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	09/12/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 psychotropic medications (drugs that affect behavior, mood, thoughts and perception) had an adequate indication for use, the specific target behaviors (TB) the medication was implemented to treat were identified and monitored, gradual dose reductions (GDRs) were performed and resident responses accurately assessed and documented, non-drug interventions were identified and attempted prior to administration of as needed (PRN) psychotropic medications, and staff monitoring for medication adverse side effects occurred for 3 of 5 residents (Residents 13, 44 & 26) reviewed for unnecessary medications. These failures detracted from staff's ability to assess the effectiveness of psychotropic medication(s), need for ongoing use and presence of medication adverse side effects (ASEs). This placed residents at risk for receiving unnecessary medications, unidentified or delayed identification of ASEs, and a diminished quality of life.Findings included . 1) Resident 13 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/08/2025, showed the resident had moderate cognitive impairment, diagnoses of dementia, anxiety disorder (feelings of worry or fear that are persistent), and psychotic disorder (mental health condition characterized by a loss of touch with reality, leading to significant disturbances in thoughts, perceptions, and behavior), and received anti-depressant and anti-psychotic medications during the assessment period. Review of the electronic health record (EHR) showed Resident 13 had the following psychotropic medication orders:a) A 09/10/2024 order for citalopram (an anti-depressant) daily for anxiety disorder.b) A 11/07/2024 order for mirtazapine (an anti-depressant) daily at bedtime for depression and protein-calorie malnutrition. c) A 11/04/2024 order for quetiapine (an anti-psychotic) 50 milligrams (mg) twice a day at 8:00 AM and 8:00 PM, and an additional order from 07/15/2025 for quetiapine 25 mg daily at 2:00 PM for dementia with moderate psychotic disturbances. The order included documentation that Resident 13's quetiapine was reinstated to 25 mg at 2:00 PM from 12.5 mg secondary to a failed GDR. An alteration in cognition care plan, revised 05/23/2025, showed Resident 13 received quetiapine for dementia with agitation. The TBs were identified as yelling, calling out, using profanity, swinging hands and refusing care. Review of the September 2025 Treatment Administration Record (TAR) showed the antipsychotic behavior monitor identified the TBs for the use of quetiapine as refusal care, agitation, and mentions of death or disaster. These TBs were inconsistent with the TBs identified on Resident 13's care plan. Review of the anxiety disorder care plan, initiated 04/30/2025, documented Resident 13 received hydroxyzine (an antihistamine) for anxiety and had identified TBs of yelling, calling out, using profanity, and swinging hands. The same TBs that were identified for the use of quetiapine. Review of the 04/02/2025 hydroxyzine order, showed it was to be administered twice a day for itching, not for anxiety disorder. An at risk for depression care plan, initiated 04/30/2025, showed Resident 13 received mirtazapine and citalopram for dementia with confusion. This was inconsistent (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the physicians' orders which documented the citalopram was ordered to treat anxiety disorder and the mirtazapine to treat depressive disorder with protein-calorie malnutrition. Specific TBs were not identified for the use of mirtazapine and citalopram. Both medications had the same TBs identified which were hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxiety or health-related complaints, and tearfulness. Review of the July, August and September 2025 Medication Administration Record (MAR) and TARs, showed Resident 13's anti-depressant behavior monitors were all blank. Additionally, the anti-depressant behavior monitors did not identify distinct TBs each medication was intended to treat. Instead waking up agitated, combativeness, and making negative statements were identified as the TBs for the use of both medications, which were inconsistent with the TBs identified on the care plan. Review of a Psychotropic Drug and Behavior Review, dated 07/07/2025, showed Resident 13 received citalopram and mirtazapine for anxiety disorder, not dementia with confusion as care planned or depression with protein-calorie malnutrition as documented in the mirtazapine order. The psychotropic review interdisciplinary team recommended a GDR of Resident 13's 2:00 PM dose of quetiapine from 25 mg to 12.5 mg. Review of the EHR showed a GDR of Resident 13's 2:00 PM dose of quetiapine from 25 mg to 12.5 mg was ordered on 07/11/2025 and implemented on 07/12/2025. Review of the nurses notes between 07/12/2025 - 07/14/2025 showed there were three nurses notes on 07/12/2025, two on 07/13/2025 and two on 07/14/2025 (day shift) that addressed Resident 13's GDR of quetiapine. All seven nurses' notes documented that the resident had no adverse effects to the GDR and/or demonstrated no behaviors and/or was pleasant and cooperative with care. A nurse's note dated 07/14/2025 at 4:15 PM, documented Resident 13 had increased mood swings, a short temper, and increased anxiety when staff were unable to answer their call light immediately. The note indicated the nurse requested Resident 13's quetiapine be increased back to 25 mg secondary to a failed GDR. A nurse's note dated 07/14/2025 at 4:25 PM, documented an order was obtained to reinstate quetiapine to 25 mg secondary to failed GDR. Review of the July 2025 TAR showed no behaviors were documented on the anti-psychotic behavior monitor between 07/12/225 -07/14/2025 (the period of the GDR). Review of the EHR showed the only documentation that Resident 13 demonstrated a TB was in the 07/14/2025 nurses note in which the resident indicated their frustration was related to call light response time. During an interview on 09/11/2025 at 9:31 AM, Staff B, Director of Nursing Services (DNS), acknowledged that Resident 13's physicians orders, care plans, consents and the psychotropic drug and behavior reviews documented conflicting indications for the use (diagnoses) for hydroxyzine, mirtazapine and citalopram, the specific TBs medications were implemented to treat were not identified or were inconsistent, and staff failed to complete behavior monitoring for mirtazapine and citalopram in July, August and September 2025. Staff B said the indication for use and the specific TBs a medication was initiated to treat should be clearly and accurately identified, documented and consistently monitored. Staff B indicated the lack of behavior monitoring could detract from staff's ability to determine effectiveness of the medication and need for continued use. When asked if Resident 13 exhibiting one episode of increased anxiety and/or agitation (associated with frustration about call light response) was sufficient to determine the quetiapine GDR had failed Staff B, DNS, stated, No. 2) Resident 44 was admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident had diagnoses of anxiety disorder, depressive disorder and unspecified dementia, and was severely cognitively impaired. Resident 44 had a physician's order, dated 05/15/2025, for Trazadone (an antidepressant), given once (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily at bedtime for insomnia. The EHR documented no side effect monitoring for the Trazadone order. On 09/10/2025 at 10:30 AM, Staff B, DNS, said staff should have been documenting if side effects were or were not observed for Resident 44's Trazadone. 3) Resident 26 was admitted to the facility on [DATE] with diagnoses of severe dementia with agitation and anxiety disorder. Review of the Admissions MDS, dated [DATE], showed they had severely impaired cognition (mental processes), had behaviors of rejection of care and verbal behaviors that affected others, and were taking antianxiety, antidepressant, and antipsychotic medications. Review of Resident 26's EHR, showed they had a behavior monitor in place for dementia/anxiety, but no other behavior monitor order was found for what behaviors each medication was treating. Resident 26's antidepressant medication, being given for antianxiety purposes, did not have consent, behavior monitor orders, or adverse side effect orders. For Resident 26's antipsychotic medication, being given for dementia with behaviors, they did not have orders for behavior monitors or adverse side effect monitors. For Resident 26's anticonvulsant medication (medication that primarily treats seizures but can also treat anxiety), prescribed for antianxiety purposes, they did not have behavior monitors or adverse side effects. Resident 26's anticonvulsant/antianxiety mediation had an as needed order. Review of the MAR/TAR from 09/01/2025 to 09/07/2025, showed it was given on 09/01/2025, 09/02/2025, 09/04/2025, 09/05/2025, 09/06/2025, 09/07/2025. Resident 26's anticonvulsant/antianxiety as needed order did not include an NPI monitor to track that NPI was given before the as needed medication. During an interview on 09/09/2025 at 1:57 PM, Staff E, Resident Care Manager, was asked to review Resident 26's EHR for NPI usage for their as needed anticonvulsant/anxiety medication for 09/02/2025, 09/06/2025, and 09/07/2025. Staff E confirmed there was no NPI usage found in the documentation for the three dates. Staff E was unable to find consent for the antidepressant medication, was unable to find behavior monitors specific to what each medication was treating, and was unable to find side effect monitors for the three medications reviewed. Reference WAC 388-97 -0620 (1)(a) -1060 (3)(k)(i) .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to provide a transfer notice and written bed hold notice at the time of transfer to the hospital, for 3 of 3 sampled residents (Resident 24, 73 & 2) reviewed for hospitalization. This failure placed residents at risk for not knowing their rights to transfers or of bed holds while in the hospital and a diminished quality of life.Findings included .RESIDENT 24Resident 24 was admitted to the facility on [DATE]. The 5 Day Minimum Data Set (MDS, an assessment tool) dated 09/05/2025, documented Resident 24 was cognitively intact.Resident 24 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. The electronic health record (EHR) had no documentation Resident 24 was provided with a transfer notice or a bed hold notice at the time of the transfer. RESIDENT 73Resident 73 was admitted to the facility on 07/082025. The admission MDS, dated [DATE], documented Resident 73 was cognitively intact.Resident 73 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. Resident 73 had a second transfer to the hospital on [DATE] and did not return to the facility. The EHR had no documentation Resident 73 was not provided with a transfer notice or a bed hold notice at the time of either transfer.RESIDENT 2Resident 2 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 2 was cognitively intact.Resident 2 had multiple hospitalizations in the past year on the following dates:09/08/2024-09/24/202405/09/2025-05/12/202505/26/2025-05/29/202508/28/2025-08/31/2025The EHR documented Resident 2 was not provided with a transfer notice or a bed hold notice for any of the listed transfers.On 09/10/2025 at 10:30 AM, Staff B, Director of Nursing Services, said when a resident is transferred to the hospital, they were sent with an emergency packet that included the transfer notice and the bed hold policy. In the event the resident was being sent to the hospital in an emergency, social services were responsive for reaching out the resident or the resident representative the following day to provide the bed hold notice and it would be documented in the EHR. When shown all the listed transfers above, Staff B said all transfer notices and bed holds should have been completed. Reference WAC 388-97-0120.

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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 bowel care in accordance with physician orders and the facility bowel protocol for 2 of 6 residents (Residents 6 & 36) reviewed for bowel management, to replace tube feeding syringes every 24 hours as ordered for 1 of 1 resident (Resident 79) reviewed for tube feeding, and to ensure non-pharmacological interventions (NPIs, non-medication interventions aimed to decrease pain) were attempted prior to administration of as needed (PRN) pain medication for 2 of 5 residents (Residents 44 & 26) reviewed for unnecessary medications. These failures placed residents at risk for unmet care needs, possible complications, and a diminished quality of life.Findings included.Review of the facility's Living Bowel Care Protocol policy, dated October 2020, showed if a resident did not have a bowel movement (BM) for three days (must be a medium or large BM) the following would occur.a) The evening shift nurse would administer Milk of Magnesia (MOM).b) If there were no results from MOM, the day shift nurse would administer a Dulcolax suppository.c) If there were no results from the Dulcolax suppository, a Fleet enema would be administered. d) If there were no results from the Fleet enema, the nurse would complete a focused abdominal assessment and digital exam and notify the physician if needed.BOWEL PROTOCOL 1) Resident 6 was admitted to the facility on [DATE] and had a diagnosis of constipation. The Annual Minimum Data Set (MDS-an assessment tool), dated 08/07/2025, documented the resident was cognitively intact. A review of the electronic health record (EHR) documented Resident 6 did not have a BM from 08/12/2025 – 08/16/2025 (5 days). Resident 6 had orders for:- Bisacodyl Oral Tablet, Polyethylene Glycol Powder and 2 Senna Tablets twice a day for constipation- Milk of Magnesia (MOM) every 24 hours as needed for no BM x3 days- Polyethylene Glycol Powder as needed for constipation no BM x3 days- Bisacodyl Rectal Suppository as needed for constipation once daily for no BM x3 days and MOM ineffective- Mineral Oil Rectal Enema as needed for constipation for no bm x3days and MOM and Bisacodyl suppository ineffective A review of August 2025 Medication Administration Record (MAR) documented Resident 6 refused MOM on 08/15/2025. On 09/10/2025 at 10:33 AM, Staff E, Resident Care Manager (RCM) said Resident 6 did not have a BM from August 12th – 16th and they refused the MOM on August 15. Staff E said the nursing staff should have reapproached Resident 6 and offered MOM again, completed a bowel assessment, and notified the provider. Staff E said it should have been documented in a progress note. On 09/11/2025 at 9:17 AM, Staff B, Director of Nursing Services (DNS), said the nursing staff should have documented the refusal in a progress note and performed an abdominal assessment. 2) Resident 36 was admitted to the facility on [DATE]. Review of the resident's physicians' orders showed the following bowel care orders: - MOM, as needed, if no BM for three days, dated 11/01/2023. - Dulcolax suppository, as needed, if MOM was ineffective, dated 11/01/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Fleet mineral oil enema, as needed, if Dulcolax suppository was ineffective. May repeat two times, dated 08/09/2024; and - Dulcolax tablets- administer two tablets every 24 hours as needed for constipation, dated 03/31/2025. Resident 36's July and August 2025 bowel records showed they went from 07/27/2025 – 08/01/2025 (6 days) without a BM. Review of the July and August 2025 Medication Administration Records (MARs) showed Resident 36 was administered Dulcolax two tablets on 07/30/2025 at 8:43 PM. The bowel record showed Resident 36 had no results from the Dulcolax and continued without a BM for the remainder of 07/30/2025, 07/31/2025 and 08/01/2025. No further as needed bowel medications were administered. Review of Resident 36's EHR showed there was no abdominal assessment documented between 07/27/2025 – 08/01/2025. On 09/11/2025 at 9:31 AM, when asked if facility nurses provided Resident 36 bowel care in accordance with the physicians' orders and facility bowel protocol, Staff B, DNS, stated, No, not that I see. Staff B said when Resident 36 did not have results from the Dulcolax tablets administered on evening shift, a Dulcolax suppository should have been administered on day shift. TUBE FEEDING SYRINGE 3) Resident 79 was admitted to the facility on [DATE] and had a diagnosis of pancreatic cancer and aftercare following surgery on the digestive system. On 09/09/2025 at 5:48 AM, it was observed that a 60 cubic centimeter (cc- a unit of volume) syringe in a graduated container was dated 09/06/2025 at the bedside of Resident 79. On 09/09/2025 at 8:00 AM, it was observed at Resident 79's bedside a syringe dated 09/06/2025 in a container. On 09/09/2025 at 8:05 AM, Staff H, Licensed Practical Nurse (LPN), said the syringe was dated 09/06/2025 and she would throw it away. Staff H said the syringe should be changed every day. On 09/11/2025 at 9:17 AM, Staff B, DNS, said a syringe and graduated container that was being used for tube feeding should be replaced every 24 hours. NON PHARMACOLGICAL INTERVENTIONS 4)Resident 44 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 44 was severely cognitively impaired. Resident 44 had an order for tramadol; 50 milligrams as needed for pain. The order also instructed staff to provide NPIs to reduce pain and document effectiveness, as followed: 1-Repositioning, 2-Relaxation, 3-Diversional Activities, 4-Food/Beverage, 5-Blanket/Sweater. The August 2025 Treatment Administration Record (TAR), documented Resident 44 was given (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tramadol 25 times, with no NPIs attempted or documented. The September (1st-9th) 2025 TAR documented Resident was given Tramadol 5 times, with no NPIs attempted or documented. On 09/10/2025 at 10:30 AM, Staff B, DNS, said the order was entered incorrectly; it should have said non-pharmacological interventions. Staff B said staff were not documenting NPIs and should have been when administering PRNs. 5) Resident 26 was admitted to the facility on [DATE] with a diagnosis of severe dementia with agitation. Review of the Admissions MDS, dated [DATE], showed they had severely impaired cognition (mental processes), and were receiving both scheduled and as needed pain medication. Review of Resident 26's EHR, showed they were receiving an as needed opioid pain medication. Review of Resident 26's MAR/TAR, showed the as needed opioid pain medication was given on 09/06/2025 and 09/07/2025 without any NPIs documented. During an interview on 09/09/2025 at 1:57 PM, Staff E, RCM, acknowledged there were no NPIs documented in Resident 26's chart related to the two as needed administrations listed above. Reference WAC 388-97-1060 (1)-1060 (3)(k)(i) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. .Based on observation and interview, the facility failed to ensure drugs and biologicals were labeled and dated in accordance with accepted professional standards of practice, and expired medications were discarded for 1 of 2 medication rooms and 1 of 2 medication carts (300 Hall medication room and medication cart) that were observed. These failures placed residents at risk to receive expired medications and negative health outcomes.Findings included . 300 Hall Medication CartObservation of the 300-hall medication cart on 09/10/2025 at 2:40 PM with Staff K, Licensed Practical Nurse (LPN), revealed the following expired and/or undated medications:1) Resident 37's glargine insulin pen (prefilled injection device containing a long-acting type of insulin used to manage blood sugar level) was opened and undated. Review of the pharmacy quick reference guide showed glargine insulin pens were to be discarded 28 days after opening.2) Resident 62's atropine eye drops had an open date of 08/22/2024. Review of the package insert showed the eye drops were to be discarded 180 days after opening.3) Resident 4's card of Ondansetron was expired, with a discard date of 08/25/2025.On 09/10/2025 at 2:40 PM Staff K, LPN, confirmed the above medications were opened and undated or past their discard dates and needed to be disposed of. 300 Hall Medication RoomObservation of the 300-hall medication room on 09/10/2025 at 2:47 PM with Staff K, LPN, revealed the following: 1) Resident 80's Humulin R insulin pen was opened and undated, which was verified by Staff K, LPN. Review of the pharmacy's quick reference guide showed Humulin R insulin pens should be discarded 28 days after opening.Reference WAC 388-97-1300(2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the staff failed to maintain infection control practice by transporting linen covered and performing hand hygiene when delivering clothes from room to room in 4 of 4 hallways (100, 200, 300 and Transitional Care (TC)) observed. These failures placed all residents at risk of an infection and diminished health.Findings included.On 09/07/2025 at 12:44 PM, Staff J, Laundry Aide, was observed delivering personal clothes down the 100 hallway from a rolling basket style cart with a stack of clothes layered onto each other inside the cart. The cart contained personals and was uncovered. Staff J was observed delivering resident clothes to room [ROOM NUMBER] and then 105. Staff J, touched the hangers in room [ROOM NUMBER] and took them out of the room and hung them on the cart. Staff J did not perform hand hygiene before going into room [ROOM NUMBER] where Staff J brought out empty hangers. Staff J was not observed performing hand hygiene before going into room [ROOM NUMBER] where they assisted the resident in finding their clothes and removed the hangers and brought them out of the room. Staff J was not observed performing hand hygiene as they came out of the room, before they grabbed clean clothes and went into room [ROOM NUMBER]. Staff J was not observed performing hand hygiene when coming out of room [ROOM NUMBER]. Staff J brought hangers out of room [ROOM NUMBER], took a blanket into room [ROOM NUMBER], and did not perform hand hygiene. On 09/09/2025 at 10:57 AM, Staff I, Laundry Aide, was observed transporting towels and clothing protectors and draw sheets in a basket with wheels down the 300 hallway to the linen closet that connects TC and the 300 rooms to the 100 and 200 rooms. The linen cart was not covered. Staff I said they were transporting linen from the laundry room to the linen closet. On 09/09/2025 at 2:38 PM, Staff G, Environmental Services Supervisor, said that he saw Staff I transporting the linen uncovered and said, I saw it and I have already given [Staff I] an in-service. Staff G said the linen should have been covered with a sheet and it was not covered. Staff G said when staff were going from room to room delivering resident's clothes, the staff should hand sanitize between rooms when delivering the personal items.On 09/11/2025 at 8:55 AM, Staff I, was observed coming out of the laundry room with a basket on wheels, transporting linen uncovered to the clean linen closet in the hallway that connects TC and the 300 rooms to the 100 and 200 rooms.On 09/11/2025 at 8:55 AM, Staff I was observed transporting the linen cart, uncovered down the TC hallway, outside the laundry room. On 09/11/2025 at 9:17 AM, Staff B, Director of Nursing Services, said there should be a sheet placed over the cart as staff were transporting and delivering personals and linen in the hallways.On 09/11/2025 at 10:14 AM, Staff I was observed transporting resident clothing in a cart, uncovered, down TC hallway to the 300 hallway.Reference WAC 388-97-1320 (1) (c), (3)