STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505217	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Ridgemont	2051 Pottery Avenue Port Orchard, WA 98366

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure results of allegations/investigations were reported to the State Agency Hotline within 5 working days for 2 of 2 residents (1 & 2) reviewed for abuse and neglect. This failure placed residents at risk for potential unmet needs and decreased quality of life. Findings included .Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses of heart failure and diabetes mellitus. The quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 1 had no cognitive impairment and was dependent on staff for some activities of daily living (ADLs).Incident Report, dated 03/16/2026, documented Staff D, Nursing Assistant (NA), stood at the end of Resident 1's bed and told them to stop stuttering. Then, slammed Resident 1's refrigerator door so hard the freezer opened. The allegation was reported to the State Agency on 03/16/2026. No evidence was provided showing a 5-day follow-up was submitted to the State Agency.On 04/13/2026 at 1:57 PM, Staff B, registered nurse (RN) and Director of Nursing (DNS), said she did not submit a 5-day follow-up for this allegation. Staff B acknowledged this should have been submitted to the State Agency. Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia and a urinary tract infection. The admission MDS, dated [DATE], documented Resident 2 had moderate cognitive impairment and was dependent on staff with ADLs.Incident Report, dated 04/01/2026, documented Resident 2's family had concerns about treatment of the resident by an unnamed staff member. The allegation statement documented the resident had bruising on their thigh shaped like a handprint. The allegation was reported to the State Agency on 04/01/2026. No evidence was provided showing a 5-day follow-up was submitted to the State Agency.On 04/13/2026 at 1:57 PM, Staff B, RN and DNS, said she did not submit a 5-day follow-up for this allegation. Staff B acknowledged this should have been submitted to the State Agency. Reference WAC 388-97-0640(5)(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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