medication for anxiety]) were marked: 1. Is taking [receiving an antianxiety medication], and 2. Indication noted [reason for taking the medication] during the look-back-period (02/25/2025 to 03/03/2025). Review of February 2025 and March 2025 MAR showed Resident 48 did not receive an antianxiety medication during the look-back-period. Review of the physician orders printed on 05/12/2025, showed Resident 48 was not prescribed an antianxiety medication. In an interview and joint record review on 05/16/2025 at 6:38 PM, Staff F stated they would follow the RAI Manual for MDS coding accuracy. A joint record review of Resident 48's February 2025 and March 2025 MAR showed Resident 48 did not receive an antianxiety medication. Further joint record review of Resident 48's quarterly MDS dated [DATE], showed that Section N was marked for use of antianxiety medication. Staff F stated Resident 48 did not receive an antianxiety and that their MDS coding was not accurate. In an interview on 05/17/2025 at 1:10 PM, Staff B stated that they expected the MDS to be completed accurately for Resident 48. URINARY CATHETER USE AND BOWEL PATTERNS RESIDENT 39 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician orders printed on 05/13/2025, showed Resident 39 had an order for Document Foley [urinary catheter] output [amount of urine] q [every] shift, dated 02/03/2025. Review of the April 2025 bowel documentation task from 04/04/2025 through 04/10/2025 showed Resident 39 had two bowel movements in the seven-day look-back-period. Review of the SCSA MDS assessment dated [DATE], showed Resident 39 was not marked for urinary catheter use under Section H0100 (Appliances). Further review showed constipation (Section H0600) was not marked, indicating Resident 39 did not have constipation. A joint record review and interview on 05/16/2025 at 5:35 PM with Staff F showed Resident 39 had an order for Document Foley output q shift. Further joint record review of Resident 39's April 2025 bowel documentation task from 04/04/2025 through 04/10/2025 showed Resident 39 had two bowel movements in the seven-day look-back-period. Staff F stated Resident 39's MDS should have been coded for urinary catheter use and constipation, and that Resident 39's MDS was coded inaccurately. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that they expected Resident 39's MDS to be completed accurately. Reference: (WAC) 388-97-1000 (1)(b) .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate the Preadmission Screen and Resident Review (PASARR) for Level II services (a process to determine what mental health services residents required after a Level I PASARR determined mental health services were necessary) for 1 of 2 residents (Resident 26), reviewed for PASARR. This failure placed the resident at risk of not receiving the necessary mental health services and a diminished quality of life. Findings included . Review of the facility's policy titled, PASRR, revised in July 2024, showed, Social services will review the completed PASRR [Level] II screening for any recommendations and will ensure that the patient [resident] receives the necessary services and that interventions are care planned . Care Planning for Level II PASRR Residents who have screened positive for Level II during the PASRR evaluation are required to have this reflected clearly in the care plan, and any recommendations made by the evaluator are to be included as the resident specific interventions. Review of a face sheet printed on 05/13/2025 showed Resident 26 was admitted to the facility on [DATE]. Review of the Level II PASRR Initial Psychiatric Evaluation Summary, dated 04/09/2019, showed Resident 30 had diagnoses of conversion disorder (a mental health condition that disrupts how the brain works causing real, physical symptoms that a person cannot control), schizophrenia (a chronic mental disorder with symptoms such as hallucinations [experience involving the apparent perception of something not present], delusions [a false belief, judgment, or perception], and cognitive challenges [affects the ability to think, learn, and process information), and anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations). Further review of the Level II PASRR form showed specific interventions recommended for the nursing facility regarding Resident 26's care. Review of the PASARR care plan dated 03/01/2021 showed no recommendations from Resident 26's Level II PASARR were included in their care plan. In an interview on 05/16/2025 at 4:59 PM, Staff G, Social Services Director, stated that when a resident had a Level II PASARR, the recommendations from the Level II PASARR were included in the residents' care plan. A joint record review and interview showed Resident 26 had a Level II PASARR dated 04/09/2019 and that the document listed interventions for Resident 26. Staff G stated that Resident 26 was a Level II PASARR positive (appropriate level of care and necessary behavioral services and support to maintain the highest practicable level of health) and that their Level II PASARR had recommendations for their care. A joint record review of the PASARR care plan dated 03/01/2021 did not show the recommendations from Resident 26's Level II PASARR form were included. Staff G stated that Resident 26 had a general care plan, it should be personalized just for [Resident 26], the care plan should have been updated with the information and recommendations word for word from their Level II PASARR. On 05/17/2025 at 4:11 PM, Staff A, Administrator, stated that they expected recommendations from Resident 26's Level II PASARR form were included in their assessments and care plans. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-1915 (4) .

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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 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 are not inappropriately placed in nursing homes for long-term care) Level I form was completed accurately and Level II PASARR referrals were made for 1 of 6 residents (Resident 36), reviewed for PASARR screening. In addition, the facility failed to complete Level I PASARR screening form for an exempted hospital discharge resident who remained in the facility for more than 30 days for 1 of 2 residents (Resident 57). These failures 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 facility's policy titled, PASRR Policy, revised in July 2024, showed Level II PASRR evaluations are required for all nursing facility residents identified to have indicators of SMI/ID during the Level I screening or at any time during residency in the nursing facility, and for any resident with confirmed SMI or ID who presents with significant changes in their cognitive or physical conditions .In certain limited circumstances, an individual may be admitted to a NF (nursing facility) without first having a PASRR Level II assessment, known as an Exempted Hospital Discharge. This is the only situation that exempts a person with SMI/ID from having a Level II PASRR completed before NF admission .(C) Whose attending physician has certified before admission to the facility that the individual is likely to require less than 30 days nursing facility services. RESIDENT 36 Review of a face sheet printed on 05/13/2025 showed Resident 36 admitted to the facility on [DATE] with diagnosis that included depression (feeling of loneliness, sadness) and anxiety disorder (having excessive/persistent worry and fear). Review of Resident 36's Level I PASARR dated 04/28/2025, showed the diagnosis of depression and anxiety disorder were not marked in Section IA (SMI). Further review showed that Section IV (4- Service Needs and Assessor Data) was marked for No level II evaluation indicated. A joint record review and interview on 05/16/2025 at 4:59 PM with Staff G, Social Services Director, showed Resident 36 had diagnoses of depression and anxiety disorder on their face sheet. An additional joint record review showed that depression and anxiety disorder were not marked in Resident 36's Level I PASARR in Section IA. Staff G stated that Resident 36's Level I PASARR was not accurate and that they should have included their diagnoses of depression and anxiety disorder. Staff G further stated that a Level II PASARR referral should have been sent to the PASARR coordinator for Resident 36. RESIDENT 57 Review of Resident 57's Level I PASARR dated 04/03/2025, showed that Section IV was marked for No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a face sheet printed on 05/13/2025 showed that Resident 57 was admitted to the facility on [DATE]. A joint record review and interview on 05/16/2025 at 4:59 PM with Staff G, showed Resident 57's Level I PASARR was marked for no level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. Further joint record review of Resident 57's face sheet showed that they admitted on [DATE]. Staff G stated they should have reviewed Resident 57's Level I PASARR and that a Level II PASARR referral should have been made. In an interview on 05/17/2025 at 10:42 AM, Staff B, Director of Nursing, stated that they expected PASARR forms to be completed accurately and that Level II PASARR referral would be sent to the PASARR coordinator if residents had a SMI diagnosis. In an interview on 05/17/2025 at 10:58 AM, Staff A, Administrator, stated that they expected the PASARR form to be accurate and Level II PASARR referrals would be sent out when required. Reference: (WAC) 388-97-1975(1)(5) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 5 of 15 residents (Residents 3, 4, 29, 51 & 39), reviewed for comprehensive care plans. The failure to develop/implement care plans for Activities of Daily Living (ADL) and urinary catheter (a flexible tube inserted into the bladder to drain urine) care placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed that the comprehensive care plan includes measurable objectives and time frames .describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. RESIDENT 3 Review of Resident 3's quarterly Minimum Data Set (MDS-an assessment tool), dated 02/11/2025, showed that Resident 3 needed substantial/maximal assistance (helper does more than half the effort) for personal hygiene. It further showed that Resident 3 had diabetes (a group of diseases that result in too much sugar in the blood) diagnosis. Review of Resident 3's ADL care plan, revised on 04/13/2025, showed Resident 3 required total assistance with personal hygiene care. Review of Resident 3's Diabetes care plan, revised on 04/13/2025, showed an intervention for Diabetic nail care by LN [Licensed Nurse]. Observation on 05/12/2025 at 10:07 AM, showed Resident 3 with long fingernails on both hands and the right thumb had brown matter underneath the nail. Resident 3 stated, I need them [fingernails] to be trimmed. Resident 3 further stated, I'm diabetic. Observation on 05/14/2025 at 10:28 AM, showed Resident 3 with long fingernails. Resident 3 stated, I had a bed bath yesterday. I've asked them twice in the past two days [to trim fingernails] and I asked an aide to ask the nurse. I'm diabetic so a nurse needs to do it. In an interview and joint observation on 05/14/2025 at 11:14 AM, Staff GG, Certified Nursing Assistant (CNA), stated that they helped dependent residents with personal hygiene and if a resident had diabetes they would let a nurse know if the nails needed to be trimmed. A joint observation of Resident 3's fingernails showed they were long on both hands. Staff GG stated, it's too long on both hands, the nurse has to cut and I will tell the nurse. In an interview and joint observation on 05/14/2025 at 11:26 AM, Staff V, Licensed Practical Nurse, stated that CNA's were responsible for personal hygiene for dependent residents including nail care and that if a resident had diabetes, the nurses would trim the nails. Staff V stated that Resident 3 had diabetes and the nurses would be doing the trimming. A joint observation showed Resident 3 had long fingernails on both hands. Staff V stated that Resident 3's nails were pretty long, need them trimmed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 05/16/2025 at 11:44 AM, Staff D, Resident Care Manager (RCM), stated that Resident 3 gets help with his nails. A joint record review of Resident 3's Diabetes care plan showed an intervention for nail care by LN. Staff D stated that the care plan should be followed. RESIDENT 4 Review of Resident 4's admission MDS dated [DATE], showed Resident 4 had a urinary catheter. Review of a provider note dated 04/25/2025, showed Resident 4 informed, sometimes [that] her urine bag is not getting emptied when it is full, it is overflowing, informed RCM to put orders to empty urine bag twice a shift. Review of Resident 4's physician orders showed an order to check [the] drainage bag twice a shift and empty drainage when ½ [half] full, started on 04/25/2025. Review of Resident 4's [Urinary] Catheter care plan, revised on 04/25/2025, showed the intervention to check [the] drainage bag twice per shift, and empty if about or at ½ level. In an interview on 05/13/2025 at 9:29 AM, Resident 4 stated that they had a urinary tract infection (infection of the bladder) three weeks ago. Nobody checked my bag [catheter drainage bag] and it backed up. A joint observation and interview on 05/13/2025 at 4:37 PM with Staff W, CNA, showed Resident 4's catheter drainage bag was more than half full. Staff W stated, looks full. A joint observation showed Staff W emptied the drainage bag into a urinal (a plastic container that collects urine) two times with a total amount of 1400 milliliters (unit of measurement). In an interview and joint record review on 05/17/2025 at 1:30 PM, Staff D stated that they expected staff to follow the care plan. A joint record review of Resident 4's catheter care plan showed the catheter drainage bag should be emptied when it was about half full. Staff D stated they expected the drainage bag to not be full, so nothing in the tubing. When told that it was observed to be full, Staff D stated, my expectation is it should not be full. RESIDENT 29 Review of Resident 29's ADL self-care care plan revised on 05/06/2025, showed that Resident 29 need one-person extensive assistance (requiring a large amount of effort from the helper) for personal hygiene. Observations on 05/12/2025 at 10:59 AM, on 05/12/2025 at 2:00 PM, on 05/13/2025 at 3:00 PM, and on 05/14/2025 at 10:25 AM, showed Resident 29's left-hand fingernails had dark brown matter underneath them. In an interview and joint observation on 05/14/2025 at 11:32 AM, Staff HH, CNA, stated that cleaning nails was included in personal hygiene. A joint observation of Resident 29's left-hand fingernails had dark brown matter underneath them. Staff HH stated that Resident 29's fingernails need to trim and [it was] not clean. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 05/16/2025 at 11:07 AM, Staff D stated that they expected staff to help them [residents] if they can't do it, when asked how staff should provide ADL care to dependent residents. Staff D stated, aides should clean under the nails. When asked how much help Resident 29 needed with nail care, Staff D stated, he needs someone to trim nails and that their nails should be clean. A joint record review of Resident 29's self-care care plan showed Resident 29 need one-person extensive assistance for personal hygiene. Staff D stated that Resident 29 needed help with cleaning their hands and we need to clean after each meal. In an interview on 05/17/2025 at 1:42 PM, Staff B, Director of Nursing, stated that they expected resident care plans to be followed. RESIDENT 51 Review of the quarterly MDS dated [DATE] showed Resident 51 required partial to moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with personal hygiene [for washing/drying face and hands]. Review of the ADLs care plan printed on 05/13/2025 showed that Resident 51 required staff assistance with personal hygiene care. Observations on 05/13/2025 at 8:52 AM and at 9:14 AM, showed Resident 51's eyelids were covered with yellowish crusty matter. Resident 51 stated they have crusty eyes all the time in the mornings, staff does not clean [their eyes]. Observation on 05/14/2025 at 9:35 AM showed Resident 51's eyes were covered with yellowish crusty matter. Resident 51 stated, it is hard to open my eyes, it hurts and also itches. Resident 51 stated that staff did not clean their eyes and that they [staff] should, they see me every day. I cannot do it. I am blind on my left eye; my eyes are dry. Observation on 05/15/2025 at 2:34 PM, showed Resident 51's eyelids were covered with yellowish crusty matter. Resident 51 stated they wished they could get a wet towel to clean my eyes. Further observation showed Resident 51's right eye had a scratch on the corner of their right eyelid with a reddish-brownish crusty matter and their left eyelid was covered with yellowish crusty matter. Resident 51 stated I need help from staff to do that [clean their eyes]. In an interview and joint observation on 05/15/2025 at 3:05 PM, Staff E, RCM, stated, the aides [CNAs] should be doing the [Resident 51's] eye wash daily. Resident 51 stated, nobody seems to do anything about it, they see it there. Staff E stated that Resident 51 had a slight redness [scratch] on their eyes and that staff should have been cleaning Resident 51's eyes. In an interview and joint record review on 05/17/2025 at 12:02 PM, Staff E stated that Resident 51 required assistance with their ADLs, pretty much total care. Staff E stated that Resident 51 needed assistance with personal hygiene, brushing hair, and washing their face. A joint record review of Resident 51's ADLs care plan and Kardex (care plan for CNAs) showed that Resident 51 required staff assistance with personal hygiene. Staff E stated that CNAs should have been cleaning Resident 51's crust from their eyes, it is part of personal hygiene. Staff E further stated that Resident 51's care plan should have been followed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/17/2025 at 3:07 PM, Staff B stated that they expected staff to follow residents care plans. Staff B stated that Resident 51 required moderate assist with personal hygiene and that staff should have been cleaning Resident 51's crust from their eyes. Staff B further stated that Resident 51's care plan should have been followed. RESIDENT 39 Review of a face sheet printed on 05/13/2025 showed Resident 39 admitted to the facility on [DATE]. Observation on 05/12/2025 at 9:30 AM showed Resident 39 had a urinary catheter hanging on the left side of the bed. Review of the physician orders printed on 05/13/2025, showed Resident 39 had an order for Document Foley [urinary catheter] output [amount of urine] q [every] shift, dated 02/03/2025. Review of Resident 39's comprehensive care plan printed on 05/13/2025, showed no care plan for urinary catheter use. A joint record review and observation on 05/16/2025 at 12:51 PM with Staff E, showed Resident 39 did not have a care plan for urinary catheter use. Staff E stated, did she has catheter? A joint observation with Staff E showed Resident 39's urinary catheter was hanging on the left side of the bed. Staff E stated Resident 39 should have had a care plan for urinary catheter. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that they expected the care plan to be updated and current. Staff B further stated that Resident 39 should have a care plan for urinary catheter. Reference: (WAC) 388-97-1020 (1)(2)(a) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RANGE OF MOTION EXERCISES RESIDENT 32 Review of Resident 32's Cerebral Palsy [a group of conditions that affect movement and posture] care plan, revised on 04/12/2025, showed an intervention to maintain good body alignment to prevent contractures [a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff]. Use braces and splints as ordered. It further showed interventions for Occupational Therapy (OT) and Physical Therapy (PT) to monitor/document and treat as indicated. In an interview and joint observation on 05/15/2025 at 2:08 PM, Staff O, LPN, stated that Resident 32 had limited range of motion in their left hand. A joint observation of Resident 32's left hand, showed they could not move three fingers on their left hand. Staff O stated, they're contracted. In an interview on 05/16/2025 at 10:44 AM, Staff AA, Restorative Aide, stated that Resident 32 was not on a restorative program and did not use any splints. In an interview and joint record review on 05/16/2025 at 11:07 AM, Staff D, RCM, stated they expected that residents with contractures were monitored for any worsening and should have range of motion and positioning. Staff D stated that Resident 32 had lower body and upper body contractures and I'm thinking he should be on restorative but he's not. A joint record review of Resident 32's Cerebral Palsy care plan showed interventions for OT and PT to monitor/document and treat as indicated. Staff D stated he's not on PT or OT. This [care plan] needs to be updated. Staff D further stated, there's no written range of motion exercises in the care plan and there should be and I need to follow up. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that a resident's care plan should be revised when there was a change in condition, quarterly, or whenever needs to be. Reference: (WAC) 388-97-1020 (5)(b) Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 4 of 9 residents (Residents 26, 2, 30 & 32), reviewed for care plan revision. The failure to revise the care plan that included interventions for Level II Preadmission Screen 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), use of opioid (narcotic pain medication), self-administration of medication, oxygen use, and range of motion, placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed that a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. Further review showed that the care plan described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including any specialized services to be provided as a result of PASARR recommendations. The policy further showed that the interdisciplinary team reviewed and updated the care plan, when there has been a significant change in the resident's condition . when the desired outcome is not met .when the resident has been readmitted to the facility from a hospital stay . and at least quarterly, in conjunction with the required quarterly MDS assessment. Review of the facility's policy titled, Medications with Boxed Warning, revised in January 2023, showed that nursing should include appropriate monitoring parameters on the resident specific care plan as appropriate. Monitoring for adverse consequences involving ongoing vigilance and may periodically involve evaluations. PASARR RESIDENT 26 Review of a face sheet printed on 05/13/2025 showed Resident 26 was admitted to the facility on [DATE]. Review of the Level II PASRR Initial Psychiatric Evaluation Summary, dated 04/09/2019, showed Resident 26 had diagnoses of conversion disorder (a mental health condition that disrupts how the brain works causing real, physical symptoms that a person cannot control), schizophrenia (a chronic mental disorder with symptoms such as hallucinations [experience involving the apparent perception of something not present], delusions [a false belief, judgment, or perception], and cognitive challenges [affects the ability to think, learn, and process information), and anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations). Further review of the Level II PASRR form showed specific interventions were recommended for the nursing facility regarding Resident 26's care. Review of the PASARR care plan dated 03/01/2021 showed that the interventions from Resident 26's Level II PASARR recommendations were not included in their care plan. In an interview and joint record review on 05/16/2025 at 4:59 PM, Staff G, Social Services Director, stated that when a resident had a Level II PASARR, the recommendations from the Level II PASARR were included in the resident's care plan. A joint record review showed Resident 26 had a Level II PASARR dated 04/09/2019 with listed interventions for Resident 26. Staff G stated that Resident 26's [NAME] II PASARR had recommendations for their care. A joint record review of the PASARR care plan dated 03/01/2021 did not show the interventions listed from Resident 26's Level II PASARR form. Staff G stated that Resident 26 had a general care plan, it should be personalized just for [Resident 26], the care plan should have been updated with the information and recommendations word for word from their Level II PASARR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/17/2025 at 4:11 PM, Staff A, Administrator, stated that they expected care plans to be reviewed and updated at least quarterly. Staff A further stated that Resident 26's PASARR care plan should have been updated with the recommendations from Resident 26's Level II PASARR form. PAIN MEDICATION RESIDENT 2 Review of the February 2025 to May 2025 Medication Administration Record (MAR) showed Resident 2 had orders for oxycodone (an opioid medication). Further review of the MAR showed no documentation that Resident 2 was being monitored for adverse side effects related to oxycodone use and/or non-pharmacological interventions were provided prior to administering the oxycodone. Review of Resident 2's pain care plan printed on 05/13/2025 did not show that opioid medication use, monitoring for adverse side effects to the medication, and/or non-pharmacological interventions were included. A join record review and interview on 05/17/2025 at 12:56 PM with Staff E, Resident Care Manager (RCM), showed Resident 2's pain care plan did not indicate opioid medication use, monitoring for adverse side effects, and non-pharmacological interventions prior to administering pain medication. Staff E stated that Resident 2's pain care plan should have been updated and personalized to include opioid use, monitoring of adverse side effects, and non-pharmacological interventions. In an interview on 05/17/2025 at 3:37 PM, Staff B, Director of Nursing, stated that Resident 2's pain care plan should have been revised to include opioid use, monitoring for adverse side effects and non-pharmacological interventions for pain. SELF-ADMINISTRATION OF MEDICATION RESIDENT 30 Review of the physician orders printed on 05/12/2025 showed Resident 30 had orders for Flonase (medication that treats nasal congestion) nasal (into the nose) spray, Incruse Ellipta (brand name - inhaler [portable device for administering a drug which is to be breathed in] used to open the airways to increase air flow to the lungs) inhaler, and Albuterol Sulfate (used to open the airways to increase air flow to the lungs) inhaler. Further review of the physician orders did not indicate Resident 30 could self-administer and/or keep the medications at bedside. Observations on 05/12/2025 at 2:05 PM and on 05/13/2025 at 3:23 PM showed that Resident 30 had an albuterol inhaler, a bottle of Flonase nasal spray, and an Arnuity Ellipta (brand name - inhaler used to open the airways to increase air flow to the lungs) inhaler on their bedside table. Resident 30 stated they administered the medications themselves. In an interview on 05/13/2025 at 4:16 PM, Staff E stated that residents on self-administration of medication program would an evaluation, order for medications to be self-administered, a locked box to store the medications, and a care plan for it. Staff E further stated that Resident 30's care plan should have been updated for self-administration of medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/17/2025 at 3:55 PM, Staff B stated that Resident 30's care plan should have been revised to include self-administration of medication. OXYGEN USE Review of the physician's progress notes dated 04/23/2025 documented that Resident 30 was on continuous oxygen at two liters (unit of measurement) per minute. Observation on 05/12/2025 at 7:15 AM showed Resident 30 was receiving three liters per minute of oxygen via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) that was connected to an oxygen concentrator (a device that delivers oxygen). Observation on 05/12/2025 at 1:24 PM and on 05/14/2025 at 1:30 PM showed Resident 30 was receiving two liters per minute of oxygen via nasal cannula. Resident 30 stated that they used oxygen at all times. A joint observation and interview on 05/14/2025 at 1:51 PM with Staff M, Licensed Practical Nurse (LPN), showed Resident 30 was receiving two liters per minute of oxygen via nasal cannula. Staff M stated that Resident 30 was on two liters per minute of oxygen continuously. In an interview on 05/17/2025 at 1:06 PM, Staff E stated that Resident 30's care plan should have been updated to include oxygen use. In an interview on 05/17/2025 at 3:50 PM, Staff B stated that Resident 30's care plan should include the oxygen use.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide necessary assistance with Activities of Daily Living (ADL) for 3 of 4 residents (Residents 3, 29 & 51), reviewed for ADLs. The failure to provide residents who were dependent on staff for assistance with personal hygiene placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed that Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. RESIDENT 3 Review of Resident 3's quarterly Minimum Data Set (MDS-an assessment tool), dated 02/11/2025, showed Resident 3 needed substantial/maximal assistance (helper does more than half the effort) for personal hygiene. It further showed that Resident 3 had diabetes (a group of diseases that result in too much sugar in the blood) diagnosis. Review of Resident 3's Diabetes care plan, revised on 04/13/2025, showed an intervention for Diabetic nail care by LN [Licensed Nurse]. Observation on 05/12/2025 at 10:07 AM, showed Resident 3 with long fingernails on both hands and showed the right thumb had brown material underneath the nail. Resident 3 stated, I need them [fingernails] to be trimmed. Resident 3 further stated, I'm diabetic. Observation on 05/14/2025 at 10:28 AM, showed Resident 3 with long fingernails. Resident 3 stated, I had a bed bath yesterday. I've asked them twice in the past two days [to trim my fingernails] and I asked an aide to ask the nurse. I'm diabetic so a nurse needs to do it. In an interview and joint observation on 05/14/2025 at 11:14 AM, Staff GG, Certified Nursing Assistant (CNA), stated that they helped dependent residents with personal hygiene and if a resident had diabetes, they would let a nurse know if the nails needed to be trimmed. A joint observation of Resident 3's nails showed they were long on both hands. Staff GG stated, it's too long on both hands, the nurse has to cut and I will tell the nurse. In an interview and joint observation on 05/14/2025 at 11:26 AM, Staff V, Licensed Practical Nurse, stated that CNAs were responsible for personal hygiene for dependent residents including nail care and that if a resident had diabetes and the nurses have to do the clipping [of] the nails. A joint observation showed that Resident 3 had long fingernails on both hands. Staff V stated that Resident 3's nails were pretty long, need them trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 05/16/2025 at 11:44 AM, Staff D, Resident Care Manager (RCM), stated that Resident 3 gets help with his nails. A joint record review of Resident 3's physician orders showed an order for diabetes nail care weekly. Staff D stated that Resident 3 had an order for nail care. RESIDENT 29 Review of a quarterly MDS dated [DATE], showed that Resident 29 needed substantial/maximal assistance for personal hygiene. Review of a self-care care plan, revised on 05/06/2025, showed that Resident 29 needed one-person extensive assistance (requiring a large amount of effort from the helper) for personal hygiene. Observations on 05/12/2025 at 10:59 AM, on 05/12/2025 at 2:00 PM, on 05/13/2025 at 3:00 PM, and on 05/14/2025 at 10:25 AM, showed Resident 29 with dark brown matter under their left-hand fingernails. In an interview and joint observation on 05/14/2025 at 11:32 AM, Staff HH, CNA, stated that cleaning nails was included in personal hygiene. A joint observation of Resident 29's hands showed dark brown matter under their left hand's fingernails. Staff HH stated Resident 29's fingernails were not clean and that they needed to be trimmed. In an interview on 05/16/2025 at 11:07 AM, Staff D stated that they expected staff to help them [dependent residents] if they can't do it. Staff D stated, aides should clean under the nails. When asked how much help Resident 29 needed with nail care, Staff D stated, Resident 29 needed help with trimming their nails and that they should be clean. In an interview on 05/17/2025 at 1:42 PM, Staff B, Director of Nursing, stated they expected nail care for dependent residents to be done and that nails should be trimmed as needed and clean. Staff B further stated that if a resident had diabetes, the nurse should do the nail care. RESIDENT 51 Review of the quarterly MDS dated [DATE] showed Resident 51 required moderate assist (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene that included washing/drying face and hands. Observations on 05/13/2025 at 8:52 AM and at 9:14 AM, showed Resident 51's eyelids had yellowish crusty matter. Resident 51 stated they have crusty eyes all the time in the mornings, staff does not clean [their eyes]. Observation on 05/14/2025 at 9:35 AM showed Resident 51 had yellowish crusty matter on their eyelids. Resident 51stated, it is hard to open my eyes, it hurts and also itches. Resident 51 further stated that staff did not clean their eyes, they should, they see me every day. I cannot do it. I am blind on my left eye; my eyes are dry. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/2025 at 2:34 PM, showed Resident 51 had crusty matter on their eyelids. Resident 51 stated they wished they could get a wet towel to clean my eyes. Further observation showed Resident 51's right eye had a scratch on the corner of their right eyelid with a reddish-brownish crusty matter and their left eye had yellowish crusty matter. Resident 51 stated, I need help from staff to do that [clean their eyes]. In an interview and joint observation on 05/15/2025 at 3:05 PM, Staff E, RCM, stated, the aides [CNAs] should be doing the [resident's] eye wash daily. Resident 51 stated, nobody seems to do anything about it, they see it there. Staff E stated that Resident 51 had a slight redness on their eyes and that staff should have been cleaning them. In an interview on 05/17/2025 at 3:07 PM, Staff B stated that Resident 51 required moderate assist with personal hygiene and that staff should have been cleaning the crust from their eyes. Reference: (WAC) 388-97-1060(2)(c) .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice for 2 of 4 residents (Residents 51 & 39), reviewed for quality of care. The failure to consistently conduct skin evaluations to include care planning, monitoring and necessary treatment for Resident 51, and the failure to consistently monitor and manage constipation (passing fewer than three stools a week or having a difficult time passing stool) for Resident 39, placed the residents and other residents at risk for unmet care needs, pain/discomfort, and related complications. Findings included . Review of the facility's policy titled, Wound Management Guidelines, revised on 03/31/2025, showed that skin checks were completed by the Licensed nurse weekly . CNA [Certified Nursing Assistant/NAC [Nursing assistant Certified]/Shower aides will report any alterations in skin identified during routine care .If a Resident is identified to have a new skin alteration the Licensed Nurse will document in the resident record the evaluation of the wound, provider notification and obtain treatment orders. The resident and/or representative will be notified of [the] change in treatment plan . Skin documentation of wounds or pressure injury [sores that happen on areas of the skin that are under pressure] identification is completed in the resident's record. An assessment will be completed for each area. Areas include . diabetic/neuropathic ulcers [slow-healing wounds that commonly appear on the feet - complication of diabetes (a group of diseases that results in too much sugar in the blood) due to lack of sensation or blood flow.] Review of the facility's policy titled, Foot Care, revised in October 2022, showed that residents would receive appropriate care and treatment to maintain mobility and foot health. The policy showed that residents would be provided with foot care and treatment in accordance with professional standards of practice. The policy further showed that foot care would include the care and treatment of medical conditions to prevent complications on the feet from these conditions such as diabetes. RESIDENT 51 Review of the face sheet printed on 05/14/2025 showed Resident 51 readmitted to the facility on [DATE]. Further review of the face sheet showed Resident 51 had diagnoses that included type 2 diabetes mellitus (chronic condition characterized by insulin [hormone that regulates blood sugar in the blood] resistance and high blood sugar levels), polyneuropathy (nerve damage that affects peripheral [outside brain and spinal cord] nerves that can lead to weakness, numbness and burning pain typically in hand and feet and potentially progressing to other areas of the body), and protein-calorie malnutrition (clinical condition resulting in mild to severe undernutrition). Review of the comprehensive care plan printed on 05/13/2025 did not show Resident 51's had a wound on their feet. Review of the diabetes care plan showed that Resident 51 would have nail care done by a licensed nurse. Review of the Medication Administration Record (MAR)/Treatment Administration Record (TAR) from January 2025 to May 2025 showed Resident 51 had one skin evaluation on 01/23/2025. Further review showed no documentation that nail care for residents with diabetes was conducted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 04/22/2025 showed Resident 51 required maximal assistance with repositioning. Further review of the MDS show Resident 51 had no foot wounds. In an interview on 05/15/2025 at 2:50 PM, Resident 51 stated, I have sores on the bottom of my [right] feet and they pointed at their right middle ear and stated, it hurts. A joint observation and interview on 05/15/2025 at 2:54 PM with Staff N, Registered Nurse, showed Resident 51 had a wound on the bottom of their right foot. Staff N stated Resident 51 had a scab (a dry, rough protective crust that forms over a cut or wound) on their right foot and that they did not see that wound before. Another joint observation and interview on 05/15/2025 at 3:05 PM with Staff N and Staff E, Resident Care Manager, showed Resident 51 had a wound on bottom of their right foot that measured 1.0 centimeters (cm- a unit of measurement) by 0.5 cm with dark discoloration and redness around the wound. It further showed that Resident 51 had a small wound on their right ear. The right ear was observed with yellowish crust in Resident's right middle ear. Staff E instructed Staff N to do a complete skin assessment. In an interview on 05/17/2025 at 9:19 AM, Staff H, Certified Nurse Assistant, stated that Resident 51 required maximum to total assist with their care. Staff H stated that Resident 51 had a wound on the bottom of their right foot, it has been there for a long time, maybe two months. Staff H further stated that they had notified an unknown nurse about Resident 51's wound when they first saw it. In an interview and joint record review on 05/17/2025 at 11:37 AM, Staff Q, Licensed Practical Nurse, stated that Resident 51 required assistance with everything [activities of daily living]. Staff Q stated that weekly skin checks were conducted for all residents. Staff Q stated they did not know that Resident 51 had wounds on their right foot and right ear. A joint record review of the skin evaluations from January 2025 to May 2025 showed Resident 51's weekly skin assessments were not conducted except for 01/23/2025 and 05/15/2025. Staff Q stated that Resident 51 should have had a weekly skin assessment done every Thursday. Staff Q stated that nail care for residents with diabetes was done weekly by a licensed nurse. A joint record review of the diabetes care plan showed Resident 51 had an intervention listed for diabetic nail care by LN [licensed nurse]. A joint review of May 2025 MAR showed no documentation that Resident 51 was provided nail care. Staff Q stated that Resident 51 should have had orders for weekly diabetic nail care in place. A joint record review and interview on 05/17/2025 at 12:07 PM with Staff E, showed Resident 51 had their weekly skin evaluation completed on 01/23/2025 and one on 05/15/2025. Staff E stated that Resident 51 should have had weekly skin evaluations conducted and that if there was a new skin issue, Staff E expected a skin evaluation to be completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 05/17/2025 at 3:18 PM, Staff B, Director of Nursing, stated that they expected staff to report to their direct supervisor when a new wound was found on a resident, and that staff completed a skin evaluation. Staff B stated that residents would have weekly skin evaluations conducted. A joint record review of the clinical records did not show Resident 51 had weekly skin evaluations [except for 01/23/2025 and 05/15/2025] and/or weekly diabetic nail care since their readmission to the facility. Staff B stated that there were no weekly skin evaluations done from February 2025 to May 2025, and that there should have been done weekly. Staff B stated that Resident 51 should have orders for weekly skin evaluations and weekly diabetic nail care in place. Staff B further stated that Resident 51's wounds on their right foot and ear could have been identified during scheduled weekly skin evaluations and wound treatments could have been started. RESIDENT 39 Review of the face sheet printed on 05/13/2025 showed Resident 39 was admitted to the facility on [DATE]. Review of the Resident 39's April 2025 bowel documentation task from 04/06/2025 through 04/10/2025 showed Resident 39 did not have any bowel movement. Review of the April 2025 physician orders showed that Resident 39 had orders for Senna (medication to treat constipation) 17.2 milligrams (a unit of measurement) as needed and Polyethylene (medication to treat constipation) 17 gram (a unit of measurement) as needed for constipation. Review of the April 2025 MAR showed that Resident 39 did not receive bowel management medications from 04/06/2025 through 04/10/2025. Review of the nursing progress notes for April 2025 showed no documentation that addressed Resident 39's constipation and/or if bowel management medications were given or refused by Resident 39. In an interview and joint record review on 05/16/2025 at 11:54 AM, Staff E stated that if residents did not have a bowel movement for three days that they would follow the facility bowel protocol. A joint record review of Resident 39's April bowel documentation task from 04/06/2025 through 04/10/2025 showed Resident 39 did not have a bowel movement. Further joint record review of the April 2025 MAR showed Resident 39 did not receive bowel management medications from 04/06/2025 through 04/10/2025. Staff E stated that staff should have given Resident 39 bowel management medication. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that they expected nurses to follow the facility bowel protocol. Reference: (WAC) 388-97-1060 (1)(3)(b) .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure podiatry (the treatment of feet and their ailments) care and services were provided for 1 of 3 residents (Resident 10), reviewed for foot care. This failure placed the resident at risk for further skin impairment, discomfort, and a diminished quality of life. Findings included . Review of the facility's policy titled, Foot Care, revised in October 2022, showed, Residents are provided with foot care and treatment in accordance with professional standards of practice . Residents are assisted in making appointments and with transportation to and from specialists (podiatrist) . Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes. Review of Resident 10's quarterly Minimum Data Set (MDS - an assessment tool) dated 04/22/2025, showed Resident 10 was cognitively intact and required substantial/maximal assistance (helper does more than half effort) with personal hygiene. Review of Resident 10's care plan printed on 05/12/2025, showed Resident 10 requires full assistance with personal hygiene. Review of the January 2025 to May 2025 Electronic Health Record (EHR-nursing progress notes and under the miscellaneous tab), showed Resident 10 was scheduled for podiatrist visit on 03/28/2025. It showed Resident 10 was in the hospital on [DATE] and was not seen by the podiatrist as scheduled. It further showed no subsequent podiatrist visits occurred or were scheduled after Resident 10 returned to the facility. Multiple observations and interview on 05/12/2025 at 2:09 PM, on 05/13/2025 at 8:00 AM, and on 05/14/2025 at 1:07 PM, showed that Resident 10's toenails on both feet were long, thick, and untrimmed with the right great toenail starting to curve into the skin. Resident 10 stated they had not seen the podiatrist and that their toenails had not been trimmed. In an interview and joint observation on 05/14/2025 at 1:32 PM, Staff X, Certified Nursing Assistant (CNA), stated the CNAs and shower aids would do nail care, unless it was for a resident with diabetes (a group of diseases that results in too much sugar in the blood), then the nurse would do the nail care. A joint observation of Resident 10's toenails showed they were long and thick. Staff X stated Resident 10's toenails needed to be trimmed. A joint observation and interview on 05/14/2025 at 1:51 PM with Staff Y, CNA, showed Resident 10's toenails were long, thick, and curved into the skin. Staff Y stated that Resident 10's toenails were long, thick, and curved into the skin and that they needed to be trimmed. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 05/16/2025 at 5:20 PM, Staff E, Resident Care Manager, stated that the podiatrist would come monthly and that they would make a list of residents to be seen on the next visit. A joint record review of the EHR with Staff E showed Resident 10 was scheduled to see the podiatrist on 03/28/2025 but was not seen due to Resident 10 was in the hospital. Staff E stated Resident 10 had not been seen by the podiatrist since returning from the hospital on [DATE] and that Resident 10 should have been seen. In an interview on 05/17/2025 at 1:10 PM, Staff B, Director of Nursing, stated that Resident 10 should have been seen by the podiatrist after returning from the hospital. Reference: (WAC) 388-97-1060 (3)(j)(viii) .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services were consistently provided to increase and/or to prevent decrease Range of Motion (ROM) for 2 of 3 residents (Residents 32 & 34), reviewed for restorative services. This failure placed the residents at risk for a decline in ROM, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Restorative Services, revised on 11/11/2005, showed, It is the policy of the facility to provide its residents the restorative services in an effort to maintain the residents highest level of self-care and independence, physically and psychosocially. RESIDENT 32 Review of the annual Minimum Data Set (MDS-an assessment tool), dated 04/05/2025, showed Resident 32 admitted to the facility on [DATE] with diagnosis that included cerebral palsy (a group of conditions that affect movement and posture). It further showed that Resident 32 had ROM impairment in their upper and lower extremities. Review of Resident 32's Cerebral Palsy care plan, revised on 04/12/2025, showed an intervention to maintain good body alignment to prevent contractures [a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff]. Use braces and splints as ordered. It further showed interventions for Occupational Therapy (OT) and Physical Therapy (PT) to monitor/document and treat as indicated. Review of Resident 32's Pain care plan, revised on 10/02/2024, showed that Resident 32 had contractures. Review of a medical provider progress note dated 05/01/2024, showed that Resident 32 had moderate risk for developing contractures .if not receiving adequate therapy. Observation and interview on 05/12/2025 at 9:31 AM, showed Resident 32's left hand in a fist. Further observation showed Resident 32 could move their thumb and pointer finger and could not move the other three fingers. When asked if anyone did exercises with them, Resident 32 stated, no. Observation and interview on 05/13/2025 at 3:09 PM, showed Resident 32's left hand in a fist. Resident 32 stated that no one did any exercises with them today. When asked if they could open their left hand that was in a fist, Resident 32 stated, ow and could not open their fist. In an interview and joint observation on 05/15/2025 at 2:08 PM, Staff O, Licensed Practical Nurse, stated that Resident 32 had limited ROM in their left hand. A joint observation of Resident 32's left hand, showed they could not move three fingers on their left hand. Staff O stated, they're contracted. (continued on next page)

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Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2025 at 10:44 AM, Staff AA, Restorative Aide, stated that Resident 32 was not on a restorative program and did not use any splints. In an interview and joint observation on 05/16/2025 at 11:07 AM, Staff D, Resident Care Manager, stated they expected that residents with contractures should be monitored for any worsening and should have range of motion and positioning. Staff D stated that Resident 32 had lower body and upper body contractures and I'm thinking he should be on restorative but he's not. A joint observation of Resident 32's left hand showed Staff D helping Resident 32 to open their fist. Staff D stated, it's not locked. Staff D further stated that Resident 32 could benefit from interventions to prevent worsening of Resident 32's left hand and they need to work on the fingers. In an interview on 05/16/2025 at 12:15 PM, Staff EE, MDS Coordinator, stated they oversaw the restorative program. Staff EE stated that Resident 32 was not on a restorative program. When asked how to care for a resident with contractures, Staff EE stated that residents should move around daily and depending on where they are at should have active range of motion or passive range of motion. In an interview on 05/17/2025 at 1:42 PM, Staff B, Director of Nursing, stated they expected residents with contractures to be on some kind of exercise program to prevent further contractures. RESIDENT 34 Review of the quarterly MDS dated [DATE], showed Resident 34 had ROM impairment on one side of their upper extremity. Review of Resident 34's Mobility care plan revised on 04/28/2025, showed that Resident 34 was on a restorative nursing program 6-7 days a week, 10-20 minutes a day. Review of the facility's document titled, Task: Nursing Rehab: Active ROM Restorative Nursing Program, from the dates 04/13/2025 through 05/13/2025, showed one day (04/25/2025) where it was documented that the program was carried out. No other day showed documentation that the restorative nursing program was carried out. In an interview on 05/12/2025 at 12:30 PM, Resident 34 stated that their left arm doesn't work that well and no one [was] doing exercises with them. In an interview on 05/14/2025 at 10:20 AM, Resident 34 stated, not yet when asked if anyone had done exercises with them that day. Resident 34 further stated, I would certainly like to do something with my arms. In an interview and joint record review on 05/16/2025 at 10:44 AM, Staff AA stated that they were responsible for carrying out the restorative program for residents. Staff AA stated that they would document in the resident's Electronic Health Record (EHR) after working with a resident who was on a restorative program. Staff AA further stated that Resident 34 was on a restorative program. A joint record review of Resident 34's EHR showed no documentation that the restorative program was being done for Resident 34. Staff AA stated, this is the only place I document. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2025 at 12:15 PM, Staff EE stated that they expected there to be documentation when the restorative aide carried out a restorative program for a resident. Staff EE stated that Resident 34 was started on a restorative program on 04/03/2025 and that it [the restorative nursing program] was entered wrong in the EHR, so there was no prompt for Staff AA to document when they had worked with Resident 34. Staff EE stated that there was probably a month of services without documentation. Staff EE stated that they expected Staff AA to put in the chart somewhere that it [restorative nursing program] was done and no there was no documentation that it had been done for Resident 34. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that they expected documentation when restorative nursing programs were carried out. Reference: (WAC) 388-97-1060 (3)(d) .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents with urinary catheters (a flexible tube inserted into the bladder to drain urine) received appropriate care and services for 2 of 8 residents (Residents 4 & 39), reviewed for catheter care. The failure to empty urinary catheter bag and/or ensure other urinary catheter care were provided placed the residents at risk for infections, related complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, [Urinary] Catheter Care, revised in August 2022, showed that the purpose of this procedure is to prevent urinary catheter-associated complications, including bladder infections. The document further showed that catheter tubing and drainage bag (collects urine from the catheter) were to be kept off the floor. RESIDENT 4 Review of Resident 4's admission minimum data set (an assessment tool) dated 02/03/2025, showed Resident 4 had a urinary catheter. Review of a provider note date 04/25/2025, showed that Resident 4 had informed, [that] sometimes her urine bag is not getting emptied when it is full, it is overflowing, informed RCM [Resident Care Manager] to put orders to empty urine bag twice a shift. Review of Resident 4's April 2025 and May 2025 physician orders showed an order to check [the urinary] drainage bag twice a shift and empty drainage [bag] when ½ [half] full started on 04/25/2025. Review of Resident 4's [Urinary] Catheter care plan, revised on 04/25/2025, showed an intervention to check [the] drainage bag twice per shift, and empty if about or at ½ level. In an interview on 05/13/2025 at 9:29 AM, Resident 4 stated that they had a urinary tract infection (infection of the bladder) three weeks ago. Nobody checked my bag [catheter drainage bag] and it backed up. In a joint observation and interview on 05/13/2025 at 4:37 PM with Staff W, Certified Nursing Assistant, showed Resident 4's catheter drainage bag was more than half full. Staff W stated, looks full. A joint observation showed Staff W emptied the drainage bag into a urinal (a plastic container that collects urine) two times with a total amount of 1400 milliliters (unit of measurement). In an interview and joint record review on 05/17/2025 at 12:54 PM, Staff P, Licensed Practical Nurse, stated that they were checking twice a shift to empty Resident 4's catheter drainage bag. A joint record review of Resident 4's physician orders showed to empty the catheter drainage bag twice a shift and empty it when it was half full. Staff P stated, I don't want to see it more than half full. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 05/17/2025 at 1:30 PM, Staff D, RCM, stated that they expected staff to follow the care plan. A joint record review of Resident 4's catheter care plan showed the catheter drainage bag should be emptied when it was about half full. Staff D stated they expected the drainage bag to not be full, so nothing in the tubing. When told that Resident 4's catheter drainage bag had been observed to be full, Staff D stated, my expectation is it should not be full. In an interview on 05/17/2025 at 1:42 PM, Staff B, Director of Nursing, stated that they expected staff to follow orders for catheter care and if there was an order to empty the catheter drainage bag when it was half full then it should be emptied. RESIDENT 39 Review of the physician orders printed on 05/13/2025, showed Resident 39 had an order for Document Foley [urinary catheter] output [amount of urine] q [every] shift, dated 02/03/2025. Further review of the physician orders did not show documentation for catheter care to include how often to change the urinary catheter, the resident's catheter size, when to change the urinary catheter bag, and/or instructions when to empty the catheter bag. Observation on 05/12/2025 at 9:30 AM showed Resident 39 had a urinary catheter hanging on the left side of the bed. A joint record review and interview on 05/16/2025 at 12:51 PM with Staff E, RCM, showed Resident 39's physicians order did not have an order for urinary catheter. Staff E stated, did she [have] catheter? A joint observation with Staff E showed Resident 39 had a urinary catheter, and the urinary catheter bag was hanging on the left side of bed. Staff E further stated Resident 39 should have had orders for urinary catheter care. In an interview on 05/17/2025 at 10:42 AM, Staff B stated they expected Resident 39 to have a standing order for catheter use including catheter size and catheter care. Reference WAC 388-97-1060(3)(c) .

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure resident who require ostomy (a surgical procedure creating an opening in the body for the discharge of body waste into a collection bag) care received services consistent with professional standards for 1 of 1 resident (Resident 17), reviewed for ostomy care. This failure placed the resident at risk for unmet care needs, skin breakdown, related complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Evaluation Guidelines for Managing Ostomy Care, revised in October 2015, showed Task completed should be documented via the Treatment Administration Record (TAR) .A physician's order should be obtained to match the required task(s) being performed. Review of the comprehensive care plan printed 05/13/2025 showed Resident 17 had a colostomy (type of ostomy). Review of Resident 17's physician orders printed on 05/13/2025 showed no orders related to colostomy. Review of Resident 17's Medication Administration Record (MAR) and/or TAR printed on 05/13/2025 showed no colostomy care directives. Observation on 05/13/2025 at 10:03 AM, showed Resident 17 had a colostomy bag connected to their left abdomen. In an interview on 05/14/2025 at 1:40 PM, Staff X, Certified Nursing Assistant (CNA), stated that CNAs and nurses could empty the colostomy bag, and that the nurse would change the colostomy bag and appliance. In an interview and joint record review on 05/15/2025 at 9:50 AM, Staff O, Licensed Practical Nurse, stated they would do colostomy care by checking the colostomy site and skin around the colostomy, check the colostomy bag and empty it, and change the bag and change the appliance per the physician orders. Staff O stated they would document those in the MAR and/or TAR. A joint record review of the May 2025 physician orders with Staff O, showed no colostomy care directives. Staff O stated, it's [order] not here, and that there were no colostomy orders for care, bag change, appliance change, or to monitor bag and site. Staff O further stated that there should have been colostomy care orders in place. In an interview and joint record review on 05/16/2025 at 6:15 PM, Staff D, Resident Care Manager, stated they have an order set for residents with a colostomy that includes colostomy care, change colostomy appliance, and change colostomy bag. A joint record review of the May 2025 physician orders with Staff D showed no colostomy care directives. Staff D stated, I have to add it [colostomy order]. It's not there. I don't know what happened. Staff D stated there should have been orders for Resident 17's colostomy care, change colostomy appliance, and change colostomy bag. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/17/2025 at 1:10 PM, Staff B, Director of Nursing, stated there should be orders for colostomy care, appliance change, bag change, and monitoring of colostomy, site, and skin. Staff B further stated they expected there to be colostomy care orders for Resident 17. Reference: (WAC) 388-97-1060 (3)(j)(iii) .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 38 Review of the oxygen care plan revised on 04/25/2025, showed Resident 38 used oxygen. Review of Resident 38's May 2025 physician orders, printed on 05/12/2025 showed an order that oxygen tubing should be changed when visibly soiled and labeled [with] current date. Observations on 05/12/2025 at 6:30 AM and at 12:24 PM and on 05/13/2025 at 7:58 AM, showed Resident 38's oxygen concentrator (a device to deliver oxygen) was in use and the oxygen tubing was not labeled/dated. Additional observations on 05/14/2025 at 10:49 AM and at 12:59 PM, showed an unsecured portable oxygen tank set on top of a stool in Resident 38's room. In an interview and joint record review on 05/13/2025 at 8:33 AM, Staff V, LPN, stated the nurses were responsible for caring for oxygen equipment and that oxygen tubing should be dated. A joint record review of Resident 38's physician orders showed that oxygen tubing should be labeled with the current date. A joint observation showed Resident 38's oxygen tubing was not dated. Staff V stated that it absolutely should be [labeled with a date]. An interview and joint observation on 05/14/2025 at 1:39 PM, Staff V stated that portable oxygen tanks should be secured and set on a dolly [a wheeled cart specifically designed to safely transport oxygen tanks], that fits oxygen tanks. A joint observation showed a free standing, unsecured portable oxygen tank on top of a stool in Resident 38's room. Staff V stated it should not be stored like that. It's not secured. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that they expected oxygen tubing to be changed when visibly soiled and staff should date it when it was changed. Staff B further stated that portable oxygen tanks should be upright, in a stand and secured. RESIDENT 30 Review of a face sheet printed on 05/13/2025 showed that Resident 30 was admitted to the facility on [DATE] with diagnoses that included COPD. Review of the May 2025 MAR showed no documentation that Resident 30 was receiving oxygen. Observation on 05/12/2025 at 7:15 AM showed Resident 30 was receiving three liters (unit of measurement) per minute of oxygen via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) that was connected to an oxygen concentrator. Observation and interview on 05/12/2025 at 1:24 PM showed Resident 30 was receiving two liters per minute of oxygen via nasal cannula that was connected to an oxygen concentrator. Resident 30 stated that they used oxygen at all times. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another observation on 05/14/2025 at 1:30 PM showed Resident 30 was receiving two liters of oxygen per minute via nasal cannula. A joint observation and interview on 05/14/2025 at 1:51 PM with Staff M, LPN, showed Resident 30 was in their room and using their oxygen via nasal cannula at two liters per minute from an oxygen concentrator. Staff M stated that Resident 30 was on two liters per minute of oxygen via nasal cannula continuously. A joint record review and interview on 05/14/2025 at 1:58 PM with Staff M, showed Resident 30's May 2025 MAR showed no oxygen orders. Staff M stated, I do not see it [oxygen use orders] here. Staff M further stated that Resident 30 should have had orders for oxygen use to include the oxygen liters per minute, changing oxygen tubing, changing the concentrator filter, and/or to check the oxygen saturation (a measurement of how much oxygen is in the blood) level. In an interview on 05/17/2025 at 1:06 PM, Staff E stated they expected that residents receiving oxygen should have standing orders for oxygen. Staff E further stated that Resident 30 should have had orders and care plan for oxygen use. In an interview on 05/17/2025 at 3:50 PM, Staff B stated that Resident 30 should have had orders for oxygen. In an interview on 05/17/2025 at 1:06 PM, Staff E stated they expected that residents receiving oxygen would have orders for oxygen with the number of liters per minute, orders for changing oxygen tubing, orders for cleaning or changing the oxygen concentrator filter, and for checking oxygen saturation every shift. Staff E further stated that Resident 30 should have had orders and care plan for oxygen use. In an interview on 05/17/2025 at 3:50 PM, Staff B stated that Resident 30 should have had orders for oxygen. Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 4 of 5 residents (Residents 10, 38, 30 & 271), reviewed for respiratory care. The failure to label/date oxygen tubing, properly store oxygen tank, and obtain oxygen orders placed the residents at risk of respiratory infections, and related complications. Findings included . Review of the facility's policy titled, Oxygen Administration, revised in October 2010, showed, staff verify that there is a physician's order .Review the physician's orders or facility protocol for oxygen administration. RESIDENT 10 Review of Resident 10's face sheet printed on 05/12/2025, showed they were admitted to the facility on [DATE] with a diagnosis that included Chronic Obstructive Pulmonary disease (COPD - an ongoing lung condition caused by damage to lungs) and dyspnea (difficulty breathing). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the May 2025 physician orders printed on 05/12/2025, showed Resident 10 had oxygen orders that included, Oxygen tubing is to be changed when it becomes visibly soiled. Labeled w/ [with] current date . every night shift Tue [Tuesday]. Observations on 05/12/2025 at 2:09 PM and on 05/13/2025 at 7:58 AM, showed Resident 10's oxygen tubing was unlabeled/undated. During a joint record review and interview on 05/13/2025 at 8:08 AM with Staff J, Licensed Practical Nurse (LPN), showed Resident 10 had orders for oxygen. Staff J stated, Oxygen tubing is to be changed when it becomes visibly soiled. Labeled with current date. Joint observation showed Resident 10's oxygen tubing was undated. Staff J stated the oxygen tubing was not labeled or dated and that there should have been a label with the date of when it was last changed. In an interview and joint record review on 05/16/2025 at 6:05 PM, Staff E, Resident Care Manager (RCM), stated Resident 10's order showed to change oxygen tubing when it becomes visibly soiled and to label with the current date. Staff E further stated they expected staff (nurses) to follow the physician order to label and date oxygen tubing for Resident 10. In an interview on 05/17/2025 at 1:10 PM, Staff B, Director of Nursing, stated they expected the oxygen tubing to be labeled and dated for Resident 10. RESIDENT 271 Review of a face sheet printed on 05/13/2025 showed Resident 271 admitted to the facility on [DATE] with diagnosis that included pneumonia (an infection that causes inflammation in the lungs). Observation on 05/13/2025 at 7:59 AM, showed Resident 271's was receiving oxygen and their oxygen tubing was not dated. Review of the May 2025 MAR printed on 05/13/2025, showed Oxygen tubing is to be changed when it becomes visibly soiled. Labeled [with] current date, oxygen concentrator filter to be cleaned every week Tuesdays Noc [night shift]. A joint observation and interview on 05/13/2025 at 8:25 AM with Staff J, showed Resident 271's oxygen tubing had no date when it was last changed. Staff J stated Resident 271's oxygen tube should have been dated. In an interview on 05/16/2025 at 11:54 AM, Staff E stated that Resident 271's oxygen tubing should have been dated. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that staff should have followed the oxygen order and Resident 271's oxygen tubing should have been labeled when it was last changed. Reference: (WAC) 388-97-1060 (3)(j)(vi) .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were trauma survivors and diagnosed with Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed) received trauma informed care, trigger assessment, and trauma-informed care assessment in accordance with professional standards of practice for 1 of 1 resident (Resident 48), reviewed for mood/behavior. This failure placed the resident at risk for unidentified triggers, re-traumatization, and a diminished quality of life. Findings included . Review of the facility's policy titled, Trauma Informed Care and Culturally Competent Care, revised in August 2022, showed that it was the policy of the facility to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice and to address the needs of trauma survivors by minimizing triggers (cause [an event or situation] to happen or exist) and/or re-traumatization. The policy showed staff would perform universal screening of residents that may include trauma history. The policy further showed an assessment would be done that involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Review of Resident 48's face sheet printed on 05/12/2025 showed Resident 48 was admitted to the facility on [DATE] with a diagnosis that included PTSD. Review of Resident 48's Electronic Health Record (EHR-under the evaluation tab and miscellaneous tab) from June 2024 through May 2025, showed no Trauma Informed Care assessment. In an interview and joint record review on 05/16/2025 at 3:40 PM, Staff G, Social Services Director, stated they would check the resident's diagnosis and record for information related to trauma and history of, then would do an assessment and record it in the resident's EHR. A joint record review of Resident 48's EHR with Staff G, showed no trauma informed care assessment. Staff G stated there was no trauma informed care assessment for Resident 48 in their EHR and there should have been. In an interview on 05/16/2025 at 3:58 PM, Staff A, Administrator, stated they expected to be a trauma informed assessment completed for Resident 48. Reference: (WAC) 388-97-1060(3)(e) .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed with the census, actual number of staff, and the hours worked for each shift for 4 of 4 days (05/12/2025, 05/13/2025, 05/14/2025 & 05/16/2025), reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily prevented the residents, family members, and visitors from exercising their rights to know the actual nursing staff hours worked in the facility. Findings included . Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised in August 2006, showed that Within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nurses directly responsible for resident care is posted in a prominent location and in a clear and readable format .The information recorded should include the actual time worked during that shift for each category and type of nursing staff and total number of licensed and non-licensed nursing staff working for the posted shift. The policy further showed that within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. Observations on 05/12/2025 at 6:41 AM at the main entrance and at the nurse's station, showed the Daily Nursing Staff posting that day had the staffing information from 05/11/2025. Observations on 05/13/2025 at 9:50 AM at the main entrance and at 8:14 AM at the nurse's station, showed the Daily Nursing Staff posting that day had the staffing information from 05/12/2025. Observations on 05/14/2025 at 10:46 AM and at 2:56 PM at the main entrance and at the nurse's station, showed the Daily Nursing Staff posting that day had the staffing information from 05/13/2025. Observations on 05/16/2025 at 9:59 AM and at 2:57 PM at the main entrance and at the nurse's station, showed the Daily Nursing Staff posting that day had the staffing information from 05/15/2025. In an interview on 05/16/2025 at 3:36 PM with Staff K, Human Resource, stated that their process for filling out the Daily Nursing Staff posting was based on the prior day of residents' census and staff working hours. In an interview on 05/17/2025 at 10:42 AM, Staff B, Director of Nursing, stated that the nurse staffing post should show the current date, census, and update the staff working hours per shift. In an interview on 05/17/2025 at 10:58 AM, Staff A, Administrator, stated that the nurse staffing post should be current and updated per shift. No associated WAC .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided in accordance with professional standards of practice to meet the needs of 4 of 6 residents (Resident 4, 30, 21 & 38), reviewed for medication management. The failure to follow physicians order and medication instruction placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included . Review of the facility's policy titled, Administering Medications, revised in April 2019, showed, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of the facility's policy titled, Oral Inhaler [portable device for administering a drug which is to be breathed in], revised in January 2023, showed that the facility would allow for safe, accurate, and effective administration of medication using oral inhaler. Further review showed that a cup of water would be provided for the resident to rinse their mouth after steroid inhaler (anti-inflammatory drugs that help treat breathing disorders, such as asthma [chronic respiratory disease that affects the airways in the lungs, making it difficult to breathe] and chronic obstructive pulmonary disease [COPD - an ongoing lung condition caused by damage to lungs]) medication. RESIDENT 4 Review of Resident 4's physician orders, printed on 05/13/2025, showed an order for Ondansetron (medication to treat nausea) eight milligram to give one tablet via G-tube (a small flexible tube surgically inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications). Observation on 05/13/2025 at 3:39 PM, showed Staff V, Licensed Practical Nurse (LPN), preparing to give Resident 4 their medications, including the ondansetron. In an interview and joint record review on 05/13/2025 at 3:45 PM, Staff V stated that Resident 4 had a G-tube but she takes Zofran [brand name for ondansetron] sublingual [under the tongue]. A joint record review of Resident 4's physician orders showed an order for Ondansetron to be given every eight hours via G-tube and with the directions to give 1 tab [tablet] by mouth. When asked how they knew to give the ondansetron by mouth, Staff V stated, per the directions. I will call the doctor to change. The way it's written, it's not supposed to be like that. Observation showed Staff V gave the Ondansetron to Resident 4 by mouth. In an interview on 05/17/2025 at 1:42 PM, Staff B, Director of Nursing, stated that if a medication order showed two routes for administration, they expected staff to call the provider to clarify and change it [the medication order]. Staff B stated, if there's a discrepancy [with the medication order], don't give, call the provider to clarify. RESIDENT 30 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's pharmacy Nursing Drug Handbook, dated 2024, indicated that Arnuity Ellipta (fluticasone furoate [brand name], a steroid [anti-inflammatory drugs that help treat breathing disorders] inhaler, used for COPD]). Further review of drug handbook showed an instruction to rinse mouth with water after use of the Arnuity Ellipta inhaler. Review of the physician orders printed on 05/12/2025 showed Resident 30 had orders for Incruse Ellipta (Umeclidinium Bromide [brand name]-inhaler used for COPD) inhaler 1 puff a day for COPD. Further review of the physician orders did not indicate that Resident 30 was on self-medication administration program. Multiple observations on 05/12/2025 at 2:05 PM and on 05/13/2025 at 3:23 PM, showed Resident 30 had an Arnuity Ellipta inhaler on their bedside table. Resident 30 stated they administered the medication themselves and that they used the Arnuity Ellipta inhaler twice a day, after breakfast and after lunch. Resident 30 further stated they did not rinse their mouth after self-administering the inhaler, I do not have to do that. In an interview and joint observation on 05/13/2025 at 4:16 PM, Staff E, Resident Care Manager, stated that if a resident had orders for a steroid inhaler, staff would have the resident rinse their mouth and spit after using the inhaler. A joint observation showed Resident 30 had an Arnuity Ellipta inhaler on top of their bedside table. Resident 30 stated that they kept their medications at bedside and that they used their medication every day. Staff E stated that Resident 30's medications should have been kept in a locked box. A joint record review and interview on 05/17/2025 at 1:27 PM with Staff E showed Resident 30's March 2025 to May 2025 Medication Administration Record did not show orders for Arnuity Ellipta inhaler. Staff E stated that Resident 30 had orders for Incruse Ellipta inhaler. Staff E further stated that Resident 30 should have had orders for the Arnuity Ellipta inhaler. Another joint record review and interview on 05/17/2025 at 1:29 PM with Staff E showed the facility's pharmacy Nursing Drug Handbook showed an instruction to rinse the mouth with water and spit after using the Arnuity Ellipta inhaler. Staff E stated that Resident 30 should be instructed and to rinse their mouth with water after using the Arnuity Ellipta inhaler. In an interview on 05/17/2025 at 4:26 PM, Staff B stated that Resident 30 should have had orders for Arnuity Ellipta inhaler and should be rinsing their mouth after using Arnuity Ellipta. RESIDENT 21 Review of a face sheet printed on 05/15/2025 showed Resident 21 admitted to the facility on [DATE] with diagnosis that included asthma. Review of April 2025 physician orders printed on 05/15/2025 showed Resident 21 had an order for fluticasone-salmeterol (a steroid inhaler for asthma) 500-50 microgram (a unit of measurement) inhaler give one puff two times a day. Further review of the physician orders did not show instruction to rinse mouth after using the inhaler. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/2025 at 8:20 AM, showed Staff R, LPN, administered the Fluticasone-Salmeterol to Resident 21. Further observation showed Staff R did not help Resident 21 rinse their mouth with water after using the inhaler. A joint record review and interview on 05/15/2025 at 8:28 AM with Staff R showed Fluticasone-Salmeterol manufacturer instructions to Step 5 Rinse your mouth. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. Staff R stated the physician orders should have had an instruction to rinse the mouth after using inhaler and that Resident 21 should be reminded/assisted to rinse their mouth after using the inhaler. RESIDENT 38 Review of a face sheet printed on 05/15/2025 showed Resident 38 admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus (a group of diseases that result in too much sugar in the blood). An observation and interview on 05/15/2025 at 12:10 PM, showed Staff O, LPN, was preparing the insulin pen (an injection device to deliver insulin) for Resident 38. Staff O removed the insulin pen cap, turned the dose to seven units, and injected the insulin to Resident 38's left upper thigh without priming (removing the air from the needle and to get the full dose) the insulin pen. Staff O stated they should have primed the insulin pen before administering the insulin to Resident 38. In an interview on 05/16/2025 at 11:54 AM, Staff E stated that the Fluticasone-Salmeterol was one of the inhalers that need to rinse mouth after use, and they expected staff to follow the instructions on the inhaler box. Staff E further stated they expected staff to prime the insulin pen before each use. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that they expected staff to help Resident 21 rinse their mouth after using an inhaler. Staff B further stated that Staff O should have primed two units on the insulin pen before they administered it to Resident 38. Reference: (WAC) 388-97- 1300 (1)(b)(i)(3)(a) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure medications with adverse side effects were adequately monitored and/or non-pharmacological interventions were provided prior to administering pain medications for 3 of 5 residents (Residents 2, 39 & 271), reviewed for unnecessary medications. This failure placed the residents at risk for unmet care needs, related complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Medications with Boxed Warning, revised in January 2023, showed, nursing should include appropriate monitoring parameters on the resident specific care plan as appropriate. Monitoring for adverse consequences involving ongoing vigilance and may periodically involve evaluations. RESIDENT 2 Review of the February 2025 to May 2025 Medication Administration Record (MAR) showed that Resident 2 had orders for oxycodone (opioid - narcotic pain medication). Further review of the MAR showed no documentation that Resident 2 was being monitored for adverse side effects related to oxycodone use and/or non-pharmacological interventions were provided prior to administering the oxycodone. Review of Resident 2's pain care plan printed on 05/13/2025 showed opioid use was not included in the care plan, monitoring of its adverse side effects and non-pharmacological interventions were also not included in the care plan. In an interview and joint record review on 05/17/2025 at 12:36 PM, Staff E, Resident Care Manager, stated that residents using opioid medications would have orders for monitoring of adverse side effects and non-pharmacological interventions. A joint record review of the May 2025 physician orders and February 2025 through May 2025 MAR did not show monitoring of adverse side effects and non-pharmacological interventions for opioid use. Staff E stated Resident 2 started opioids on 02/25/2025. Staff E further stated that Resident 2 should have been monitored for adverse side effects for opioid use and non-pharmacological interventions should be offered prior to administering it. A join record review and interview on 05/17/2025 at 12:56 PM with Staff E, showed Resident 2's pain care plan did not include opioid medication use, monitoring for adverse side effects, and/or non-pharmacological interventions prior to administering the opioid medication. Staff E stated that Resident 2's pain care plan should have been personalized to include opioid use, monitoring of adverse side effects, and non-pharmacological interventions. In an interview on 05/17/2025 at 3:37 PM, Staff B, Director of Nursing, stated that Resident 2 started on oxycodone on 02/25/2025, monitoring of adverse side effects and non-pharmacological interventions should have been included in their care plan. RESIDENT 271 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 271's May 2025 MAR printed on 05/13/2025, showed orders for insulin (a medication to manage blood sugar) Glargine (brand name- a type insulin) administer 45 units (unit of measurement) subcutaneously (under the skin) once a day, Lispro (brand name-a type of insulin) administer 10 units before meals. Further review of Resident 271's MAR did not show monitoring for hypoglycemia (blood sugar level is lower than the standard range) and/or hyperglycemia (blood sugar level is higher than the standard range). Review of the May 2025 Treatment Administration Record (TAR) printed on 05/13/2025, did not show Resident 271 was being monitored for hypoglycemia and/or hyperglycemia. Review of Resident 271's care plan for diabetes (a group of diseases that result in too much sugar in the blood), revised in 05/11/2025, showed interventions to Monitor/document for side effects and effectiveness. RESIDENT 39 Review of Resident 39's May 2025 MAR printed on 05/13/2025, showed an order for hydromorphone (an opioid medication used to manage moderate to severe pain) two milligrams (a unit of measurement) one time a day. Further review of the MAR did not show Resident 39 was monitored for side effects of hydromorphone. Review of the May 2025 TAR printed on 05/13/2025, did not show Resident 39 was monitored for side effects of hydromorphone use. In an interview and joint record review on 05/16/2025 at 11:54 AM, Staff E stated that residents who got insulin for diabetes should have had an order for monitoring signs and symptoms of hypoglycemia and hyperglycemia in the physician order. A joint record review of Resident 271's May 2025 MAR and TAR did not show documentation that Resident 271 was being monitored for signs and symptoms of hypoglycemia or hyperglycemia. Staff E stated that they did not see an order in Resident 271's MAR and TAR and that there should have been. Another joint record review and interview on 05/16/2025 at 12:38 PM with Staff E, showed Resident 39's May 2025 MAR had no monitoring for side effects of hydromorphone use. Staff E stated that Resident 39 should have had side effects monitoring for hydromorphone use. In an interview on 05/17/2025 at 10:42 AM, Staff B stated that Resident 271 should have had an order for monitor signs and symptoms hypoglycemia and hyperglycemia. Staff B further stated that Resident 39 should have had an order for monitoring side effects of hydromorphone use. Reference: (WAC) 388-97-1060 (3)(k)(i)(4) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 38 Review of Resident 38's physician orders, printed on 05/12/2025, showed an order for Albuterol Sulfate inhaler. Further review of the physician orders did not show instructions if Resident 38 could self-administer their medication. Review of Resident 38's Electronic Health Records (EHR-nursing progress notes from 05/14/2024 to 05/15/2025), showed no documentation that Resident 38 had an assessment for self-administration of medication. Observation and interview on 05/13/2025 at 8:55 AM, showed Resident 38 took an inhaler out of the top drawer of their nightstand and inhaled two puffs. Resident 38 stated they [the facility] know I have it. Resident 38 further stated they had not been assessed for self-administration of medications and I've been using it [the inhaler] for years. Observation on 05/14/2025 at 1:01 PM, showed an albuterol sulfate inhaler stored in Resident 38's unlocked nightstand drawer. Resident 38 stated, it's my rescue one [inhaler] that came from my doctor. In an interview and joint record review on 05/14/2025 1:38 PM, Staff V, LPN, stated that residents may not have medications at their bedside and may not self-administer medications unless they have an order. Staff V stated that Resident 38 had not had an assessment done for self-administration of medications. A joint record review of Resident 38's physician orders showed no self-administration of medication order. Staff V stated, I don't see anything [an order]. Staff V was observed asking Resident 38 if they had any medications in their nightstand table. Resident 38 stated, yes, my albuterol inhaler. Staff V was asked if the inhaler should be in Resident 38's room, Staff V stated, no, only if we can get a doctor order for it. RESIDENT 34 Review of Resident 34's EHR (evaluation tab, miscellaneous tab, nursing progress notes from 05/12/2024 to 05/13/2025, and May 2025 physician orders), showed no documentation that Resident 34 had an assessment or an instruction in the physician order for self-administration of medication. Observation on 05/14/2025 at 10:22 AM, showed three bottles of multi-collagen [a supplement to provide structure, strength and support throughout the body] supplements on Resident 34's bedside table. Observation on 05/14/2025 at 12:41 PM, showed three bottles of multi-collagen supplements on Resident 34's bedside table. Resident 34 stated, I take them every day. A joint record review and interview on 05/14/2025 at 1:38 PM with Staff V, showed no self-administration of medications instruction in the physician orders. Staff V stated there should be an order to self-administer medication and also an order to keep medication at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation and interview on 05/14/2025 at 2:07 PM with Staff V, showed three bottles of multi collagen on Resident 34's bedside table. Resident 34 also showed Staff V that they had another bottle of multi-collagen and a bottle of probiotics [microorganisms that provide health benefits] in their unlocked nightstand drawer. Resident 34 stated that they were taking both medications. Staff V further stated that medications should not be stored at bedside unless she [the resident] has an order. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that medications should be stored in the medication cart and should not be at bedside unless there is a self-administration assessment. When asked about keeping Resident 38's inhaler and Resident 34's medications at their bedside, Staff B stated, no, that's not the practice and no, would not expect that. Based on observation, interview, and record review, the facility failed to ensure expired medications and biologicals were discarded for 1 of 1 medication room (Medication Room) and for 2 of 2 crash carts (300 Hall & 400 Hall Crash Carts), reviewed for medication storage and labeling. In addition, the facility failed to properly store medications for 5 of 19 residents (Residents 30, 38, 34, 10 & 5). These failures placed the residents at risk for receiving compromised and/or ineffective biological and medical supplies. Findings included . Review of the facility's policy titled, Storage of Medications, revised in April 2020, showed that the facility stored all drugs and biologicals in a safe, secure, and orderly manner. The policy further showed that discontinued, outdated, or deteriorated medications or biologicals would be returned to the dispensing pharmacy or destroyed. Review of the facility's policy titled, Self-Administration of Medications, revised in September 2004, showed that medications may be kept in a locked drawer at the bedside if the resident was determined to be appropriate for the self-administration of medication program. MEDICATION ROOM - SMALL REFRIGERATOR A joint observation and interview on 05/15/2025 at 11:05 AM with Staff E, Resident Care Manager, showed the small refrigerator had one undated multiuse vial of tuberculin (a combination of proteins that are used in the diagnosis of tuberculosis [TB- a bacterial infection that mainly affects the lungs]). Staff E stated that a tuberculin vial could be used for 30 days from when it was first opened. Staff E further stated that the tuberculin vial should have been dated when first opened. MEDICATION ROOM - MEDICATION REFRIGERATOR A joint observation and interview on 05/15/2025 at 11:12 AM with Staff E, showed an opened bottle of vanilla Med Plus 2.0 (nutritional supplement) with use-by-date of 04/25/2025, an opened bottle of vanilla Med Plus with use-by-date of 05/14/2025, an opened bottle of vanilla Med Plus with use-by-date of 04/11/2025, and three unopened bottles of vanilla Med Plus with best by date of 12/30/2024. Staff E stated that the Med Plus bottles should have been discarded by the use-by-date and/or by best-by-date. 300 HALL CRASH CART (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/16/2025 at 12:03 PM showed the 300 Hall Crash Cart had four bottles of five milliliter (ml - a unit of measurement) sodium chloride (normal saline - sterile salt water) with an expiration date of March 2025. A joint observation and interview on 05/16/2025 at 12:18 PM with Staff O, Licensed Practical Nurse (LPN), showed the 300 Hall Crash Cart had four five ml bottles of sodium chloride with an expiration date of March 2025. Staff O stated, they expired in March 2025. Staff O further stated that the expired normal saline bottles should not have been in the 300 Hall crash cart. 400 HALL CRASH CART Observation on 05/16/2025 at 12:23 PM, showed the 400 Hall Crash Cart had a Peripherally Inserted Central Catheter (PICC-a long, flexible tube that is inserted into a vein in the arm) line dressing change tray kit with an expiration date of 05/31/2023, a bottle of 340 ml sterile water with an expiration date of November 2015, and a [NAME] (brand name) humidifier (a device that adds moisture to the air) adaptor with expiration date of September 2016. A joint observation and interview on 05/16/2025 at 12:42 PM with Staff P, LPN, showed a PICC line kit with an expiration date of 05/31 2023, a bottle of sterile water with an expiration date of November 2015, and a humidifier adaptor with an expiration date of September 2016. Staff P stated the items were expired and they should not have been in the 400 Hall crash cart. On 05/16/2025 at 1:15 PM, Staff E stated that the four normal saline bottles from the 300 Hall crash cart should have been discarded. Staff E further stated that the expired PICC line dressing kit, sterile water bottle, and the humidifier adaptor should not have been in the 400 Hall crash cart. On 05/16/2025 at 3:35 PM, Staff B, Director of Nursing, stated that they expected the crash carts to be checked nightly and that expired items should be discarded. Staff B stated that expired items in the 300 Hall and 400 Hall crash carts should have been discarded. Staff B stated that the tuberculin vial should have been dated when it was first opened. Staff B further stated that the opened and unopened bottles of Med Plus should have been discarded by the use-by-date or the best-by-date. MEDICATION STORAGE RESIDENT 30 Review of Resident 30's self-administration of medication evaluation assessment dated [DATE] showed it was incomplete, no answers were filled in the form, it was blank. Review of the physician orders printed on 05/12/2025 showed Resident 30 had orders for Flonase (medication that treats nasal congestion) nasal (into the nose) spray - two spray in both nostrils (into the nose) one time a day, Incruse Ellipta (Umeclidinium Bromide- a brand) inhaler [portable device for administering a drug which is to be breathed in]- one puff inhale orally one time a day for Chronic Obstructive Pulmonary Disease (COPD - an ongoing lung condition caused by damage to lungs), and Albuterol Sulfate (medication used to open the airways to increase air flow to the lungs) inhaler - two puffs orally every six hours as needed for COPD. Further review of the physician orders did not show instructions if Resident 30 could self-administer and/or keep their inhalers at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 05/12/2025 at 2:05 PM and on 05/13/2025 at 3:23 PM showed that Resident 30 had an albuterol inhaler, a bottle of Flonase nasal spray, and an Arnuity Ellipta (fluticasone furoate- [brand name], a steroid [anti-inflammatory drugs that help treat breathing disorders]) inhaler on their bedside table within the resident's reach. Resident 30 stated they administer the medications themselves and that they used albuterol inhaler once at night, the nasal spray once a day, and the Arnuity Ellipta inhaler twice a day after breakfast and after lunch. In an interview and joint observation on 05/13/2025 at 4:16 PM, Staff E stated that when residents request to self-administer their medications, staff would complete a self-administration medication assessment, obtain orders for the medication the resident would self-administer and to keep medication at bedside. A joint observation and interview with Staff E showed Resident 30 had an albuterol inhaler, a bottle of fluticasone nasal spray, and an Arnuity Ellipta inhaler on top of their bedside table. Resident 30 stated that they kept their medications at bedside and that they used them every day. Staff E stated that Resident 30's medications should have been kept in a locked box. In an interview on 05/17/2025 at 3:55 PM, Staff B stated that Resident 30 should have had an evaluation and orders for self-administration of medications, and medications should have been stored in a locked box. RESIDENT 10 Review of the physician orders printed on 05/12/2025, showed Resident 10 was prescribed Albuterol Sulfate inhaler. It further showed no instructions for self-administration of medication in the physician orders. Observations on 05/12/2025 at 2:09 PM and on 05/13/2025 at 8:00 AM, showed Resident 10 had an Albuterol Sulfate inhaler lying on top of their bedside table. Resident 10 stated they used their inhaler when they felt short of breath. A joint observation and interview on 05/13/2025 at 8:08 AM, Staff J, LPN, showed Resident 10 with an Albuterol Sulfate inhaler lying on top of their bedside table. Staff J stated the inhaler should not have been on Resident 10's bedside table since they did not have a self-administration order. In an interview and joint record review on 05/16/2025 at 5:50 PM, Staff E stated that Resident 10 did not have an order for self-administration and did not have a self-administration assessment. Staff E further stated that Resident 10's inhaler should have been kept in a locked box if they were on a self-administration program. In an interview on 05/17/2025 at 1:10 PM, Staff B stated that they expected Resident 10's inhaler to be kept locked.RESIDENT 5 Review of the face sheet printed on 05/13/2025 showed Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's April 2025 and May 2025 EHR under the assessment tab and miscellaneous tab, did not show an assessment for self-administration of medication was done. (continued on next page)

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	505009	A. Building B. Wing	05/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's physician orders, printed on 05/13/2025, did not show an instruction for self-administration of medication. Review of Resident 5's comprehensive care plan printed on 05/13/2025, did not show documentation that Resident 5 could independently store medication. Observations on 05/12/2025 at 9:35 AM and on 05/13/2025 at 8:20 AM showed Resident 5 had a bottle of Centrum (brand name) vitamins and a bottle of Fish oil (supplement) on top of their nightstand. A joint observation and interview on 05/13/2025 at 8:25 AM with Staff J showed that Resident 5 had two bottles of supplements [Centrum and Fish Oil] on top of their nightstand. Staff J stated that medications should not be kept at their bedside. In an interview on 05/16/2025 at 11:54 AM, Staff E stated medications should not be kept at the resident's bedside and should be locked in the drawer or a locked box. In an interview on 05/17/2025 at 10:42 AM, Staff B stated medications should be locked in the drawer. Reference: (WAC) 388-97-1300(2) .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure expired foods were discarded for 1 of 1 refrigerator (Solarium Room Residents' Refrigerator), and failed to ensure dishwasher temperatures were maintained within the required ranges for 1 of 1 dishwasher, reviewed for food service safety. In addition, the facility failed to follow reheating food requirements for 1 of 1 (Staff L). These failures placed all residents at risk of food-borne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and a diminished quality of life. Findings included . Review of the facility's policy titled, Personal Food Storage, updated in [DATE], showed, food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety .The manufacturer's use by/expiration date supersedes any facility labeled use by date. Review of the facility provided document titled, ELT [Ecolab (brand name) Low Temperature] and ELTHH [Ecolab Low Temperature] Dishmachine, dated 2024, showed that Low-temperature Ecolab dish machine operating temperature for washing would be at a minimum of 120°F (degrees-Fahrenheit - measure of temperature). Review of the May 2025 Sanitizer Dish Machine Log, revised in April 2015, showed that the temperature for the dishwashing machine would be 120°F to 140°F. Further review of the document showed, report any inappropriate temperatures or sanitizing issues to the supervisor immediately for corrective action. Review of facility's policy titled, Reheating Food in the Microwave, revised in July 2024, showed, 1. Food heated in the microwave should be covered, rotated, and stirred while cooking for even heating. 2. Using a sanitized, calibrated thermometer, take at least three points of temperature to ensure even, safe heating. 3. Food should reach a minimum temperature of 165°F, holding for 15 seconds. 4. After reheating the resident's foods, the temperature should be taken prior to serving to the resident and this information should be documented on the Microwave Reheating Log. SOLARIUM ROOM RESIDENTS' REFRIGERATOR A joint observation and interview on 05/15/2025 at 10:05 AM with Staff S, Dietary Services Manager, showed the Solarium Room Residents' Refrigerator had two cups of Yoplait (brand name) yogurt with use-by-date of 05/14/2025 for Resident 27. Staff S stated that Resident 27's yogurts should have been discarded. In an interview on 05/16/2025 at 2:59 PM, Staff A, Administrator, stated they expected expired food items in refrigerators to be discarded. Staff A further stated that Resident 27's yogurts should have been discarded by the use-by-date. DISHWASHER TEMPERATURES (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/12/2025 at 6:13 AM showed the kitchen dishwasher machine washing temperature reached a temperature of 106°F that day. A joint observation and interview on 05/12/2025 at 6:16 AM with Staff T, Dietary Aide, showed the dishwasher washing temperature reached 107°F that day. Staff T stated that the dishwasher machine was a low temperature machine. Staff T stated that low temperature dish machine should reach a minimum of 120°F and the machine has not been reaching a temperature of 120°F or above since last year. Staff T further stated that maintenance personnel had been made aware of the dishwasher machine temperatures. In an interview and joint observation on 05/15/2025 at 9:44 AM, Staff S stated that the facility used a low temperature dishwasher machine, and that the washing temperature would be ideally above 120°F. A joint observation of the dishwasher washing temperature showed it reached 103°F that day. Staff S stated that the dishwasher washing temperature should reach 120°F. Multiple joint observations and interview on 05/15/2025 at 10:27 AM and at 10:28 AM with Staff S, showed the dishwasher reached a washing temperature of 111°F that day. Staff S stated that the dishwasher machine had not reached a temperature of 120°F since last year and it should have been. A joint record review and interview on 05/15/2025 at 1:30 PM with Staff S showed the Sanitizer Dish Machine Log from 05/01/2024 to 05/15/2025 had the following dish machine washing temperatures that were below 120°F: June 2024 06/10/2024 - 117°F breakfast, 119°F lunch 06/14/2024 - 114°F dinner September 2024 09/09/2024 - 107°F lunch, 09/10/2024 - 110°F breakfast,113°F lunch 09/16/2024 - 111°F breakfast, 115°F lunch 09/17/2024 - 111°F breakfast,114°F lunch 09/23/2024 - 111°F breakfast,113°F lunch 09/24/2024 - 113°F breakfast, 119°F lunch 09/25/2024 - 118°F lunch 09/30/2024 - 110°F breakfast, 115°F lunch October 2024 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/01/2024 - 113°F breakfast, 114°F lunch 10/02/2024 - 108°F breakfast,117°F dinner 10/03/2024 - 119°F breakfast, 115°F lunch, 113°F dinner 10/04/2024 - 114°F breakfast, 116°F lunch, 110°F dinner 10/05/2024 - 116°F breakfast, 114°F lunch, 112°F dinner 10/06/2024 - 113°F breakfast, 115°F lunch, 118°F dinner 10/07/2024 - 111°F breakfast, 115°F lunch, 119°F dinner 10/08/2024 - 112°F breakfast, 114°F lunch, 100°F dinner 10/09/2024 - 111°F breakfast, 115°F lunch 10/10/2024 - 113°F breakfast, 113°F lunch 10/11/2024 - 111°F breakfast, 115°F lunch, 110°F dinner 10/12/2024 - 110°F breakfast, 114°F lunch, 112°F dinner 10/13/2024 - 111°F breakfast, 115°F lunch, 110°F dinner 10/14/2024 - 112°F breakfast, 115°F lunch, 117°F dinner 10/15/2024 - 114°F breakfast, 115°F lunch 10/16/2024 - 112°F breakfast, 113°F lunch 10/17/2024 - 112°F breakfast, 113°F lunch 10/18/2024 - 109°F breakfast, 110°F lunch, 116°F dinner 10/19/2024 - 107°F breakfast, 109°F lunch, 107°F dinner 10/20/2024 - 109°F breakfast, 111°F lunch, 112°F dinner 10/21/2024 - 113°F breakfast, 115°F lunch, 110°F dinner 10/22/2024 - 111°F breakfast, 114°F lunch 10/23/2024 - 111°F breakfast, 112°F lunch 10/24/2024 - 111°F breakfast, 111°F lunch, 114°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/25/2024 - 110°F breakfast, 111°F lunch, 118°F dinner 10/26/2024 - 111°F breakfast, 110°F lunch, 112°F dinner 10/27/2024 - 109°F breakfast, 110°F lunch, 110°F dinner 10/28/2024 - 116°F breakfast, 116°F lunch, 110°F dinner 10/29/2024 - 110°F breakfast, 112°F lunch, 110°F dinner 10/30/2024 - 109°F breakfast, 118°F lunch, 119°F dinner 10/31/2024 - 108°F breakfast, 112°F lunch, 119°F dinner November 2024 11/01/2024 - 109°F breakfast, 111°F lunch, 110°F dinner 11/02/2024 - 108°F breakfast, 113°F lunch, 111°F dinner 11/03/2024 - 106°F breakfast, 117°F lunch, 119°F dinner 11/04/2024 - 110°F breakfast, 112°F lunch, 110°F dinner 11/05/2024 - 112°F breakfast, 116°F lunch, 115°F dinner 11/06/2024 - 106°F breakfast, 111°F lunch, 111°F dinner 11/07/2024 - 108°F breakfast, 110°F lunch, 118°F dinner 11/08/2024 - 112°F breakfast, 108°F lunch, 119°F dinner 11/09/2024 - 106°F breakfast, 111°F lunch, 110°F dinner 11/10/2024 - 110°F breakfast, 108°F lunch, 110°F dinner 11/11/2024 - 112°F breakfast, 114°F lunch, 115°F dinner 11/12/2024 - 107°F breakfast, 110°F lunch, 110°F dinner 11/13/2024 - 108°F breakfast, 111°F lunch, 117°F dinner 11/14/2024 - 110°F breakfast, 112°F lunch, 113°F dinner 11/15/2024 - 108°F breakfast, 112°F lunch, 114°F dinner 11/16/2024 - 106°F breakfast, 112°F lunch, 110°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/17/2024 - 106°F breakfast, 112°F lunch, 107°F dinner 11/18/2024 - 111°F breakfast, 119°F lunch, 108°F dinner 11/19/2024 - 110°F breakfast, 119°F lunch, 111°F dinner 11/20/2024 - Blank for breakfast, lunch, and dinner 11/21/2024 - 115°F breakfast, 108°F lunch, 115°F dinner 11/22/2024 - 108°F breakfast, 110°F lunch, 114°F dinner 11/23/2024 - 106°F breakfast, 113°F lunch, 108°F dinner 11/24/2024 - 108°F breakfast, 110°F lunch, 111°F dinner 11/25/2024 - 110°F breakfast, 114°F lunch, 111°F dinner 11/26/2024 - 109°F breakfast, 113°F lunch, 115°F dinner 11/27/2024 - 108°F breakfast, 110°F lunch, 115°F dinner 11/28/2024 - 110°F breakfast, 116°F lunch, 110°F dinner 11/29/2024 - 108°F breakfast, 112°F lunch, 118°F dinner 11/30/2024 - 110°F breakfast, 108°F lunch, 110°F dinner December 2024 12/01/2024 - 111°F breakfast, 111°F lunch, 117°F dinner 12/02/2024 - 110°F breakfast, 115°F lunch, 109°F dinner 12/03/2024 - 112°F breakfast, 113°F lunch, 110°F dinner 12/04/2024 - 109°F breakfast, 111°F lunch, 102°F dinner 12/05/2024 - 110°F breakfast, 112°F lunch, 110°F dinner 12/06/2024 - 112°F breakfast, 115°F lunch, 100°F dinner 12/07/2024 - 111°F breakfast, 112°F lunch, 101°F dinner 12/08/2024 - 107°F breakfast, 106°F lunch, 109°F dinner 12/09/2024 - 111°F breakfast, 115°F lunch, 115°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/10/2024 - 109°F breakfast, 113°F lunch, 109°F dinner 12/11/2024 - 108°F breakfast, 111°F lunch, 110°F dinner 12/12/2024 - 110°F breakfast, 113°F lunch, 100°F dinner 12/13/2024 - 111°F breakfast, 112°F lunch, 110°F dinner 12/14/2024 - 108°F breakfast, 111°F lunch, 100°F dinner 12/15/2024 - 110°F breakfast, 113°F lunch, 111°F dinner 12/16/2024 - 109°F breakfast, 111°F lunch, 100°F dinner 12/17/2024 - 108°F breakfast, 109°F lunch, 109°F dinner 12/18/2024 - 106°F breakfast, 108°F lunch, 100°F dinner 12/19/2024 - 111°F breakfast, 106°F lunch, 111°F dinner 12/20/2024 - 111°F breakfast, 111°F lunch, 110°F dinner 12/21/2024 - 106°F breakfast, 109°F lunch, 100°F dinner 12/22/2024 - 110°F breakfast, 112°F lunch, 110°F dinner 12/23/2024 - 112°F breakfast, 110°F lunch, 112°F dinner 12/24/2024 - 113°F breakfast, 112°F lunch, 111°F dinner 12/25/2024 - 108°F breakfast, 110°F lunch, 100°F dinner 12/26/2024 - 110°F breakfast, 106°F lunch, 112°F dinner 12/27/2024 - 106°F breakfast, 110°F lunch, 113°F dinner 12/28/2024 - 104°F breakfast, 108°F lunch, 117°F dinner 12/29/2024 - 106°F breakfast, 110°F lunch 12/30/2024 - 107°F breakfast, 110°F lunch, 115°F dinner 12/31/2024 - 110°F breakfast, 109°F lunch, 110°F dinner January 2025 01/01/2025 - 108°F breakfast, 106°F lunch (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	01/02/2025 - 110°F breakfast, 108°F lunch, 112°F dinner 01/03/2025 - 110°F breakfast, 111°F lunch, 110°F dinner 01/04/2025 - 110°F breakfast, 111°F lunch 01/05/2025 - 108°F breakfast, 109°F lunch, 119°F dinner 01/06/2025 - 111°F breakfast, 110°F lunch, 110°F dinner 01/07/2025 - 109°F breakfast, 111°F lunch, 116°F dinner 01/08/2025 - 106°F breakfast, 108°F lunch, 110°F dinner 01/09/2025 - 106°F breakfast, 111°F lunch, 112°F dinner 01/10/2025 - 110°F breakfast, 107°F lunch, 110°F dinner 01/11/2025 - 109°F breakfast, 110°F lunch, 116°F dinner 01/12/2025 - 113°F breakfast, 106°F lunch, 114°F dinner 01/13/2025 - 107°F breakfast, 111°F lunch, 115°F dinner 01/14/2025 - 108°F breakfast, 110°F lunch, 110°F dinner 01/15/2025 - 106°F breakfast, 113°F lunch, 110°F dinner 01/16/2025 - 115°F breakfast, 108°F lunch, 113°F dinner 01/17/2025 - 110°F breakfast, 106°F lunch, 110°F dinner 01/18/2025 - 111°F breakfast, 110°F lunch, 119°F dinner 01/19/2025 - 108°F breakfast, 111°F lunch, 109°F dinner 01/20/2025 - 105°F breakfast, 110°F lunch, 113°F dinner 01/21/2025 - 107°F breakfast, 111°F lunch, 106°F dinner 01/22/2025 - 107°F breakfast, 110°F lunch, 110°F dinner 01/23/2025 - 106°F breakfast, 108°F lunch, 112°F dinner 01/24/2025 - 107°F breakfast, 110°F lunch, 110°F dinner 01/25/2025 - 106°F breakfast, 112°F lunch, 112°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	01/26/2025 - 106°F breakfast, 118°F lunch, 110°F dinner 01/27/2025 - 110°F breakfast, 111°F lunch, 113°F dinner 01/28/2025 - 107°F breakfast, 109°F lunch, 102°F dinner 01/29/2025 - 107°F breakfast, 110°F lunch, 116°F dinner 01/30/2025 - 109°F breakfast, 111°F lunch, 116°F dinner 01/31/2025 - 106°F breakfast, 111°F lunch, 100°F dinner February 2025 02/01/2025 - 110°F breakfast, 106°F lunch, 112°F dinner 02/02/2025 - 106°F breakfast, 114°F lunch, 110°F dinner 02/03/2025 - 107°F breakfast, 111°F lunch, 111°F dinner 02/04/2025 - 110°F breakfast, 109°F lunch, 116°F dinner 02/05/2025 - 107°F breakfast, 106°F lunch, 106°F dinner 02/06/2025 - 115°F breakfast, 105°F lunch, 110°F dinner 02/07/2025 - 108°F breakfast, 107°F lunch, 110°F dinner 02/08/2025 - 111°F breakfast, 108°F lunch, 112°F dinner 02/09/2025 - 110°F breakfast, 106°F lunch, 106°F dinner 02/10/2025 - 108°F breakfast, 110°F lunch, 111°F dinner 02/11/2025 - 107°F breakfast, 107°F lunch, 116°F dinner 02/12/2025 - 115°F breakfast, 106°F lunch, 110°F dinner 02/13/2025 - 110°F breakfast, 113°F lunch, 106°F dinner 02/14/2025 - 108°F breakfast, 110°F lunch, 100°F dinner 02/15/2025 - 106°F breakfast, 108°F lunch, 112°F dinner 02/16/2025 - 108°F breakfast, 113°F lunch, 100°F dinner 02/17/2025 - 112°F breakfast, 106°F lunch, 119°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	02/18/2025 - 111°F breakfast, 111°F lunch, 112°F dinner 02/19/2025 - 107°F breakfast, 111°F lunch, 106°F dinner 02/20/2025 - 105°F breakfast, 109°F lunch, 101°F dinner 02/21/2025 - 109°F breakfast, 107°F lunch, 106°F dinner 02/22/2025 - 107°F breakfast, 110°F lunch, 100°F dinner 02/23/2025 - 118°F breakfast, 113°F lunch, 107°F dinner 02/24/2025 - 108°F breakfast, 115°F lunch, 115°F dinner 02/25/2025 - 109°F breakfast, 111°F lunch, 100°F dinner 02/26/2025 - 106°F breakfast, 108°F lunch, 116°F dinner 02/27/2025 - 108°F breakfast, 110°F lunch, 100°F dinner 02/28/2025 - 118°F breakfast, 106°F lunch, 114°F dinner March 2025 03/01/2025 - 107°F breakfast, 111°F lunch, 106°F dinner 03/02/2025 - 109°F breakfast, 112°F lunch, 100°F dinner 03/03/2025 - 108°F breakfast, 111°F lunch, 110°F dinner 03/04/2025 - 107°F breakfast, 110°F lunch, 100°F dinner 03/05/2025 - 108°F breakfast, 100°F lunch, 112°F dinner 03/06/2025 - 113°F breakfast, 118°F lunch, 108°F dinner 03/07/2025 - 111°F breakfast, 110°F lunch, 108°F dinner 03/08/2025 - 106°F breakfast, 107°F lunch, 108°F dinner 03/09/2025 - 115°F breakfast, 108°F lunch, 109°F dinner 03/10/2025 - 111°F breakfast, 115°F lunch 03/11/2025 - 113°F breakfast, 114°F lunch, 108°F dinner 03/12/2025 - 106°F breakfast, 110°F lunch, 108°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	03/13/2025 - 117°F breakfast, 108°F lunch, 115°F dinner 03/14/2025 - 118°F breakfast, 106°F lunch, 106°F dinner 03/15/2025 - 114°F breakfast, 111°F lunch, 110°F dinner 03/16/2025 - 108°F breakfast, 115°F lunch, 100°F dinner 03/17/2025 - 109°F breakfast, 115°F lunch, 113°F dinner 03/18/2025 - 115°F breakfast, 115°F lunch, 116°F dinner 03/19/2025 - 110°F breakfast, 110°F lunch, 100°F dinner 03/20/2025 - 108°F breakfast, 116°F lunch, 112°F dinner 03/21/2025 - 110°F breakfast, 115°F lunch, 114°F dinner 03/22/2025 - 108°F breakfast, 118°F lunch, 116°F dinner 03/23/2025 - 113°F breakfast, 110°F lunch, 100°F dinner 03/24/2025 - 110°F breakfast, 112°F lunch, 112°F dinner 03/25/2025 - 109°F breakfast, 114°F lunch, 106°F dinner 03/26/2025 - 108°F breakfast, 110°F lunch, 106°F dinner 03/27/2025 - 108°F breakfast, 106°F lunch, 106°F dinner 03/28/2025 - 111°F breakfast, 111°F lunch, 108°F dinner 03/29/2025 - 109°F breakfast, 115°F lunch, 112°F dinner 03/30/2025 - 108°F breakfast, 108°F lunch, 110°F dinner 03/31/2025 - 108°F breakfast, 114°F lunch, 116°F dinner April 2025 04/01/2025 - 110°F breakfast, 114°F lunch, 112°F dinner 04/02/2025 - 106°F breakfast, 110°F lunch, 100°F dinner 04/03/2025 - 110°F breakfast, 111°F lunch, 110°F dinner 04/04/2025 - 114°F breakfast, 113°F lunch, 100°F dinner (continued on next page)

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	505009	A. Building B. Wing	05/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/05/2025 - 110°F breakfast, 108°F lunch, 104°F dinner 04/06/2025 - 115°F breakfast, 108°F lunch, 108°F dinner 04/07/2025 - 109°F breakfast, 115°F lunch, 111°F dinner 04/08/2025 - 111°F breakfast, 113°F lunch, 110°F dinner 04/09/2025 - 107°F breakfast, 110°F lunch, 106°F dinner 04/10/2025 - 108°F breakfast, 112°F lunch, 109°F dinner 04/11/2025 - 113°F breakfast, 115°F lunch, 100°F dinner 04/12/2025 - 108°F breakfast, 110°F lunch, 106°F dinner 04/13/2025 - 107°F breakfast, 115°F lunch, 100°F dinner 04/14/2025 - 111°F breakfast, 112°F lunch, 114°F dinner 04/15/2025 - 109°F breakfast, 114°F lunch, 107°F dinner 04/16/2025 - 108°F breakfast, 115°F lunch, 110°F dinner 04/17/2025 - 111°F breakfast, 115°F lunch, 100°F dinner 04/18/2025 - 114°F breakfast, 115°F lunch, 110°F dinner 04/19/2025 - 111°F breakfast, 115°F lunch, 108°F dinner 04/20/2025 - 115°F breakfast, 114°F lunch, 100°F dinner 04/21/2025 - 110°F breakfast, 113°F lunch, 119°F dinner 04/22/2025 - 112°F breakfast, 116°F lunch, 110°F dinner 04/23/2025 - 108°F breakfast, 109°F lunch, 117°F dinner 04/24/2025 - 115°F breakfast, 119°F lunch, 115°F dinner 04/25/2025 - 109°F breakfast, 111°F lunch, 112°F dinner 04/26/2025 - 108°F breakfast, 111°F lunch, 108°F dinner 04/27/2025 - 106°F breakfast, 110°F lunch, 100°F dinner 04/28/2025 - 111°F breakfast, 112°F lunch, 108°F dinner (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/29/2025 - 113°F breakfast, 115°F lunch, 100°F dinner 04/30/2025 - 111°F breakfast, 114°F lunch, 112°F dinner May 2025 05/01/2025 - 108°F breakfast, 115°F lunch, 108°F dinner 05/02/2025 - 109°F breakfast, 111°F lunch, 100°F dinner 05/03/2025 - 108°F breakfast, 119°F lunch, 110°F dinner 05/04/2025 - 115°F breakfast, 116°F lunch, 108°F dinner 05/05/2025 - 111°F breakfast, 113°F lunch, 119°F dinner 05/06/2025 - 110°F breakfast, 115°F lunch, 100°F dinner 05/07/2025 - 111°F breakfast, 110°F lunch, 112°F dinner 05/08/2025 - 108°F breakfast, 119°F lunch, 108°F dinner 05/09/2025 - 108°F breakfast, 111°F lunch, 112°F dinner 05/10/2025 - 108°F breakfast, 115°F lunch, 108°F dinner 05/11/2025 - 111°F breakfast, 119°F lunch, 106°F dinner 05/12/2025 - 110°F breakfast, 112°F lunch, 111°F dinner 05/13/2025 - 112°F breakfast, 114°F lunch, 101°F dinner 05/14/2025 - 111°F breakfast, 115°F lunch, 105°F dinner 05/15/2025 - 115°F breakfast Staff S stated that the dishwasher machine had not been reaching a washing temperature of 120°F and it should have been. Staff S further stated that they had informed maintenance staff of the dishwasher washing temperatures. In an interview on 05/16/2025 at 2:59 PM, Staff A stated that they expected the low temperature dishwasher machine worked properly and at the required temperature. Staff A further stated that the dishwasher temperature for washing should have been at a minimum of 120°F. RE-HEATING FOOD STAFF L (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/13/2025 at 3:03 PM, showed Staff L, Certified Nursing Assistant, took Resident 7's lunch tray to the microwave room, warmed it in the microwave, and delivered the tray back to Resident 7 without taking the temperature of their food. In an interview on 05/13/2025 at 3:51 PM, Staff L stated they warmed up the food for one and half minutes. Staff L stated they did not know that they should have checked the temperature of the food prior to serving it to Resident 7. A joint observation and interview on 05/17/2025 at 10:42 AM, Staff E, Resident Care Manager, showed that there was a temperature log on top of the microwave and a thermometer next to the temperature log. Staff E stated that Staff L should have checked the temperature of the food prior to serving it to Resident 7. A joint record review and interview on 05/17/2025 at 10:42 AM, Staff B, Director of Nursing, showed the policy titled, Reheating Food in the Microwave, indicated that After reheating the resident's foods, the temperature should be taken prior to serving [it] to the resident and this information should be documented on the Microwave Reheating Log. Staff B stated that Staff L should have followed the policy and should have taken the temperature of the food prior to serving it to Resident 7. Reference: (WAC) 388-97-1100(2)(3) .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 25 Review of the face sheet printed on 05/14/2025 showed Resident 25 was admitted to the facility on [DATE] and discharged on 03/30/2025. Review of the nursing progress notes dated 03/29/2025 showed Resident 25 discharged home that day. A joint record review and interview on 05/16/2025 at 5:52 PM with Staff F, Minimum Data Set (an assessment tool) Coordinator, showed Resident 25's face sheet indicated they discharged on 03/30/2025. Staff F stated that Resident 25 was discharged from the facility on 03/30/2025. A joint record review of the progress note dated 03/29/2025 showed Resident 25 discharged from the facility on 03/29/2025. Staff F stated that Resident 25 was discharged on 03/29/2025 and that the discharge date on their face sheet should have matched the discharge date documented in the progress notes. In an interview on 05/17/2025 at 4:04 PM, Staff B stated that Resident 25 discharge date on their face sheet should have been 03/29/2025. RESIDENT 2 Review of Resident 2's Hospice [compassionate care provided to individuals who are in the final stages of a terminal illness] admission Plan of Care, dated 03/02/2025 showed Resident admitted to hospice services on 03/02/2025. Review of the clinical records titled, Hospice Routine admission Orders, Hospice, and Certification of Terminal Illness, in Resident 2's clinical records under miscellaneous tab showed three documents (three hospice documents: Hospice Routine admission Orders, Hospice and Certification of Terminal Illness) belonged to Resident 169's clinical records. A joint record review and interview on 05/16/2025 at 6:08 PM with Staff F showed the three documents titled, Hospice Routine admission Orders, Hospice, and Certification of Terminal Illness, in Resident 2's miscellaneous tab belonged to Resident 169. Staff F stated that the three hospice documents were not Resident 2's clinical records and should not have been there. In an interview on 05/17/2025 at 3:37 PM, Staff B stated that Resident 169's documents should not have been in Resident 2's clinical records. RESIDENT 30 Review of the face sheet printed on 05/13/2025 showed Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's document titled, Self-Administration of Medication Evaluation, dated 07/09/2024 was not filled out, it was blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 05/17/2025 at 1:29 PM with Staff E showed Resident 30's Self-Administration of Medication Evaluation, dated 07/09/2024 was blank. Staff E stated that the document was bank and that it should have been completed after assessing Resident 30 for self-administration of medication. In an interview on 05/17/2025 at 3:57 PM, Staff B stated that Resident 30's self-administration of medication evaluation dated 07/09/2024 should have been completed. Reference: (WAC) 388-97-1720 (1)(a)(i)(ii) Based on interview and record review, the facility failed to ensure clinical records were properly completed for 4 of 7 residents (Residents 36, 25, 2 & 30), reviewed for resident records. The failure to fill out resident forms accurately placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . RESIDENT 36 Review of a face sheet printed on 05/13/2025 showed Resident 36 was admitted to the facility on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (having excessive/persistent worry and fear). Review of Resident 36's Level I 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 are not inappropriately placed in nursing homes for long-term care) dated 04/28/2025, did not show depression and anxiety disorder were documented in Section IA (SMI). A joint record review and interview on 05/16/2025 at 4:59 PM with Staff G, Social Services Director, showed Resident 36 had diagnoses of depression and anxiety disorder on their face sheet. Further joint record review showed that depression and anxiety disorder were not marked in Resident 36's Level I PASARR in Section IA. Staff G stated that Resident 36's Level I PASARR was not accurate and that they should have included their diagnoses of depression and anxiety disorder. In an interview on 05/17/2025 at 10:42 AM, Staff B, Director of Nursing, stated that they expected PASARR forms to be completed accurately. In an interview on 05/17/2025 at 10:58 AM, Staff A, Administrator, stated that they expected the PASARR form information should be accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. RESIDENT 7 Observation on 05/13/2025 at 3:03 PM, showed Staff L, CNA, entered Resident 7's room, Staff L helped Resident 7 to sit up on the edge of the bed, then left the room with Resident 7's lunch tray. Staff L did not perform hand hygiene before entering and/or after leaving Resident 7's room. Observation on 05/13/2025 at 3:09 PM, showed Staff L entered Resident 7's room with their lunch tray, put on a pair of gloves and assisted Resident 7 to the bathroom. Staff L went to the nurse's station to get a cup of coffee for Resident 7. Staff L did not perform hand hygiene before putting on new gloves, between tasks, and/or after leaving Resident 7's room. Observation on 05/13/2025 at 3:16 PM, showed Staff L entered Resident 7's room with a cup of coffee and placed it on the lunch tray. Staff L then moved the bedside table in front of Resident 7. Staff L did not perform hand hygiene before entering and/or after leaving Resident 7's room. RESIDENT 23 Observation on 05/13/2025 at 3:18 PM, showed Staff L entered Resident 23's room, donned gloves, cleaned Resident 23's bedside table, removed their soiled gloves and left Resident 23's room. Staff L did not perform hand hygiene before putting their gloves on, between tasks and/or after leaving Resident 23's room. In an interview on 05/13/2025 at 3:51 PM, Staff L stated they should have done hand hygiene before putting their clean gloves on, after removing their soiled gloves, and/or after leaving the rooms of Resident 7 and Resident 23. In an interview on 05/16/2025 at 11:54 AM, Staff E, RCM, stated Staff L should have performed hand hygiene before entering Resident 23's room, between tasks, and/or after leaving the resident's room. In an interview on 05/16/2025 at 3:05 PM, Staff C stated they expected all staff to do hand hygiene before entering and/or after leaving the residents' room, before donning and after removing their soiled gloves. In an interview on 05/16/2025 at 3:25 PM, Staff B stated, staff should be doing hand hygiene between care, before touching food and when needed. Staff B further stated, gloves cannot replace hand hygiene. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases by: 1. Not ensuring the Infection Prevention and Control Program (IPCP) policies and procedures were reviewed annually, as required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Not monitoring the expiration for eyewash station solutions for 3 of 4 eyewash stations (300 Hall Nurse's Station, 500 Hall Resident Care Manager [RCM] Office, Laundry Room), reviewed for water management. 3. Not ensuring Enhanced Barrier Precautions (EBP - precautions to protect the spread of infectious organisms) were followed for 1 of 9 residents (Residents 1). 4. Not performing hand hygiene during care and treatments for 4 of 11 residents (Residents 4, 7, 23 & 38). 5. Not appropriately handling soiled linen during transport for 2 of 2 residents (Residents 2 & 19), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk of acquiring infections, related complications, and personal injury. Findings included . Review of facility's policy titled, Infection Prevention and Control Program, revised in December 2023, showed the infection prevention and control committee, medical director, director of nursing services, and other key clinical and administrative staff review the infection control policies at least annually. Review of the facility's policy titled, Water Management Plan, revised on 04/22/2025, showed that eyewash stations are inspected weekly and if bottles of saline [sterile salted water] are used instead, check the expiration date on the bottles and replace as necessary. Review of the facility's policy titled, Enhanced Barrier Precautions, revised on 03/21/2024, showed that in addition to Standard Precautions (minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status), the facility will implement EBP for residents with indwelling medical devices for the duration of the stay or the indwelling device is discontinued. The policy further stated that indwelling medical devices includes urinary catheters (a device that drains urine from the bladder into a collection bag outside of the body). The policy further showed that Personal Protective Equipment (PPE - gloves, gown, and surgical mask) for EBP was necessary when performing high-contact care activities. Review of facility's policy titled Handwashing/Hand Hygiene, revised in October 2023, showed 1. Hand hygiene is indicated: a. immediately before touching a resident; c. after contact with blood, body fluids, or contaminated surfaces; d. after touching resident; after touching the resident's environment; f. before moving from work on a soiled body site to clean body site on the same resident; and g. immediately after glove removal . 5. the use if gloves does not replace hand washing/hand hygiene. INFECTION PREVENTION AND CONTROL PROGRAM-ANNUAL REVIEW Review of the IPCP including standards, policies, and procedures showed that the policies and procedures have not been reviewed at least annually. The following policies were last reviewed and/or dated below: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The IPCP policies - December 2023 2. The Surveillance of Infections - September 2017 3. Antibiotic Stewardship policy - December 2016 4. Influenza vaccine policy - March 2022 5. Pneumococcal Vaccine policy - October 2023 6. COVID-19 (a highly transmissible infectious virus that causes respiratory illness) Vaccine policy - September 2023 In an interview and joint record review on 05/17/2025 at 11:03 AM, Staff C, Infection Preventionist (IP), stated they had not reviewed the IPCP policies and procedures, or had not reviewed them in Quality Assurance and Performance Improvement meetings. Staff C further stated they were not sure when it was last reviewed. A joint record review of the IPCP policies and procedures with Staff C showed that IPCP policies were not reviewed annually. Staff C stated IPCP policies should be reviewed to be updated with the most current standards, policies, and procedures. In an interview on 05/17/2025 at 2:25 PM Staff B, Director of Nursing, stated that they expected the IPCP policies and procedures to have been reviewed at least annually. EYEWASH STATION Observation on 05/16/2025 at 11:56 AM, showed the eyewash station in the 300 Hall Nurse's Station had two Honeywell (brand name) eye saline [sterile salt water] solution bottles with an expiration date of March 2024. Observation on 05/16/2025 at 12:14 PM, showed the eyewash station in the 500 RCM Office had two Honeywell eye saline solution bottles with an expiration date of March 2024. In an interview and joint observation on 05/16/2025 at 2:20 PM with Staff A, Administrator, and Staff I, Maintenance Director, Staff I stated that they checked the eyewash stations monthly. A joint observation showed the eyewash station in the 300 Hall nurse's station had two Honeywell eye saline solution bottles and the 500 RCM office had two Honeywell eye saline solution bottles. Staff A stated all four bottles expired in March 2024. Staff I stated that the bottles should have been replaced. Staff A stated they expected the eye saline solution bottles to be replaced when they expired. An interview and joint observation on 05/16/2025 at 3:25 PM with Staff I, showed the eyewash station in the laundry room had a Honeywell eye saline solution bottle that expired in January 2025. Staff I stated the bottle expired in January 2025 and that the eye saline solution bottle should have been replaced. EBP RESIDENT 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Enhanced Barrier Precautions care plan, printed on 05/17/2025, showed Resident 1 was placed on EBP for urinary catheter use. Observation on 05/14/2025 at 2:50 PM, showed Staff V, Licensed Practical Nurse (LPN) and Staff W, Certified Nursing Assistant (CNA), entered Resident 1's room (EBP room) without wearing PPE (gloves and gown) before repositioning Resident 1. In an interview and joint record review on 05/14/2025 at 3:00 PM, Staff V stated that for residents on EBP, they would follow the EBP signage instructions. Staff V stated that Resident 1 was on EBP due to urinary catheter, and they provided care and repositioned Resident 1. A joint record review of the EBP signage outside Resident 1's door, showed that staff were required to wear gowns and gloves for high contact resident care activities that included transferring or repositioning. Staff V stated they should have worn gown and gloves prior to providing care to Resident 1. In an interview on 05/14/2025 at 3:08 PM, Staff W stated that they should have worn gowns and gloves prior to providing care to Resident 1. In an interview on 05/16/2025 at 4:45 PM, Staff C stated they expected staff to follow the EBP precautions for Resident 1. In an interview on 05/17/2025 at 2:25 PM with Staff B stated they expected staff to follow the EBP precautions for residents who were on EBP.RESIDENT 38 Observation and interview on 05/15/2025 at 7:52 AM, Staff O, LPN, entered Resident 38's room to provide their medication. Staff O did not do hand hygiene prior to entering Resident 38's room. Staff O moved Resident 38's bedside table to the side, picked up Residents 38's bed control from the floor and handed it to Resident 38. Staff O then placed Resident 38's bedside table closer to them, put on gloves, and handed Resident 38 their medications. Staff O did not do hand hygiene between tasks and prior to putting new gloves on. Staff O stated they should have performed hand hygiene before entering Resident 38's room, after picking up their bed control from the floor, and before putting new gloves on. In an interview on 05/16/2025 at 3:11 PM, Staff C stated that Staff O should have performed hand hygiene before entering Resident 38's room, after picking up the bed control from the floor, and before putting on gloves. Staff C further stated they expected staff to do hand hygiene before entering/after leaving residents' rooms, after touching residents' belongings, before/after providing resident care. In an interview on 05/16/2025 at 3:49 PM, Staff B stated they expected staff to do hand hygiene before and after care, when working from dirty to clean, before entering residents' rooms, before placing gloves on, and after touching residents' belongings. Staff B further stated that Staff O should have performed hand hygiene prior to entering Resident 38's room, after picking up their bed control from the floor, and before putting on clean gloves. TRANSPORTING OF SOILED LINEN/SOILED DISPOSABLE BRIEFS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Laundry and Bedding, Soiled, revised in September 2022, showed that soiled laundry/bedding would be handled, transported, and processed according to best practices for infection prevention and control. The document further showed, All used laundry is handled as potentially contaminated using standard precautions . Contaminated laundry is bagged or contained at the point of collection. RESIDENT 2 Observation on 05/12/2025 at 9:55 AM, showed Resident 2's soiled bed linens were unbagged and on the floor near their bed. RESIDENT 19 Observation on 05/12/2025 at 10:01 AM, showed Staff U, CNA, exiting Resident 19's room. Further observation showed Staff U holding an open clear bag of soiled linens and clothing items in their right hand and another clear bag of soiled briefs in their left hand. Staff U then took the soiled bagged items to Resident 2's room and added Resident 2's soiled linens that were on the floor to the opened soiled linen bag. In an interview on 05/12/2025 at 10:06 AM, Staff U stated that soiled briefs would be tied in a bag and taken to the soiled utility room and the soiled linens would be taken to the laundry chute. Staff U stated that they took the bagged soiled briefs and soiled linens from Resident 19 to Resident 2's room and added Resident 2's soiled linens. Staff U further stated that they placed Resident 2 soiled linens on the floor because they were not visibly soiled and that Resident 19's soiled linens were not visibly soiled when they took them to Resident 2's room. In an interview on 05/16/2025 at 3:06 PM, Staff C stated they expected soiled linens and soiled briefs to be bagged and sealed in residents' rooms before transporting them to the designated locations. Staff C stated that soiled linens should not be on the floor unbagged. Staff C further stated that Resident 2's soiled linens should not have been left on the floor and that staff [Staff U] should not have taken the soiled linens and soiled briefs from Resident 19's room to Resident 2's room. In an interview on 05/16/2025 at 3:26 PM, Staff B stated that they expected staff to handle soiled linen and soiled briefs without dragging them on the floor, tied in a bag, and transported to the designated areas. Staff B stated that soiled linens and/or soiled briefs should not be directly touching the floor and should not be taken from one room to another. Staff B further stated that Resident 2's soiled linens should not have been on the floor unbagged and that staff [Staff U] should not have taken Resident 19's soiled briefs and linens to Resident 2's room. Reference: (WAC) 388-97-1320 (1)(a)(c)(3) HAND HYGIENE/GLOVE USE RESIDENT 4 Review of the admission Minimum Data Set (an assessment tool) dated 02/03/2025, showed Resident 4 had a feeding tube (a medical device inserted into the digestive tract to deliver nutrition). (continued on next page)

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	05/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Shoreline	1250 Northeast 145th Street Seattle, WA 98155

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's physician orders printed on 05/13/2025, showed an order to change Resident 4's feeding tube daily and as needed for loose or soiled dressings. Observation on 05/13/2025 at 4:17 PM, showed Staff V removed Resident 4's soiled dressing while wearing a gown, mask, and gloves. Staff V removed their soiled gloves and put on new gloves. No hand hygiene was done between glove changes. Staff V cleaned the wound (feeding tube site), removed their soiled gloves and put on new gloves. No hand hygiene was done between glove changes. Staff V provided Resident 4's wound treatment, removed their soiled gloves and put on new gloves. No hand hygiene was done between glove changes. In an interview on 05/13/2025 at 4:56 PM, Staff V stated that normally [I] would wash hands or sanitize hands between glove changes. In an interview on 05/17/2025 at 10:29 AM, Staff C stated that they expected hand hygiene to be done before and after glove use. Staff C further stated that during a dressing change the process was to wash hands, put on clean gloves, provide care, and if have to take off gloves and put on new ones, you should do hand hygiene in-between. In an interview on 05/17/2025 at 1:42 PM, Staff B stated that they expected hand hygiene to be done before donning [putting on] gloves and after doffing [taking off] gloves.