STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 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 ensure a system by which residents received required written notices at the time of transfer and/or discharge, or as soon as practicable, for 4 of 4 residents (Residents 71, 102, 6, & 12), offer a bed hold for 1 of 4 residents (Resident 6), and call report to receiving facility for 1 of 4 residents (Resident 6) reviewed for hospitalization and discharge. Failure to provide residents with a written notification and offer a bed hold placed them at risk of being uninformed about their rights and a discharge that was not in alignment with the resident's stated goals for care and preferences. Failure to call report to the receiving facility, at the time of transfer, placed residents at risk of a break in continuity of care and a diminished quality of life.Findings included .<Facility Policy>The facility's August 2018 Transfer or Discharge policy showed residents and/or their representatives would be informed in writing of the reason for and date of the transfer or discharge. The policy showed, for emergent transfers, the notification would be provided as soon as practical. The policy showed staff would notify the receiving facility that the transfer was being made.The facility's October 2022 Bed-Holds and Returns policy showed residents and/or their representatives would be provided written information regarding the facility's bed hold process, both upon admission and at the time of transfer. The policy showed, for emergent transfers, the facility would provide this notification within 24 hours. <Resident 71> Review of Resident 71's health records showed they were transferred to an acute care hospital on [DATE]. Review of Resident 71's health records showed the facility did not provide a written transfer notification to Resident 71. <Resident 102> Review of Resident 102's health records showed they transferred to an acute care hospital on [DATE] and no written transfer notification was provided to them or their representative. <Resident 6> Review of Resident 6's health records showed they were transferred to an acute care hospital on [DATE] and 04/16/2025. Resident 6's health records showed the facility did not provide a written transfer notification or the bed hold policy to Resident 6 or their guardian for either transfer. Resident 6's health records showed report was not called to the receiving hospital for the 02/20/2025 transfer. In an interview on 07/28/2025 at 12:00 PM Staff L (admission Coordinator) stated a bed hold policy was not provided to Resident 6 or their representative for the 02/20/2025 or 04/16/2025 transfers (continued on next page)

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
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but should have been. In an interview on 07/28/2025 at 12:44 PM Staff E (RCM) stated they were unable to provide documentation that a report was called to the receiving hospital for Resident 6's transfer on 02/20/2025. Staff E stated it was important to call report to receiving hospital to ensure good continuity of care. <Resident 12> According to the 01/21/2025 and 03/01/2025 Discharge Return Anticipated MDS, Resident 12 discharged to the hospital on [DATE] and again on 03/01/2025 related to a change in the resident's condition. The MDS showed Resident 12 had medical conditions including kidney failure and heart failure. Record reviews showed no documentation facility staff provided Resident 12 or their representative a written notification of the reason for transfer to the hospital as required. In an interview on 07/28/2025 at 11:50 AM, Staff C (Social Service Director) stated the admission staff were responsible for providing the transfer/discharge notices. In an interview on 07/28/2025 at 12:00 PM, Staff L stated they were responsible for offering a bed hold notice to residents/representatives during hospitalizations. Staff L stated nursing staff were responsible for written notice sending with residents. In an interview on 07/28/2025 at 12:30 PM, Staff F (RCM) stated they notify a resident's family about transferring residents to the hospital and send e-interact form to the hospital with residents. Staff F stated they were not aware of providing written notifications to residents and/or their representatives. In an interview on 07/28/2025 at 12:50 PM, Staff B (Director of Nursing) stated they sent only the e-interact form with residents to the hospital. Staff B was not aware of providing the transfer/discharge notice to residents and/or their representatives during hospitalizations. Staff B stated the facility should but did not provide Residents 71, 102, 6, & 12 the required written transfer/discharge notice. REFERENCE: WAC 388-97-0120(2)(a-d)(3)(a)(4), -0140(1)(a((b)(c)(i-iii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Pre-admission Screening and Resident Review (PASRR) assessments were completed as required for 4 (Residents 26, 7, 5, & 9) of 6 residents reviewed for PASRR screening. Facility staff failed to ensure Level 1 PASRR screenings were accurate and/or obtained prior to a resident's admission to the facility, and/or failed to ensure Level 2 PASRR evaluations were obtained on admission or after identification that a level 2 was required. These failures placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included. <Facility Policy>The facility's July 2024 PASRR policy showed the purpose of a PASRR assessment was to ensure residents with mental health or intellectual disabilities were appropriately placed and received the services they required. The policy showed PASRRs would be reviewed annually or during a significant change in condition, and Social Services was responsible.<Resident 26> According to the 06/02/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 26 had diagnoses including severe vascular dementia with behavioral disturbance, a mood disorder, and a cognitive (memory/thought process) communication deficit. The MDS showed Resident 26 received antipsychotic medications on a routine basis and took antidepressant medications. Review of progress notes dated 11/7/2024, 11/12/2024, 11/13/2024, 11/15/2024, 11/19/2024, 12/10/2024, 02/05/2025, 03/04/2025, 03/07/2025 and 03/10/2025 showed Resident 26 had periods of agitation and irritability and had refusals of care. Review of Resident 26 ‘s corrected 05/01/2024 Level 1 PASRR screening showed staff identified the resident required a referral for a Level 2 PASRR due to having a Serious Mental Illness (SMI) and noted on the form that a Level 2 PASRR was never sent as required. Review of Resident 26's records did not include a Level 2 PASRR referral. In an interview on 07/28/2025 at 12:21 PM Staff C (Social Services Director) stated they were aware that level 2 PASSR referrals were not completed by the facility but should have been. Staff C stated they made a referral in April 2025 for Resident 26 but still did not receive a detemination. <Resident 7> According to the 06/18/2025 Quarterly MDS, Resident 7 had diagnoses including a progressive cognitive function disorder, anxiety, depression, a psychotic disorder, a chronic brain disorder that could severely impact a person's thoughts, feelings, and behaviors, and post-traumatic stress disorder. The MDS showed Resident 7 received antipsychotic, antianxiety, and antidepressant medications during the look back period. Review of Resident 7's 04/11/2025 corrected Level 1 PASRR screening showed staff identified the resident required a referral for a Level 2 PASRR evaluation due to their SMI. In an interview on 07/29/2025 at 8:13 AM Staff C reviewed Resident 7's records and stated no Level 2 PASRR was completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 5> According to a 06/11/2025 admission MDS, Resident 5 admitted to the facility on [DATE] and had multiple complex diagnoses including a mental illness characterized by extreme mood swings, anxiety, and depression. This MDS showed Resident 5 required the use of an antidepressant medication during the assessment period. Record review showed Resident 5 admitted from the hospital with a 06/03/2025 Level 1 PASRR. Section 1 of this Level 1 PASRR showed the resident had an SMI indicator of a mood disorder. The last section of the form showed Resident 5 required a Level 2 evaluation referral for the SMI identified. Review of Resident 5's records showed the Level 2 evaluation was not entered into the resident's records as required until 06/16/2025, 11 days after Resident 5 was admitted to the facility. In an interview on 07/29/2025 at 9:20 AM, Staff C stated PASRR evaluations were important to ensure a resident's mental health was properly managed and/or to identify if the resident needed any additional services. Staff C stated PASRRs should be scanned into the resident's records on admission. Staff C reviewed Resident 5's Level II PASRR and stated it did not come with Resident 5 on admission. Staff C stated if a Level II PASRR was completed it should have been obtained on admission. <Resident 9> According to a 06/27/2025 admission MDS Resident 9 admitted to the facility on [DATE] and had multiple medically complex diagnoses including anxiety and depression and required the use of antidepressant medication during the assessment period. Record review showed Resident 9 admitted from the hospital with a 06/21/2025 Level 1 PASRR that showed the resident had an SMI indicator of a mood disorder and showed no Level II evaluation was indicated at that time due to an exempted hospital discharge. The hospital exemption showed a physician certified that Resident 9 would likely require fewer than 30 days at the facility and showed a Level II must be completed if the scheduled discharge does not occur. Review of Resident 9's records showed the resident was not discharged from the facility within 30 days and no Level II PASRR was completed. In an interview on 07/29/2025 at 9:20 AM, Staff C stated it was their expectation if a resident was not discharged before the 30 days occurred, a new Level 1 should be submitted, with a referral for a Level II requested, if a resident had SMI indicators. Staff C stated they did not complete a new Level 1 PASSR screening after Resident 9 remained in the facility longer than 30 days but should have. REFERENCE: WAC 388-97 -1915 (1)(2)(a-c).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 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 assist residents with Activities of Daily Living (ADLs - personal hygiene, grooming, bathing, eating etc.) for 6 residents (Resident 77, 31, 99, 79, 8, & 28) of 8 dependent residents reviewed for ADLs. The failure to provide ADL assistance to dependent residents as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes. Findings included . <Facility Policy>According to the facility's revised March 2018 Supporting ADLs policy, residents would be provided with the care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.<Resident 77> According to the 07/08/2025 Annual Minimum Data Set (MDS – an assessment tool) Resident 77 had medically complex conditions including heart failure, a history of stroke, and a progressive condition causing cognitive decline. Resident 77 was dependent on staff for personal hygiene, toileting hygiene, and lower body dressing. Review of the revised 08/2024 ADL self-care performance deficit Care Plan (CP) showed Resident 77 had deficits related to weakness, a history of stroke, and gait imbalance. The CP showed staff were to provide one-person assistance with personal hygiene. Review of Resident 77's care staff task documentation from 07/01/2025 through 07/23/2025 showed staff documented personal hygiene care provided daily for all shifts. There were no documented refusals of personal hygiene by Resident 77 on any shift. Observation on 07/22/2025 at 9:27 AM showed Resident 77 had long fingernails extending one quarter inch past the fingertip with some fingernails chipped. Resident 77 stated they would like their fingernails trimmed. Observation on 07/24/2025 at 12:01 PM showed Resident 77 fingernails extended one quarter inch past their fingertips. Resident 77's right thumbnail was long, jagged, dry, and cracked. In an interview on 07/28/2025 at 8:34 AM Staff E (Resident Care Manager - RCM) observed Resident 77's fingernails and stated they were a little long. Resident 77 told Staff E they would like their nails to be cut. In an interview on 07/29/2025 at 10:04 AM Staff E stated nurses should provide nail care weekly. Staff E stated they do not currently have a schedule for residents' nail care if a resident was not diabetic. Staff E stated nail care was not on the caregiver task sheet, not on the medication or the treatment administration records, and not specified on the CP, but should be so nurses knew to provide nail care. <Resident 31> According to the 07/13/2025 Quarterly MDS, Resident 31 had significant difficulty in their thinking abilities. The MDS showed Resident 31 had diagnoses of a brain bleed, a progressive cognitive function (memory/thought process) disorder, and a need for assistance with their personal care. The MDS showed Resident 31 was dependent on staff for ADLs including oral hygiene, toileting, bathing, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, and personal hygiene. Review of Resident 31's physician's orders showed a 03/21/2022 order directing licensed nurse staff to perform nail care every Monday. Observation on 07/23/2025 at 9:04 AM showed Resident 31 with their fingernails extending past their fingertips with white debris under their nails. In an observation and interview on 07/24/2025 at 8:35 AM, Resident 31's fingernails continued to be long in length and contained white debris underneath the nails. Resident 31 stated they did not like their nails long and their nails needed to be cut. Observation on 07/25/2025 at 10:26 AM showed Resident 31's nails continued to be long. Review of Resident 31's July 2025 treatment administration record on 07/28/2025 at 12:52 PM showed licensed nursing staff signed that nail care was performed for the resident that day. In an observation and interview on 07/28/2025 at 2:08 PM, Resident 31's nails remained long and unchanged from previous observations. Staff E confirmed Resident 31's nails were long. <Resident 99> According to a 07/15/2025 admission MDS, Resident 99 had severe memory impairment, was dependent on staff for personal hygiene, and had no rejection of care during the assessment period. Observations on 07/22/2025 at 9:06 AM and 07/25/2025 at 7:36 AM showed Resident 99's fingernails extended past their fingertips with dark debris underneath. Review of a revised 07/18/2025 self-care performance CP showed Resident 99 required total assistance from staff for personal hygiene. In an interview on 0725/2025 at 1:15 PM, Staff N (RCM) observed Resident 99's fingernails and stated they should have, but were not trimmed by staff and free of debris. <Resident 79> According to a 07/14/2025 admission MDS, Resident 79 had clear speech, required moderate assistance from staff for personal hygiene, and had no rejection of care during the assessment period. In an observation on 07/23/2025 at 10:02 AM, Resident 79 was unshaven with many chin hairs forming a full beard. In an interview at this time, Resident 79 stated they did not receive any assistance with shaving from staff since their admission and preferred to be, “clean shaven.” Observation on 07/25/2025 at 10:53 AM showed Resident 79 was still unshaven. Review of a revised 07/08/2025 self-care performance CP showed Resident 79 required assistance from staff for personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 07/24/2025 at 2:09 PM, Staff P (Registered Nurse) confirmed Resident 79 was unshaven and asked the resident if they wanted assistance with shaving. Resident 79 stated yes, and then expressed happiness to the nurse that it would be done. In an interview on 07/29/2025 at 10:22 AM, Staff N stated it was their expectation staff assisted residents with their ADLs, including shaving and nailcare. Staff N stated assistance with ADLs was important for a resident's dignity and made the residents feel better about themselves. <Resident 8> According to the 06/19/2025 Quarterly MDS, Resident 8 admitted to the facility on [DATE] after a stroke with right-sided weakness. The MDS showed Resident 8 required moderate assistance from staff with personal hygiene and was totally dependent on staff for showers and toileting. The MDS showed Resident 8 had no rejection of care during the assessment period. Review of a 06/05/2025 revised Self Care Performance Deficit CP showed Resident 8 had limited mobility related to weakness and hemiplegia. The CP included directions for staff to assist Resident 8 with showers and personal hygiene. Observation on 07/22/2025 at 12:43 PM and on 07/24/2025 at 8:58 AM showed Resident 8 lying in their bed, in the same white T shirt with long broken fingernails. In an interview on 07/25/2025 at 10:23 AM, Staff F (RCM) stated staff should provide morning care ADLs to all residents including personal hygiene, dress them up and clip resident's nails weekly and as needed. In an interview on 07/28/2025 at 11:07 AM, Staff I (Registered Nurse) stated Resident 8 needed assistance with all ADLs including transfers, toileting, bathing and personal hygiene including nail care. Staff I stated they did not get a report from staff that Resident 8 refused care. In an interview on 07/28/2025 at 12:53 PM, Staff B (Director of Nursing) stated they expected staff to provide ADL care every morning to all dependent residents including oral care, shaving, dressing, and assistance to get out of bed as residents allowed, but staff did not. <Resident 28> According to the 06/15/2025 Quarterly MDS, Resident 28 admitted to the facility on [DATE] after a stroke with left-sided weakness, heart failure, and kidney failure. The MDS showed Resident 28 required maximal assistance from staff with personal hygiene including shaving and nail care, was totally dependent on staff for bathing and toileting, and had no rejection of care during the assessment period. Review of a 09/22/2023 revised Self Care Performance Deficit CP showed Resident 28 had limited mobility related to weakness, stroke, and impaired balance. The CP interventions showed Resident 28 required one-person maximal assistance from staff with person hygiene including shaving and nail care. Observations on 07/22/2025 at 1:14 PM, on 07/23/2025 at 9:13 AM, and on 07/24/2025 at 1:02 PM showed Resident 28 lying in bed in hospital gown with long broken fingernails, and facial hair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/24/2025 at 1:02 PM, Resident 28 stated they liked to have their chin hair shaved but staff did not have time for that. Resident 28 stated they liked their fingernails to be long and did not want staff to clip their fingernails. In an interview on 07/25/2025 at 10:23 AM, Staff F stated it was their expectation that staff provide shaving assistance to residents as needed every shift when they saw hair growth. In an interview on 07/28/2025 at 11:10 AM, Staff I stated Resident 28 needed assistance with all ADLs including transfers, toileting, bathing, and personal hygiene including shaving. In an interview on 07/28/2025 at 12:53 PM, Staff B stated they expected staff to provide morning care to all residents including oral care, shaving, dressing, and getting them up in their wheelchair as residents allowed but staff did not. REFERENCE: WAC 388-97-1060(2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review the facility failed to provide Restorative Nursing Programs (RNP) as residents were assessed to require for 6 of 8 residents (Resident 8, 11, 1, 6, 7, & 31) reviewed for position and mobility. This failure placed residents at risk for decline in mobility and Range of Motion (ROM), functional status, and other negative health outcomes.Findings included.<Facility Policy>According to the facility's July 2017 Restorative Nursing Services Policy, residents would receive restorative nursing care, as needed, to help promote optimal safety and independence. The policy showed restorative goals and objectives would be resident-centered and outlined in the resident's Care Plan (CP).<Resident 8> According to the 06/19/2025 Quarterly Minimum Data Set (MDS, an assessment), Resident 8 had impairment of functional limitation in ROM on both legs. The MDS showed Resident 8 was dependent on staff for dressing and transfers from bed to chair, required substantial assistance from staff for rolling side to side in bed, and had no rejection of care during the assessment period. Review of Resident 8's 01/25/2025 revised Risk for decrease mobility and ROM CP directed to staff to provide an active ROM RNP for both arms three to six times a week and sit to stand from the wheelchair using the walker for both legs three to six times a week. Observations on 07/22/2025 at 12:50 PM, 07/23/2025 at 9:23 AM, and on 07/25/2025 at 1:54 PM showed Resident 8 lying in their bed and stated they did not get up in their wheelchair for a while. Review of July 2025 RNP documentation showed Resident 8 received their both of their assigned RNPs for their arms and legs on 7 of 27 opportunities each. In an interview on 07/28/2025 at 9:27 AM, Staff V (Restorative Nursing Aide) stated they were unable to provide Resident 8's programs due to their workload and the resident's refusals. Staff V stated they should document the refusals and notify their supervisor, but they did not. In an interview on 07/28/2025 at 11:33 AM, Staff H (Restorative Coordinator) stated they were aware of staff not providing the RNP to residents as assigned. Staff H stated they were in the process of hiring another restorative aide so they could provide assigned programs to residents. <Resident 11> According to the 07/06/2025 Annual MDS, Resident 11 had right sided weakness and a right-hand contracture (tightening of muscles or other tissues causes the joints to become very stiff). The MDS showed Resident 11 participated in a ROM RNP for four days, a splinting/brace RNP for zero days during the seven-day lookback period, and had no rejection of care. Review of a 05/16/2024 Self Care Deficit CP showed Resident 11 had right sided weakness and a contracture of their right wrist. The CP had no documented care directions or interventions for staff to provide care to the contracted right hand and no RNP assigned to prevent worsening the contracture. Review of Resident 11's July 2025 physician orders showed no order to apply a splint/brace to their right contracted hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 07/22/2025 at 12:25 PM, on 07/23/2025 at 8:17 AM and 1:52 PM, on 07/24/2025 at 10:22 AM, and on 07/28/2025 at 1:20 PM showed Resident 11 was sitting in their wheelchair and not wearing a splint on their right hand. In an interview on 07/25/2025 at 10:30 AM, Staff V stated Resident 11 did not have a RNP for their right-hand contracture. In an interview on 07/25/2025 at 11:53 AM, Staff W (Rehab Director) reviewed Resident 11's record and stated there was no documentation or RNP for Resident 11's right hand contracture. Staff W stated Resident 11 was screened quarterly and did not have any documentation about their right hand contracture. In an interview on 07/28/2025 at 12:25 PM, Staff H stated RNPs were important to maintain a resident's functional ability, prevent decline, and to prevent contractures. Staff H stated staff should assess the resident for contractures and refer to the rehabilitation for program, but they did not. In an interview on 07/29/2025 at 9:31 AM, Staff B (Director of Nursing) reviewed Resident 11's record and stated there was no RNP or treatment for the resident's right hand contracture. Staff B stated staff should assess the resident for their right hand contracture and should have a program for a right hand brace under the RNP to prevent the contracture from worsening, but they did not. <Resident 1> According to the 04/24/2025 admission MDS, Resident 1 had functional limitation in ROM to one side, on both, upper and lower extremities (arm and leg). The MDS showed Resident 1 had a diagnosis of, but not limited to, falls with fractures. Review of Resident 1's records showed a 05/08/2025 risk for decreased mobility/impaired functional ROM to left upper extremity and both lower extremities related to multiple fractures with pain CP. The CP showed Resident 1 would receive a RNP of active ROM services and ambulation three to six times a week. Resident 1's records showed the RNP for May 2025 was not offered the first week and only offered once the second week. Resident 1's RNP for June 2025 was only offered twice in the first week, twice the third week, and twice the fourth week. Resident 1's RNP for July 2025 was only offered twice in the first and second week. Resident 1's RNP was not offered the minimum of three times a week they were assessed to require for the three months reviewed. In an observation and interview on 07/22/2025 at 11:55 AM Resident 1 was sitting on the edge of their bed. Resident 1 and their representative stated they were not offered the RNP “very often” and felt like they needed these services to maintain their mobility. Resident 1's representative stated the resident admitted to the facility due to falls with multiple fractures and they were concerned about the resident's mobility declining due to lack of exercise and movement. Resident 1's representative stated the resident had falls in the facility since admission due to attempting to ambulate on their own, without assistance. <Resident 6> According to the 06/02/2025 Quarterly MDS, Resident 6 had functional limitation in ROM to one side, on both, upper and lower extremities. The MDS showed Resident 6 had diagnoses of, but not limited to, stroke, left lower extremity fracture, need for assistance with personal care, and other (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abnormalities of their gait and mobility. Review of Resident 6's records showed a 04/03/2025 actual impaired mobility/impaired functional ROM to bilateral upper and lower extremities CP. The CP showed Resident 6 received RNP passive and active ROM services. The RNP showed Resident 6 was to be offered the services three to six times a week. Resident 6's RNP for May 2025 showed they were only offered services twice during the second week. Resident 6's RNP for June 2025 showed they were only offered services once during the first week, twice during the second week, twice during the third week, and once during the fourth week. Resident 6's RNP for July 2025 showed they were only offered services once the first and second week, twice the third week, and once the fourth week. Resident 6's RNP was not offered the minimum of three times a week they were assessed to require for the three months reviewed. In an observation on 07/22/2025 at 12:28 PM Resident 6 was sitting up in a wheelchair alone in their room. Resident 6 showed decreased ROM to bilateral upper and lower extremities. In an interview on 07/28/2025 at 8:11 AM Staff S (Restorative Nursing Aide - RNA) stated Residents 1 and 6 were assessed to require a RNP three to six times a week was not offered at the minimum of three times a week. Staff S stated they had too large of a workload and when they went on vacation, the other RNA was required to offer all RNPs ordered in the facility, but this was impossible. Staff S stated management was aware the RNPs were not being offered and believed they were attempting to hire more RNAs. Staff S stated additional staff were not scheduled to assist with the completion of the RNPs ordered throughout the facility to ensure all residents were offered their RNP at a minimum of three times a week. In an interview on 07/29/2025 at 10:41 AM Staff B stated they were aware of RNPs not getting offered as the residents were assessed to require. Staff B stated the RNP was short staffed. Staff B stated the RNP was important to maintain functional mobility and ROM. <Resident 7> According to the 06/18/2025 Quarterly MDS, Resident 7 had diagnoses including history of a brain bleed, weakness to one side of their body, and contractures to both hands. The MDS showed the resident had functional limitation in ROM to one upper extremity and both lower extremities. Resident 7 participated in a RNP and received Active Range of Motion (AROM) on seven days during the look back period. Review of a 06/18/2025 “…actual/and at risk for decreased mobility/contractures/impaired functional [ROM]…” CP showed an intervention that staff would provide Resident 7 with an AROM RNP to their upper and lower extremities three to six time per week. Observation on 07/23/2025 at 8:47 AM showed Resident 7 lying in bed. The resident had bilateral contractures to their hands/fingers. Review of Resident 7's June 2025 task documentation showed for the week of 06/01/2025 to 06/07/2025, staff provided the resident with their RNP on one occasion, not three to six times as care planned. Review of Resident 7's July 2025 task documentation showed from 07/01/2025 to 07/07/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed staff provided the RNP to the resident zero times. From 07/08/2025 to 07/14/2025, staff provided the RNP to Resident 7 on two occasions. From 07/15/2025 to 07/21/2025, staff provided the RNP to Resident 7 on two occasions. From 07/22/2025 to 07/28/2025, staff provided the RNP to Resident 7 on one occasion. Resident 7's July 2025 task documentation showed staff did not provide the RNP three to six times per week as care planned. <Resident 31> According to Resident 31's 07/13/2025 Quarterly MDS, the resident had diagnoses of a brain bleed, weakness to one side of their body, and required assistance with personal care. The MDS showed Resident 31 had functional limitation in range of motion to both upper and lower extremities and received a RNP once during the look back period. Review of an 11/29/2023 revised “…[RNP]…” CP showed an intervention that staff provide an AROM RNP to Resident 31 three to six times weekly. The CP showed staff would assist the resident to perform seated AROM to Resident 31's bilateral lower extremities. Review of Resident 31's May 2025 task documentation showed from 05/01/2025 to 05/07/2025, staff provided the resident with their RNP on two occasions. From 05/08/2025 to 05/14/2025, staff provided the RNP once. From 05/15/2025 to 05/21/2025, Staff provided the RNP twice. Resident 31 did not receive their RNP three to six times weekly as care planned during those three weeks. Review of Resident 31's June 2025 task documentation showed from 06/01/2025 to 06/07/2025 staff provided the RNP to the resident twice. From 06/08/2025 to 06/14/2025, staff provided the RNP once. From 06/15/2025 to 06/21/2025, staff provided the RNP twice. From 06/22/2025 to 06/30/2025, staff provided the RNP twice. Resident 31 did not receive their RNP three to six times weekly as care planned during the month of June. Review of Resident 31's July 2025 task documentation showed from 07/01/2025 to 07/07/2025, staff did not provide the RNP at all. From 07/15/2025 to 07/21/2025, staff provided the RNP twice. From 07/22/2025 to 07/28/2025, staff provided the RNP once. Resident 31 did not receive their RNP three to six times per week during those weeks as care planned. In an interview on 07/28/2025 at 12:18 PM, Staff H confirmed Resident 7 and Resident 31 should receive their RNPs as care planned but were not. Staff H stated the RNP was important to help prevent functional decline and improve activities of daily living function if possible. REFERENCE: WAC 388-97-1060(3)(d)(j)(ix).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to: ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 2 residents (Resident 71 & 77) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms); ensure staff used appropriate Hand Hygiene (HH) during resident care for 4 residents (Resident 31, 7, 28, & 79) who were observed for care; ensure staff followed Transmission Based Precautions (TBP - a set of infection control practices used to prevent the spread of infectious agents, in addition to standard precautions) for 1 resident (Resident 79) of 1 reviewed for TBP; and ensure the facility was free of uncleanable surfaces for 2 residents (Resident 17 & 71). These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases. Findings included .<Facility Policy>A review of the facility's September 2022 Isolation policy showed, when a resident was placed on precautions, appropriate signage would be placed on the entrance door of their room to alert staff and visitors of necessary measures. The policy showed staff would implement precautions when residents experienced loose stools to reduce the increased risk of environmental contamination and transmission of the pathogen, even before it has been officially identified. The policy showed staff would change gloves after having contact with infective material (including body fluids, stool) to prevent cross contamination.According to the facility's October 2023 Hand Hygiene policy, HH was to be performed before touching a resident, after contact with blood, body fluids, contaminated surfaces, or the resident's environment, and immediately after glove removal. The policy stated the use of gloves did not replace hand washing and HH.<Enhanced Barrier Precautions> <Resident 71> According to the 04/25/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 71 had the inability to control blood sugar levels, venous insufficiency (condition in which veins struggle to return blood to the heart), a history of a skin infection of their left lower limb, and used a wheelchair. Review of the 01/23/2025 EBP Care Plan (CP), showed Resident 71 had chronic venous (pertaining to the vein) ulcers. The CP goal was to minimize the risk of spreading multidrug resistant infection or potential infection. Staff were to put on a gown and gloves during dressing, personal hygiene, and when changing linen. Observation on 07/22/2025 at 8:52 AM showed an EBP sign posted on the door of Resident 71's room. The sign directed everyone entering the room to wear gloves and a gown for high contact care such as dressing and bathing. Observation on 07/24/2025 at12:21 PM showed Staff E (Resident Care Manager - RCM) assisting Resident 71 with their socks. Staff E did not have gloves or a gown on during care. <Resident 77> According to the 07/08/2025 Annual MDS, Resident 77 had a condition that required the use of an indwelling catheter (flexible tube inserted in the bladder). Review of the 06/07/2025 EBP CP showed Resident 77 had an indwelling catheter and staff were to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	put on gloves and a gown when providing care such as dressing, bathing, personal hygiene, and catheter care. Observation on 07/22/2025 at 8:52 AM showed an EBP sign was posted on Resident 77's door. The sign directed everyone entering the room to wear gloves and a gown for high contact care such as dressing and bathing. Observation on 07/24/2025 at12:22 PM showed Staff E moving Resident 77's catheter to the side of their bed; Staff E did not have a gown on. In an interview on 07/29/2025 at 1:13 PM Staff U (Licensed Practical Nurse - LPN) stated for EBP rooms, staff had to make sure they wore PPE including gloves and gowns before providing direct care. <Hand Hygiene> <Resident 31> Observation on 07/25/2025 at 10:30 AM showed Staff X (Certified Nursing Assistant - CNA) and Staff Y (CNA) providing incontinence care to Resident 31 for a bowel movement. Staff Y was observed to wipe Resident 31 clean. Staff Y removed their soiled gloves and put on new gloves without performing HH after wiping bowel movement. Staff Y wiped Resident 31 again, grabbed a skin barrier ointment from Resident 31's bedside drawer while wearing the soiled gloves, and applied the skin barrier ointment to the resident. Staff X and Staff Y placed a clean brief on Resident 31 and both staff assisted the resident to turn by touching the resident's legs and back with their soiled gloves. Staff Y, while continuing to wear the soiled gloves, covered Resident 31 with their blankets. Staff X removed their gloves and grabbed the trash bag containing the soiled brief and wipes. Staff X exited the resident's room with the trash bag, took the trash bag to the soiled utility room, exited the soiled utility room and entered a different resident's room and washed their hands in that resident room. In an interview on 07/25/2025 at 10:43 AM, Staff Y confirmed they did not perform HH after removing their soiled gloves and before putting on new gloves. Staff Y stated they should have done HH before putting on clean gloves. <Resident 7> Observation on 07/28/2025 at 10:00 AM showed Staff Z (LPN) performing a dressing change to Resident 7. Staff Z removed the old, soiled dressing and then removed their soiled gloves. Staff Z put on a new pair of gloves without performing HH after they removed the soiled gloves. Staff Z cleansed Resident 7's wound and prepared a new dressing for the resident. Staff Z removed their gloves and put on a new pair of gloves without performing HH. Staff Z applied a clean dressing to Resident 7. In a joint interview on 07/28/2025 at 1:35 PM, Staff B (Director of Nursing) and Staff T (Regional Director of Quality Assurance) stated it was their expectations staff performed HH when changing their gloves between dirty and clean tasks. <Resident 28> Observation on 07/28/2025 at 9:01 AM showed Staff J (CNA) providing incontinent care to Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28. Staff J was wearing disposable gloves, grabbed wipes, and provided incontinent care to Resident 28 who had a bowel movement. Staff J cleaned the resident, removed the soiled gloves, put clean gloves on, grabbed clean brief from the nightstand, put that on the resident, fixed the bedding, and covered the resident with a clean blanket. Staff J completed all care including incontinent care and making the bed without performing HH between dirty and clean areas. In an interview on 07/28/2025 at 9:37 AM, Staff J stated they changed their gloves in between but did not wash their hands after changing the soiled gloves. Staff J stated they should have washed their hands in between the dirty and clean care. In an interview on 07/28/2025 at 9:43 AM, Staff F (RCM) stated they expected staff to change their gloves and perform HH between dirty and clean care. Staff F stated HH was very important to prevent the spread of infections in the facility. <Resident 79> Observations on 07/25/2025 at 10:12 AM showed Staff EE (CNA) providing incontinence care for Resident 79. Staff EE, while wearing gloves, picked up a package of wet wipes, removed the soiled brief, and began cleaning Resident 79's front and back side. Upon finishing, and without removing the soiled gloves, Staff EE opened a drawer to put the wipes away, touched the bedside table with the soiled gloves, and then removed the right glove. Staff EE then went over to the door, touched the handle, and opened the door with their soiled glove on the left hand. Staff EE removed the soiled left glove and put on a new pair of gloves, without performing HH. Staff EE assisted Resident 79 with getting a new brief on, during the process a bandage started coming off the resident's right elbow and Staff E, using the same gloves, reapplied the bandage. Staff EE finished providing care and touched the resident's bed controller while wearing the same soiled gloves. Observations on 07/25/2025 at 10:27 AM, showed Staff FF (LPN) providing wound care to two different sites for Resident 79. Staff FF cleansed each wound, changed gloves after each site prior to applying new dressings, but did not perform HH between glove changes. In an interview on 07/28/2025 at 12:50 PM, Staff D (Infection Preventionist) stated it was their expectation HH be performed between glove changes to decrease the risk of spreading infection. <TBP> <Resident 79> Record review showed a 07/26/2025 progress note with documentation by staff that Resident 79 was being monitored for having loose bowel movements. The note stated Resident 79 reported having watery stools, the provider was notified, and an order was obtained to test a sample for an infection of the colon. Observations on 07/28/2025 at 7:59 AM showed no TBP sign at Resident 79's door. In an interview on 07/28/2025 at 12:50 PM, Staff D stated it was their expectation staff would initiate TBPs for a resident having loose stools when testing was ordered to rule out a contagious infection. Staff D stated they were unaware of any residents currently being tested related to loose, watery stools. Staff D reviewed Resident 79's records and confirmed staff documented symptoms, a sample (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was sent to the lab, and results were not received back yet. Staff D stated Resident 79 should have but was not placed on TBP while waiting for testing to be completed. In an interview on 07/28/2025 at 1:13 PM, Staff N (RCM) stated they were unaware Resident 79 was having loose stools and being tested for an infection. Staff N stated the resident should be isolated until test results were received. <Uncleanable Resident Equipment> <Resident 17> Observation on 07/22/2025 at 10:01 AM showed Resident 17 sitting in their wheelchair in their room. The leather arm rests on Resident 17's wheelchair were torn and wrapped with tape. The foam material was wrapped with tape leaving the surface uncleanable. In an interview on 07/24/2025 at 10:21 AM, Staff I (Registered Nurse) stated the wheelchair armrests should be changed for Resident 17 because it was difficult to clean the foam and sticky area with tape on both armrests. <Resident 71> Observation on 07/29/2025 at 9:30 AM showed Resident 71's motorized wheelchair cushions on the arm, foot, and seat cushions were worn down, torn, and had sections where the cover and cushion below was either missing or was exposed. There was dirt and debris along the back of the wheelchair. In an interview on 07/29/2025 at 1:13 PM Staff U stated the staff helped to maintain the wheelchair for Resident 71 and motorized wheelchairs were not sent to maintenance. Staff U stated the nursing staff sanitized the wheelchair but did not report the wheelchair needed repair. Staff U stated it was difficult to clean the wheelchair because of the condition it was in, being torn and worn down. Staff U stated the wheelchair could harbor infections because the staff could not totally sanitize it. REFERENCE: WAC 388-97-1320(1)(a)(c)(2)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review the facility failed to provide a comfortable, appropriately sized bed for 2 of 2 residents (Resident 71 & 77) reviewed for accommodation of needs. This failed practice placed residents at risk for discomfort and skin issues.Findings included .<Facility Policy>According to the facility's February 2021 Homelike Environment policy, residents would be provided a safe, comfortable, and homelike environment emphasizing comfort, personal needs and preferences. <Resident 71>According to a 04/25/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 71 had obesity, chronic wounds to their lower legs, and impairments to both of their lower extremities. The MDS assessment showed Resident 71 was fully dependent on staff to move from their bed to their wheelchair and to move from lying to a sitting position on the side of the bed. Review of the revised 06/23/2025 Activities of Daily Living Care Plan (CP) showed a goal for Resident 71 to maintain their current level of function in bed mobility and transfers. Staff were to provide 2-person maximum assistance with dressing daily, and assistance with transferring.Review of July 2025 caregiver task sheets showed staff assisted Resident 71 daily with dressing and grooming, and provided range of motion exercises three times per week.In an interview on 07/22/2025 at 8:54 AM, Resident 71 stated there was a problem with their bed being lopsided on the left side of their bed. Resident 71 stated this made it harder for them to get up off the bed when they were transferred and stated they told staff about this, but so far nothing was done to fix their bed. Resident 71 stated they would tell staff again. Observation at this time of the left side of the bed showed the bed tilted upwards (lopsided) towards the foot of the bed in comparison to the right side of the bed.Observations on 07/23/2025 at 8:53 AM and on 07/24/2025 at 8:29 AM showed Resident 71 lying in bed and the foot of the bed tilted upward. In an interview on 07/28/2025 at 8:35 AM Staff E (Resident Care Manager) observed Resident 71's bed was lopsided. Staff E stated they were not aware of the bed being lopsided. Staff E looked under the mattress and observed the small metal bar used to secure the mattress in place was under the foot of the mattress instead of along the side of the mattress which elevated the foot of the mattress. Staff E pushed the metal bar down so it would fit along the mattress and stated the mattress cover was also not zipped properly which also caused the mattress to partially stick and also contributed to the mattress being lopsided. In an interview on 07/29/2025 at 10:18 AM Staff E stated it was important to maintain Resident 71's bed for safety and comfort, so the bed did not impede Resident 71's circulation. Staff E stated staff should have reported this to the nurse. <Resident 77>According to the annual 07/08/2025 MDS assessment, Resident 77 had non-Alzheimer's dementia, history of stroke, muscle weakness, and needed assistance with personal care.Review of the revised 08/20/2024 ADL self-care performance deficit CP showed Resident 77 had limited mobility due to weakness. The CP showed staff were to assist with bed mobility and monitor for complaints of back pain. Observation on 07/23/2025 at 8:53 AM showed Resident 77 was in bed with their knees slightly bent and their head above the top of their mattress.Observation and interview on 07/24/2025 at 12:01 PM showed Resident 77 stated their bed was too small and they would like to be able to extend their legs. Observation on 07/24/2025 at 8:40 AM showed Resident #77 legs were bent towards the edge of the bed and their feet were firmly against the footboard of the bed. Resident 77 stated they were tall in height and needed a longer bed. Observation on 07/25/2025 at 8:36 AM showed Resident 77 scrunched up in bed, with their legs bent at the knees and their feet pressed firmly against the footboard of their bed. The resident was unable to straighten their legs. Resident 77's head rested on a pillow on the arm of their wheelchair next to their bed. When asked why they rested their head on a pillow on the wheelchair, Resident 71 stated they needed to sleep and tried to stretch their legs but was unable to straighten them. In an interview on 07/29/2025 at 10:18 AM Staff E confirmed Resident 77's bed was not long enough for Resident 77 to straighten their legs and stated they would ask if the facility had a longer bed or could adjust the length of the bed. Staff E stated Resident 77's bed should be comfortable for their comfort and for the safety of the resident. REFERENCE: WAC 388-97-0860(2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure walls and blinds in resident rooms were maintained in a homelike condition for 6 of 19 sample resident rooms (Rooms 211-1, 214-1, 220, 201, 106 & 118) and failed to ensure resident's personal property was kept safe for 1 of 2 residents (Resident 8) reviewed for personal property. These failures left residents at risk for a less than homelike environment, loss of personal property and a diminished quality of life.Findings included .<Facility Policy>Review of the facility's revised February 2021 Homelike Environment policy showed residents should be provided with a safe, clean, comfortable, and homelike environment and would be encouraged to use their personal belongings to the extent possible.room [ROOM NUMBER]-1> Observation on 07/22/2025 at 11:51 AM showed room [ROOM NUMBER]-1 had scratched paint on the wall next to the resident's bed. The toilet seat cover in the resident's bathroom was scratched with a large patch of paint peeling along the front of the seat. The inside of the toilet bowl was stained brown. The bathroom ceiling tiles had a large brown stain. <room [ROOM NUMBER]-1> Observation on 07/22/2025 at 10:15 AM showed room [ROOM NUMBER] had a large white paint patch that did not match the color of the rest of the paint on the wall near the resident's chair. <room [ROOM NUMBER]> Observation on 07/24/2025 at 12:00 PM showed the wood railing on the wall near room [ROOM NUMBER]'s doorway, located by the power wheelchair, had large paint gouges on the railing. In an observation and interview on 07/29/2025 at 10:40 AM Staff O (Maintenance Assistant) stated staff should report all maintenance issues through their in-house maintenance system so maintenance staff could address the issues. Staff O observed room [ROOM NUMBER] and stated the toilet seat should be replaced and the ceiling tiles in the bathroom should also be replaced. Staff O observed room [ROOM NUMBER] and stated the wall behind the resident's chair looked like someone started to repair the paint but did not complete the work. Staff O observed the railing on room [ROOM NUMBER] and stated the wood railing scratched by the wheelchair should be repainted and repaired. Staff O stated all these items needed to be reported to maintenance so staff could repair these items for residents' comfort and safety. <room [ROOM NUMBER]> Observation on 07/23/2025 at 8:50 AM of room [ROOM NUMBER] showed the the wall behind bed B had paint scraped off near the head of the bed. The ceiling tiles above the window had a large brown stain. In an observation and interview on 07/29/2025 at 10:52 AM, Staff O confirmed the wall needed repainting and the ceiling tile needed replacement. <room [ROOM NUMBER]> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 07/22/2025 at 9:31 AM showed parts of the trim around the window in room [ROOM NUMBER] broken off leaving jagged edges. The area with the missing trim had small nails still sticking out. <room [ROOM NUMBER]> Observations on 07/22/2025 at 2:10 PM showed window trim missing on the bottom and left side of the window in room [ROOM NUMBER]. The area with the missing trim had small nails sticking out. Observations at this time showed a dark stain on the ceiling tile above the window. In an interview on 07/29/2025 at 12:34 PM, Staff T (Regional Director of Quality Assurance) stated an environment in good repair was important to ensure a homelike environment for the residents. Staff T confirmed the trim was broken/missing and the nails were sticking out in both room [ROOM NUMBER] and 118. Staff T stated the nails could be a potential risk for injury and stated the trim and ceiling tile stain should be fixed. REFERENCE: WAC 388-97-0880.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review the facility failed to initiate, investigate, and resolve grievances for 2 of 2 residents (Resident 1 & 8) reviewed for missing personal property. This failure placed residents at risk for emotional distress and a diminished quality of life.Findings included.<Facility Policy>The Facility Administrator stated they did not have a grievance policy. According to the facility policy Resident Rights revised in February 2021, residents have the right to voice their grievances to the facility without discrimination and without fear of discrimination.According to a facility policy titled, Personal Property, dated August 2022, the facility would promptly complete an investigation of misappropriation of resident's property. <Resident 1> According to the 04/24/2025 admission Minimum Data Set (MDS – an assessment tool) Resident 1 had clear speech and was usually understood and usually understood others. The MDS showed Resident 1 had moderate memory impairment and had a family representative listed as the primary respondent. Review of Resident 1's health records showed a 04/18/2025 inventory list with full dentures listed. Review of a 05/12/2025 Grievance form showed Resident 1's full upper and lower dentures were missing. The form showed staff were unable to locate the missing dentures so the Social Service Director (SSD) would contact Resident 1's representative to coordinate a replacement of the full upper and lower dentures. In an interview on 07/22/2025 at 10:37 AM Resident 1 and their representative stated their full upper and lower dentures were missing for “about two and a half months and they had not heard anything further about how the facility would replace them.” Resident 1's representative stated the resident could only have soft foods until they got the dentures replaced. In an interview on 07/29/2025 at 8:46 AM Staff C (SSD) and Staff G (Social Service Assistant) stated they did not have a copy of the grievance form and were unaware that the SSD was to coordinate a replacement for Resident 1's missing upper and lower dentures. In an interview on 07/29/2025 at 9:35 AM Staff A (Administrator) stated they understood the SSD had made a referral for Resident 1's missing upper and lower dentures and this was a miscommunication. Staff A stated Resident 1, and their representative to be updated, and the missing upper and lower dentures to be resolved by now. Staff A stated it was important for the missing dentures to be replaced so Resident 1 could eat regular textured foods. <Resident 8> According to the 06/19/2025 Quarterly MDS Resident 8 had clear speech and was able to make themselves understood. The MDS showed Resident 8 had intact memory and demonstrated no behavior. In an interview on 07/22/2025 at 12:53 PM, Resident 8 stated someone took their personal bottle of lotion and their personal reacher more than a month ago. Resident 8 stated they told multiple staff members about missing their personal property, but nothing had happened yet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 07/22/2025 at 12:59 PM, showed no bottle of lotion in Resident 8's room. In an interview on 07/25/2025 at 11:37 AM, Staff F (Resident Care Manager) stated Resident 8 told staff about missing their bottle of lotion and reacher a week or so ago, but the facility did not replace the lotion bottle. Staff F stated the facility gave Resident 8 a plastic reacher, but the resident did not like the device. Staff F stated they would expect staff to initiate the grievance process when a resident complained of missing items. Review of an updated grievance log on 07/25/2025 showed no grievance was documented for Resident 8. In an interview on 07/28/2025 at 10:40 AM, Staff C stated they would expect staff to initiate the grievance form and notify Staff A (the grievance officer) for a resolution. Staff C stated they have not heard about Resident 8 missing items. In an interview on 07/28/2025 at 1:43 PM, Staff A stated they have not received any grievance for Resident 8's missing items. Staff A stated staff should have initiated a grievance form to replace Resident 8's missing items, but the facility did not. REFERENCE: WAC 388-97-0460.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review, the facility failed ensure residents were free from physical restraints for 1 of 1 residents (Resident 99) reviewed for physical restraints, and 1 supplemental resident (Resident 7). The failure to obtain a physician's order prior to use of a physical restraint, and evaluate to ensure least restrictive measures were in place placed the resident at risk for entrapment, injury, decreased range of motion and decreased quality of life.Findings included .<Facility Policy>According to the facility's March 2015 Restraint and Device Guideline policy, the facility would maintain resident safety by avoiding unnecessary use of safety devices. If a safety device was considered necessary, staff would complete an assessment, obtain a physician's order, and obtain informed consent from the resident or their representative. The safety device would be implemented with appropriate staff education and Care Plan (CP) revision.<Resident 99> According to a 7/15/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 99 had a memory problem, highly impaired vision, and was dependent on staff to roll from side to side in their bed. This MDS showed Resident 99 had multiple diagnoses including a Traumatic Brain Dysfunction, cataracts, a history of falls, and no restraints were used for Resident 99 at the time of the assessment. Review of the physician's orders showed a 07/11/2025 order for a perimeter mattress, a 07/14/2025 order for a fall mat, and a 07/22/2025 order for a concave mattress. There were no other orders related to potentially restraining devices. According to a 07/11/2025 assistive devices CP, Resident 99's goal was to remain free from complications related to restraint use. This CP showed Resident 99 needed their bed with a perimeter mattress (a mattress with built up edges) against the wall, bed brakes locked, and a fall mat placed next to the bed to prevent injury from falls. This CP did not identify any other potential restraints. Record review showed facility staff completed the following safety device evaluations: a 07/09/2025 consent and assessment for Resident 99's bed against the wall and fall mat, a 07/10/2025 consent and assessment for the perimeter mattress, and a 07/21/2025 consent and assessment for a tiltable wheelchair that could function as a restraint when tilted. Observations on 07/22/2025 at 9:06 AM showed Resident 99 in their bed with two pillows placed between the perimeter mattress and the bed frame that tilted the mattress laterally and had the potential to restrict the resident's movement. Observations on 07/24/2025 at 1:45 PM showed Resident 99 in bed with two pillows placed between the perimeter mattress and the bed frame. Resident 99's family member was present in the room at the time and clarified they did not place the two pillows under the mattress. In an interview and observation on 07/24/2025 at 1:47 PM, Staff B (Director of Nursing) confirmed pillows were under Resident 99's mattress and stated any intervention that had the potential to restrain a resident's movement required assessment, consent, and a physician's order to minimize the associated risks. Staff B stated if Resident 99 required the placement of two pillows under their mattress, it was considered a restraint, there should be an order, consent, an assessment, and it should be included on the resident's CP. Staff B stated Resident 99 had several falls, was at risk for falls, and required the use of pillows under the mattress. No further observations were made of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pillows placed under Resident 99's mattress. In an interview on 07/29/2025 at 12:03 PM, Staff B stated pillows placed under a mattress could be perceived as a restraint, create increased risks for injury, and would expect an assessment, consent, and CP prior to being used by staff. <Resident 7> According to a 06/18/2025 Quarterly MDS, Resident 7 had diagnoses including a progressive loss of memory and cognitive function and weakness to one side of their body. This MDS showed Resident 7 was being treated for a pressure ulcer and no restraints were being used for at the time of the assessment. Observations on 07/24/2025 at 9:01 AM showed Resident 7 lying in bed. There was a pillow stuffed between the resident's bed frame and the mattress, propping the mattress up on the right side. Review of the physician's orders showed there were no orders directing staff to place pillows under Resident 7's mattress. Review of the revised 06/26/2025 “skin breakdown” CP showed staff should place a pillow on the open side of Resident 7's mattress for right hand resting comfort but included no direction to place pillows under the mattress. Record review showed no assessment was completed or consent obtained related to the pillows placed under Resident 7's mattress. In an interview on 07/29/2025 at 12:03 PM, Staff B stated pillows placed under a mattress could be perceived as a restraint, created increased risks for injury, and stated they expected an assessment, consent, and CP prior to being used by staff. REFERENCE: WAC 388-97-0620(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure 1 (Resident 12) of 5 residents and 1 supplemental resident (Resident 31) whose medication regimens were reviewed, were free of unnecessary psychotropic medications. This failure left residents at risk for unnecessary medications, adverse side effects and other negative health outcomes. Findings included . <Facility Policy>The facility's revised July 2020 Psychotropic Medication Use policy showed to improve residents' quality of life, residents with specific diagnoses would be provided psychotropic medication at the lowest effective dose and documented in resident's medical record. The policy showed the facility would use nonpharmacological interventions to minimize and allow discontinuation of the need for medication. Residents on psychotropic medications would receive gradual dose reduction (GDR), unless contraindicated, to discontinue these medications.<Resident 12> According to a 06/09/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 12 had multiple medically complex diagnoses including Alzheimer's dementia (a brain disorder that slowly diminishes memory and thinking skills). The MDS showed Resident 12 received an antipsychotic medication on seven of seven days during the assessment period and was assessed with no rejection of care during the assessment period. Review of the revised 05/14/2025 Behavior Care Plan (CP) showed Resident 12 had inappropriate behaviors of refusing medication/care, delusions, and paranoia. This CP included the interventions for staff to monitor behaviors, offer non-pharmacological interventions, and notify the physician if the resident's behavior interfered with their medical needs. Review of a Monthly Medication Review (MMR) completed on 06/07/2025 showed the facility's pharmacy provider recommended a Gradual Dose Reduction (GDR) of an antipsychotic medication. The facility provider declined the antipsychotic medication GDR and wrote that Resident 12 had stable behavior. Review of Resident 12's July 2025 physician's orders showed a 03/25/2025 order to administer an antipsychotic medication every day for vascular dementia with psychotic disturbance. The physician's order directed staff to monitor Resident 12 for behaviors of non-compliance with care, delusions, and paranoia and to document every shift. This order directed staff to provide nonpharmacological interventions and document in the resident's record. Review of Resident 12's July 2025 Medication Administration Record (MAR) on 07/28/2025 showed Resident 12 received antipsychotic medication on 11 days and refused on 16 days out of 27 days that month. The MAR showed staff documented Resident 12's non-compliance with care behavior only two times in 27 days. Review of the June 2025 MAR showed Resident 12 refused antipsychotic medications on 16 days out of 30 days. In an interview on 07/25/2025 at 12:32 PM, Staff F (Resident Care Manager) stated Resident had behaviors of refusing medications and care at times. Staff F stated Resident 12 was delusional in the past but they did not hear of any behavior for a while. Staff F stated the provider discontinued some of Resident 12's medications due to refusals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 - Few	In an interview on 07/29/2025 at 9:46 PM, Staff I (Registered Nurse) stated Resident 12 had refused all their medications. Staff I stated Resident 12 refused their antipsychotic medication almost day and staff did not know if the antipsychotic medication was effective or not. In an interview on 07/29/2025 at 10:26 AM, Staff B (Director of Nursing) explained the facility process was for staff to review each resident's medications and refer them to the pharmacist for an MRR to make sure residents did not receive unnecessary medications. Staff B stated Resident 12 had behaviors of refusing medications and care. Staff B reviewed Resident 12's MAR and stated the facility should have discontinued the antipsychotic medication but did not. <Resident 31> According to the 07/13/2025 Quarterly MDS, Resident 31 had diagnoses including a group of conditions that caused progressive cognitive decline and a psychotic disorder. The MDS showed Resident 31 did not show behaviors of psychosis or rejection of care during the assessment period. The MDS showed Resident 31 did not receive antipsychotic medications during the assessment period. Review of Resident 31's revised 01/20/2025 “Mood/Behavior/Psychosocial Issues” CP showed staff would monitor the resident's behavior as needed, monitor for side effects of psychotropic drug use if applicable, and notify the social services director of any decline in mood or behavior. Observation on 07/23/2025 at 9:04 AM showed Resident 31 lying quietly in bed. Observation on 07/25/2025 at 10:34 AM showed two Certified Nursing Assistants (CNAs) providing incontinence care to Resident 31. Resident 31 was calm and allowed the care. Observation on 07/28/2025 at 12:21 PM showed Resident 31 lying in bed, asleep. Similar observations were made at 2:08 PM. Review of a 07/24/2025 facility incident report showed Resident 31 alleged a staff member made fun of them and jumped on their bed. The facility's investigation concluded the allegation was not substantiated and showed a new intervention to re-initiate an antipsychotic medication due to an “increase in hallucinations.” The follow up of the investigation showed all staff members reported “similar accounts” of Resident 31's behaviors including confusion and increased occurrences of auditory and visual hallucinations since the antipsychotic medication was previously discontinued. Review of Resident 31's progress notes showed a 07/24/2025 physician note for the antipsychotic was previously discontinued on 06/14/2025. The note showed since the discontinuation of the antipsychotic medication, the nursing team reported intermittent aggressive behaviors. The note gave orders to staff to reinstate the antipsychotic medication. A 07/14/2025 physician progress note showed there were no reported auditory or visual hallucinations and Resident 31 was “currently stable without any psychotic behaviors” since the discontinuation of the antipsychotic medication. The note showed Resident 31 tolerated the discontinuation of the antipsychotic medication well without any “additional symptoms of behaviors and moods.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 - Few	Review of nurse progress notes dated 07/13/2025, 07/12/2025, 07/09/2025, 07/08/2025, and 07/07/2025 showed nursing staff documented Resident 31 did not have any behavioral issues noted on their shifts. Review of a 06/18/2025 nurse progress note showed Resident 31 did not have any behavioral changes related to the discontinuation of the antipsychotic medication. Review of Resident 31's comprehensive progress notes from 06/10/2025 to 07/23/2025 showed staff did not document any adverse behaviors of the resident. In an interview on 07/29/2025 at 10:53 AM, Staff Y (Certified Nursing Assistant) stated they primarily worked the day shift. Staff Y stated they did not recall any instances of Resident 31 having behaviors such as yelling out. Staff Y stated they often worked with Resident 31 and were able to anticipate the resident's needs. In an interview on 07/29/2025 at 11:56 AM, Staff B stated staff saw an increase in Resident 31's behaviors since the antipsychotic was discontinued and referred to the resident's recent allegation. Staff B stated it was their expectation nonpharmacological interventions were attempted prior to the re-initiation of the antipsychotic medication but staff did not do this. Staff B reviewed Resident 31's progress notes and confirmed there was a lack of documentation describing any behaviors the resident recently experienced. REFERENCE: WAC 388-97-0620 (1)(a).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review, the facility failed to ensure assessments accurately reflected residents' health status and/or care needs for 1 (Resident 26) of 19 reviewed for assessments. The failure to accurately assess residents' cognitive patterns placed residents at risk for unidentified and unmet care needs and a diminished quality of life.Findings included .<Facility Policy>According to the facility's revised November 2018 Dementia Protocol, the facility would review the current physical, functional, and psychosocial status of individuals with dementia, and would summarize the individual's condition, related complications, and functional abilities and impairments. The Interdisciplinary team would evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes. <Resident 26>According to the 06/08/2025 modified Quarterly Minimal Data Set (MDS - an assessment tool) Resident 26 had diagnoses of severe vascular dementia with behavioral disturbance, a mood disorder, and cognitive (memory/thought process related) communication deficit. The MDS showed Resident 26 was assessed with Brief Interview for Mental Status (BIMS) score of 15 out 15, indicating Resident 26 had no cognitive impairment. Review of Resident 26's 06/06/2025 BIMS evaluation showed Resident 26 was assessed with a score of 12 out of 15, indicating Resident 26 was moderately impaired. Review of previous BIMS evaluations showed on 03/11/2025 and 12/24/2024 Resident 26 was assessed with a BIMS of 99, indicating the evaluation could not be completed because Resident 26 could not participate in the BIMS evaluation. Review of a 06/23/2025 psychological evaluation showed the provider noted Resident 26 was nonverbal and did not engage or cooperate with the evaluation's questions. In an interview on 07/28/2025 at 12:33 PM Staff C (Social Services Director) stated they were responsible for completion of the BIMS evaluations for residents and to make sure the BIMS evaluation was done correctly. Staff C stated it was important to accurately evaluate a resident with cognitive impairment and the assessment would help to identify resident's needs. Staff C stated the BIMS evaluation completed on 06/06/2025 for Resident 26 was not accurate. In an interview on 07/28/2025 at 12:54 PM Staff BB (MDS nurse) stated it was very important for the MDS assessment to be accurate and for the BIMS assessment to be correct. In an interview on 07/28/2025 at 1:05 PM Staff H (MDS nurse) stated they were supposed to interview residents before they complete an MDS assessment. Staff HH stated they did not physically check Resident 26 when they completed the MDS assessment on 06/08/2025 and relied on the BIMS evaluation completed by Staff C on 06/06/2025 instead. In an interview on 07/29/2025 at 1:37 PM Staff B (Director of Nursing) stated the BIMS assessment had to be accurate as it related to cognitive deficit and for resident's care needs. Staff B stated the BIMS assessment was incorrect for Resident 26 and the assessment did not assess the resident correctly to accurately reflect Resident 26's cognitive decline and this could have had an impact on Resident 26's care. REFERENCE: WAC 388-97-1000 (1)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide baseline Care Plans (CP) to 2 (Residents 5, & 79) of 8 residents reviewed for care planning and 1 supplemental resident (Resident 99). The failure to provide residents and/or their representatives with a summary of their baseline CP placed residents and/or their representatives at risk for not being informed of their initial plan for the delivery of care and services, and placed residents at risk for unmet care needs.Findings included .<Resident 5>According to a 06/11/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 5 admitted to the facility on [DATE] with multiple complex diagnoses including fractures, end stage kidney disease, and respiratory failure.In an interview on 07/22/2025 at 2:16 PM, Resident 5 stated they did not have a meeting with staff to discuss their CP, were unsure what their current care goals were, and stated they did not get copies of any paperwork after admission.Review of a 06/05/2025 Baseline CP evaluation form, signed by staff on 06/06/2025, showed staff documented the baseline CP was not reviewed or provided to the resident and/or their representative and gave an explanation, the baseline plan of care was reviewed with the resident and the CP would be available upon completion and did not indicate the Baseline CP was provided to the resident within 24 hours as required.<Resident 99>According to a 07/15/2025 admission MDS, Resident 99 admitted to the facility on [DATE] with multiple medically complex diagnoses including fractures and a traumatic brain injury.Review of a 07/09/2025 Baseline CP evaluation form, signed by staff on 07/10/2025, showed staff documented the baseline CP was not reviewed or provided to the resident and/or their representative and documented the nurse reviewed the baseline CP with the resident's family and the CP would be available once completed and did not indicate the Baseline CP was provided to the resident within 24 hours as required.<Resident 79>According to a 07/14/2025 admission MDS, Resident 79 admitted to the facility on [DATE] with multiple medically complex diagnoses including heart failure, and end-stage kidney disease.In an interview on 07/23/2025 at 8:45 AM, Resident 79 stated the facility did not provide them with a copy of their baseline CP and they were unsure of what their goals were while in the facility.Review of a 07/08/2025 Baseline CP evaluation form showed staff documented the baseline CP was not reviewed or provided to the resident and/or their representative and documented the nurse reviewed the basic plan of care with family and in part with resident and the CP would be available once completed and did not indicate the Baseline CP was provided to the resident within 24 hours as required.In an interview on 07/29/2025 at 10:22 AM, Staff N (Resident Care Manager) stated they reviewed baseline CPs with residents at care conferences, which usually occurs the first week after admission, but stated it was not their standard practice to provide a copy to the residents and/or representatives.In an interview on 07/29/2025 at 11:33 AM, Staff DD (Admissions Nurse) stated they met with new residents within 48 hours and worked on introductions, reviewing and ordering medications, reviewing their history, advance directives. Staff DD stated they start the baseline CP but indicated they did not complete them within 48 hours.REFERENCE: WAC 388-97-1020 (3).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 comprehensive Care Plans (CPs) for 4 of 19 sample residents reviewed (Residents 99, 26, 77 & 1). This failure placed residents at risk of unmet care needs, frustration, and diminished quality of life. Findings included . <Facility Policy>According to the facility's March 2022 Comprehensive Person-Centered CP policy, the facility would develop a comprehensive, person-centered CP for each resident. The CP would be consistent with each resident's assessed needs, and should include objective, measurable goals.According to the facility's November 2018 Dementia - Clinical Protocol, the facility would identify and document the resident's condition and level of support needed during care planning to maximize remaining function and quality of life.<Resident 99> According to a 07/15/2025 admission MDS, Resident 99 had adequate hearing with the use of hearing aids or other hearing appliances. Review of Resident 99's revised 07/14/2025 communication Care Plan (CP) showed staff did not address the use of hearing aids or other hearing appliances. According to a 07/10/2025 physician's order, the nurse was to ensure both hearing aids were used daily during the day. Observations on 07/23/2025 at 8:26 AM and 10:22 AM, and on 07/24/2025 at 1:45 PM showed Resident 99 without hearing aids or other hearing appliances. In an interview on 07/24/2025 at 1:45 PM, Resident 99's family was visiting and stated the resident wore hearing aids, but the staff did not always help place them, and indicated the hearing aids were locked away when not in use. Observation on 07/25/2025 at 1:12 PM with Staff N (Resident Care Manager - RCM) showed Resident 99 without hearing aids or other hearing appliances. Staff N stated it was their expectation staff assisted Resident 99 to apply the hearing aids as directed in the CP. Staff N stated assisting residents with their hearing devices assisted with communication needs and their everyday living. Staff N stated Resident 99's CP should address any communication needs and/or what assistance was required. <Resident 26> According to the 06/02/2025 Quarterly MDS, Resident 26 had diagnoses of severe vascular dementia with behavioral disturbance, a mood disorder, a cognitive communication deficit, and malnutrition. Review of the revised 10/22/2024 Nutritional Problem CP showed Resident 26 had potential nutritional problems related to their mood disorder, traumatic brain injury, difficulty swallowing, and requests for multiple snacks. The goal listed in the CP showed Resident 26's weight would remain stable and staff were to provide the prescribed diet as ordered, check Resident 26's weight monthly, and get snacks from the kitchen or vending machine. Staff were also to explain /reinforce to Resident 26 the importance of maintaining the diet ordered and explain the consequences of refusals. The Nutrition Problem CP did not show Resident 26 had dementia, a malnutrition disorder, or a cognitive (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication deficit. The CP did not show when staff should offer supplements, what to do when Resident 26 refused meals, when to contact the provider regarding weight loss or refusal of meals or show how staff were to explain the consequences of not following the recommended diet to Resident 26 because of their cognitive communication deficit. Record review showed on 06/01/2025, Resident 26 weighed 129 pounds and on 07/28/2025, Resident 26 weighed 116 pounds, indicating a -10.08% loss in weight in less than two months. In an interview on 07/28/2025 at 1:29 PM Staff CC (Registered Dietician) stated they were responsible for updates to Resident 26's CP but did not update the Nutrition Problem CP with directions to provide supplements or showing that Resident 26 preferred noodles. In an interview on 07/29/2025 at 9:50 AM Staff E (RCM) stated staff offered food alternatives for nutrition for Resident 26. Staff E stated these alternatives were not listed in the CP but nurses should know to do this. Staff E stated Resident 26's CP should be updated to reflect alternatives, be personalized to Resident 26's needs and provide effective interventions for nutrition but was not. <Resident 77> According to the 07/08/2025 Annual MDS, Resident 77 had a history of a stroke, dementia, and cognitive (memory) deficits. Review of the 07/21/2025 Activities of Daily Living (ADL) Performance Deficit CP, Resident 77 had weakness. The goal listed on the CP showed Resident 77 would improve their current level of function in transfers, dressing, toileting, and ADL scores. Interventions listed on the CP showed staff were to provide one-person assistance with personal hygiene, but did not specify fingernail care. Observation on 07/22/2025 at 9:27 AM showed Resident 77 had long nails extending a quarter inch past the nail beds. Some of Resident 77's nails were chipped, Resident 77 stated they would like their nails to be cut. In an observation on 07/24/2025 at 12:01 PM Resident 77 nails extended a quarter inch past the nail bed. Resident 77's right thumbnail was long, jagged, dry, and cracked. In an interview on 07/29/2025 at 10:04 AM Staff E stated nurses should provide nail care weekly. Staff E stated they did not currently have a schedule for residents' nail care unless a resident was diabetic. Staff E stated nail care was not on the caregiver task sheet, not on the medication or treatment administration records, and not specified on the CP, but should be so nurses knew to provide nail care. In an interview on 07/29/2025 at 1:37 PM Staff B (Director of Nursing) stated the CP for residents with dementia should be individualized and articulate supervision, risks, communication deficits, triggers and care needs. The Dementia CP should also reflect appetite changes, and any notes captured in the Nutrition at Risk meetings but were not for Resident 26. <Resident 1> According to a 04/24/2025 admission MDS, Resident 1 admitted on [DATE]. The MDS showed Resident 1 had diagnoses including Non-Alzheimer's Dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/22/2025 at 11:49 AM Resident 1 did not know how to call staff using the call light and stated they waited for staff to walk by their room if they needed help. Resident 1's representative stated the resident didn't know how to use the call light due to their dementia and would do things on their own without asking staff for help when needed. Review of Resident 1's health records on 07/25/2025 showed no CP developed for their Dementia care. In an interview on 07/28/2025 at 12:44 PM Staff E stated Resident 1 did not have a resident-specific Dementia CP but should have. Staff E stated it was important to develop a resident-specific Dementia CP to instruct staff on the best ways to care for the residents. In an interview on 07/29/2025 10:41 AM Staff B (Director of Nursing) stated they expected staff to develop a CP addressing all areas of care affected by a resident's Dementia. REFER TO: F692-Nutrition/Hydration Status Maintenance; F677 – ADL Care Provided for Dependent Residents REFERENCE: WAC 388-97 -1020(1), (2)(a)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview the facility failed to ensure resident Care Plans (CPs) were updated as needed for 2 (Residents 11 & 28) of 19 sample residents, and failed to ensure the Interdisciplinary Team (IDT) attended resident care conferences to ensure residents could express their preferences and goals for 2 of 8 residents (Resident 39, & 5) reviewed for care conferences. These failures placed residents at risk for unmet care needs, and frustration. Findings included . <Facility Policy>According to the facility's March 2022 Comprehensive Person-Centered Care Plans, the IDT, in collaboration with the resident and their representative, would develop, implement, and revise a CP for each resident to address their physical, psychosocial, and functional needs. The policy showed the IDT would review and update the CP and conduct care conferences with the residents and their representatives at least quarterly (every 3 months). The policy showed residents were to be informed of their right to participate and given advance notice of conferences. If participation was not practicable, the medical record would be updated with the reason and efforts made to include the resident and/or representative.<CP Revision> <Resident 11> According to the 07/06/2025 Annual Minimum Data Set (MDS - an assessment tool), Resident 11 had clear speech and was able to make themselves understood. Resident 11 had multiple medically complex diagnoses including stroke (medical condition occurs when blood flow to the part of the brain is interrupted) with the right side of the body weakness and a right-hand contracture (tightening of muscles or other tissues causes the joints to become very stiff). The MDS showed Resident 11 required assistance from staff with personal hygiene and had no rejection of care during the assessment period. Observations on 07/22/2025 at 12:25 PM, on 07/23/2025 at 8:12 AM, on 07/24/2025 at 8:00 AM and 1:22 PM, and on 07/25/2025 at 11:00 AM showed Resident 11 seated in their wheelchair, with their right hand in their lap and no brace or splint on right hand. Resident 11 stated staff did not put any brace on their right hand. Review of a 06/16/2024 revised Self Care Deficit CP showed Resident 11 had a stroke with right side weakness and contracture of right wrist. The CP had no documented care directions or interventions for staff to manage the right-hand contracture. In an interview on 07/25/2025 at 12:21 PM, Staff B (Director of Nursing) stated staff should assess Resident 11 for right hand contracture and should update the CP with interventions, so staff could provide the better care to Resident 11 to prevent further damage, but they did not. <Resident 28> According to the 06/15/2025 Quarterly MDS, Resident 28 had multiple medically complex diagnoses including stroke with left side weakness, heart failure, and kidney failure. The MDS showed Resident 28 had a limitation in their range of motion on their left arm and both legs. The MDS showed Resident 28 required maximal assistance from staff with bed mobility and repositioning in bed and had no rejection of care during the assessment period. Review of Resident 28's July 2025 physician's orders showed a 07/31/2024 order directing staff to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apply compression socks to both lower legs in the morning and to remove them at bedtime for edema (swelling). Observations on 07/23/2025 at 10:30 AM, on 07/24/2025 at 8:39 AM, and on 07/28/2025 at 12:17 PM showed Resident 28 was lying in bed. Both feet were edematous. The resident was not wearing compression socks. Review of a revised 12/26/2024 Heart Failure CP showed staff should monitor for signs and symptoms of heart failure, including edema of Resident 28's legs and feet. The CP had no documented care directions or interventions showing staff what to do if they noticed edema on Resident 28's legs and feet. In an interview on 07/28/2025 at 9:19 AM, Staff I (Registered Nurse) stated Resident 28 had edema on both lower legs. Staff I stated Resident 28 refused to wear compression socks at times. In an interview on 07/28/2025 at 12:59 PM, Staff B stated the CPs were not updated according to Resident 28's current medical condition and refusals. Staff B stated they expected CPs to be accurate and revised timely so staff could provide better care for residents. <Care Conferences> <Resident 39> According to a 05/26/2025 Quarterly MDS Resident 39 had no memory impairment. The MDS showed Resident 39 received a therapeutic diet. The MDS showed Resident 39 had diagnoses including an iron deficiency, high blood pressure, chronic kidney disease, protein malnutrition, and adult failure to thrive. Review of Resident 39's health records showed a 05/07/2025 food preferences evaluation that only reflected the resident's restrictions caused by the resident's cultural/religious foods requirements. The evaluation did not identify the cultural/religious food preferences the resident requested. Resident 39's health records showed a 05/08/2025 care conference form showing they expressed some dislikes regarding the food at the facility. The care conference form showed only Staff F (Resident Care Manager) and Staff G (Social Service Assistant) were the only staff in attendance. In an interview on 07/22/2025 at 1:31 PM Resident 39 stated they spoke with several different staff requesting some of their cultural/religious food preferences and gave coconut as an example. Resident 39 stated they were told the facility could not provide any. In an interview on 07/28/2025 at 1:51 PM Staff F reviewed the care conference notes and stated they did not communicate Resident 39's food concerns to the dietary manager but should have. Staff F stated only the RCM and Social Service Assistant attended the care conferences. Staff F stated the dietary and activities departments did not attend care conferences. In an interview on 07/29/2025 at 10:47 AM Staff B stated they expected the IDT to attend resident care conferences. Staff B stated the IDT included the RCM, social services, therapy (if the resident received therapy services), activities, business office manager (only when needed), a representative from the dietary department, and a resident representative if appropriate. Staff B stated the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative from the dietary department should attend Resident 39's care conference so the dietary department would address any food concerns at the time of care conference, but they did not. Staff B stated it was important the IDT attended resident care conferences to give residents and their representatives an opportunity to discuss the resident's care directly with the appropriate department. <Resident 5> According to a 06/11/2025 admission MDS, Resident 5 had multiple medically complex diagnoses including fractures, end-stage kidney disease, and respiratory failure. This MDS showed Resident 5 had clear speech, made themself self-understood, and was able to understand others. In an interview on 07/22/2025 at 2:16 PM, Resident 5 stated they did not meet with the IDT team to discuss their CP and goals for discharge. Review of Resident 5's records showed a 06/12/2025 care conference form with documentation that only Staff DD (Admissions Nurse) and Staff C (Social Services Director) were in attendance with Resident 5. REFERENCE: WAC 388-97 -1020(2)(c)(d), 1020 (2)(d), (4)(c)(i-ii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure: nurses only signed for tasks completed for 1 of 19 sample residents (Resident 2), physician's orders were clarified as needed for 4 (Residents 7, 1, 12, & 5) of 19 sample residents, and failed to follow physician's orders for 1 of 19 sample residents (Resident 5). These failures placed residents at risk for medication errors, delayed treatment, receiving unnecessary medications, and adverse outcomes. Findings included . <Facility Policy>According to the facility's July 2016 Medication and Treatment Orders policy, staff were to administer medications in accordance with prescribers' written orders and, if necessary, staff would contact the prescriber for clarification. Staff were to document all interactions and order clarifications in the medical record, as appropriate.<Signing for Orders Not Completed> <Resident 2> Record review showed a 06/07/2025 pharmacist's recommendation for staff to obtain bloodwork for Resident 2. Review of Resident 2's June 2025 Medication Administration Record (MAR) showed staff signed the bloodwork was obtained on 06/17/2025. Review of Resident 2's “results” tab in their record showed no lab results for the June 2025 recommended bloodwork. Review of the facility's lab binder on 07/24/2025 at 1:54 PM showed there was no receipt for June 2025 or July 2025 indicating the lab obtained bloodwork. In an interview on 07/28/2025 at 2:05 PM, Staff E (Resident Care Manager - RCM) reviewed Resident 2's records and confirmed the lab was not collected as ordered. <Clarifying Physician Orders> <Resident 7> Review of Resident 7's physician's orders showed a 05/08/2025 order directing staff to administer an Over-the-Counter (OTC) pain relieving medication to the resident every eight hours as needed for pain. These physician's orders showed a 07/07/2025 order directing staff to administer an opioid pain-relieving medication to Resident 7 every six hours as needed for pain. These orders did not direct staff at what pain level to administer which medication. Review of Resident 7's May 2025 MAR showed staff administered the as needed OTC medication for pain levels of 4/10, 5/10, and 6/10 on a scale of 0-10 with 10 being the highest pain level. The May 2025 MAR showed staff administered the narcotic pain medication for pain levels of 2/10, 3/10, 4/10, 5/10, 6/10, 7/10, and 9/10. Review of Resident 7's June 2025 MAR showed staff administered the as needed OTC pain medication for pain levels of 4/10 and 5/10. This MAR showed staff administered the opioid medication for pain levels of 3/10, 4/10, 5/10, 6/10, 7/10, and 8/10. Review of Resident 7's July 2025 MAR showed staff administered the as needed OTC pain medication for pain levels of 2/10, 3/10, and 4/10. This MAR showed staff administered the opioid medication for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain levels of 3/10, 4/10, 5/10, 6/10, 7/10, and 8/10. In an interview on 07/28/2025 at 1:08 PM, Staff E confirmed the as needed OTC and as needed opioid pain medications should be clarified by the physician with parameters that directed staff at what pain level each of the medications should be given. <Resident 1> According to a 04/24/2025 admission MDS, Resident 1 admitted to the facility on [DATE]. Resident 1 had diagnoses including fractures and other multiple traumas with pain, renal insufficiency or failure, diabetes, nerve pain, and arthritis. Review of Resident 1's 04/18/2025 Chronic Pain Care Plan (CP) showed nurses should provide nonpharmacological interventions prior to administering pain medications. Review of Resident 1's physician's orders showed a scheduled medication for pain. Resident 1's physician's order for the pain medication did not include dose limitation parameters or documentation of nonpharmacological pain interventions to be administered prior to pain medication. Resident 1's physician's orders did not include an order to monitor for signs of Hypo/Hyperglycemia (low/high blood glucose levels). In an interview on 07/28/2025 at 12:44 PM Staff E stated they were expected to include nonpharmacological pain interventions in the body of the pain medication order for staff to document what they attempted prior to administering pain medications and maximum daily dose parameters. Staff E was not able to provide documentation to support nonpharmacological pain interventions that were attempted prior to pain medication administration for Resident 1. Staff E stated it was important to include nonpharmacological pain interventions and maximum dose limitations for residents receiving pain medication to ensure they weren't receiving medications unnecessarily and not receiving more than the maximum daily dose allotment. Staff E stated they expected staff to monitor and document signs and symptoms of hypo/hyperglycemia every shift. Staff E was unable to provide documentation showing staff monitored Resident 1 for signs and symptoms of hypo/hyperglycemia. In an interview on 07/29/2025 at 10:41 AM Staff B (Director of Nursing) stated they expected staff to document attempted nonpharmacological pain intervention, pain medication maximum dose parameters, and monitoring for signs and symptoms of hypo/hyperglycemia. Staff B was unable to provide supporting documentation of attempted nonpharmacological pain interventions, maximum daily dose of pain medication parameters within the physician order, or documentation of staff monitoring for signs and symptoms of hypo/hyperglycemia for Resident 1. <Resident 12> According to a 06/09/2025 Quarterly MDS, Resident 12 had multiple medically complex diagnoses including diabetes (high blood sugars) and required an insulin medication during the assessment period. Review of Resident 12's July 2025 MAR showed a Physician Order for an insulin medication to be administered for diabetes with directions to staff to hold the dose if blood sugars were less than 120. This dose was not held as ordered on 07/10/2025 when Resident 12's blood sugar was at 118. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/29/2025 at 10:41 AM, Staff B stated it was their expectation nursing staff to check the physician orders prior to medication administration as ordered and follow ordered parameters. <Resident 5> According to a 06/11/2025 admission MDS, Resident 5 had multiple medically complex diagnoses including anxiety. Review of Resident 5's June 2025 MAR showed two orders for the same medication to be used for anxiety. The first order gave directions to staff to administer one tablet every six hours as needed for anxiety. The second order gave directions to staff to administer two tablets every six hours as needed for anxiety. There were no directions given to staff to indicate which dose should be administered over the other order. In an interview on 07/29/2025 at 10:22 AM, Staff N (RCM) stated duplicate medication orders should be clarified with the physician to decrease the risk of errors and potentially over-medicating a resident. In an interview on 07/29/2025 at 11:56 AM, Staff B stated it was their expectation physician orders be followed, medications held per parameter orders, and duplicate orders clarified. <Following Orders> <Resident 5> According to a 06/11/2025 admission MDS, Resident 5 had multiple medically complex diagnoses including high blood pressure. Review of Resident 5's June 2025 MAR showed the resident received two blood pressure medications daily with directions to staff to hold the doses for a Systolic Blood Pressure (SBP - a measure of the pressure in your arteries when your heart beats) less than (<) 100, or if the Heart Rate (HR) was < 60. This MAR showed staff administered both blood pressure medications outside of parameters on 06/16/2025 and 06/27/2025 when Resident 5's HR was < 60. Review of Resident 5's July 2025 MAR showed staff administered one of the blood pressure medications outside of parameters on 07/05/2025 when Resident 5's HR was < 60. In an interview on 07/29/2025 at 10:22 AM, Staff N stated it was important for staff to follow physician's orders to reduce the chance for medication errors. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 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 ensure residents were assessed, monitored, refusals were documented, the provider was notified of changes, and they received the treatment they were assessed to require for 2 of 3 (Residents 28 & 1) who were reviewed for edema (swelling) management. The failure to monitor, document, implement interventions, and to follow the physician orders for edema management, placed residents at risk for decline in medical status, decreased quality of life, and unmet care needs and discomfort.Findings included .<Facility Policy>The Facility did not provide Edema Management policy. On 07/25/2025 the facility Administrator stated the facility did not have an Edema Management policy.<Resident 28> According to the 06/15/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 28 admitted to the facility on [DATE] with multiple medically complex conditions including left side of body weakness, heart failure, and kidney failure. The MDS showed Resident 28 had impairment with functional limitation in range of motion to their left arm and both legs. The MDS showed Resident 28 required maximal assistance from staff with bed mobility and repositioning in bed and had no rejection of care during the assessment period. Review of the revised 12/26/2024 Heart Failure Care Plan (CP) showed interventions that staff would monitor Resident 28 for dependent edema on their legs and feet, distended neck veins, weight gain unrelated to oral intake, and notify the provider as needed. Review of July 2025 Physician Orders showed a 07/31/2024 order that directed staff to put compression socks on Resident 28's legs during the daytime and remove the compression socks at night. A 07/08/2025 order directed staff to weigh Resident 28 three times a week every Monday, Wednesday, and Friday. Review of Resident 28's weight record showed the resident's weight on 06/13/2025 was 230 pounds, on 07/04/2025 was 250 pounds, 07/08/2025 was 249 pounds, and on 07/18/2025 was 259 pounds. This weight record showed Resident 28 gained 10 pounds in 10 days. The facility did not provide any documentation showing staff notified the provider about the weight gain. Observations on 07/22/2025 at 1:26 PM, 07/23/2025 at 10:30 AM and 3:02 PM, on 07/24/2025 at 8:39 AM and 2:18 PM, 07/25/2025 at 11:35 AM, and on 07/28/2025 at 9:17 AM showed Resident 28's left hand and both feet with edema. These observations showed Resident 28 had no compression socks on their legs/feet on all these days. Review of Resident 28's record on 07/28/2025 showed there was no indication facility staff assessed, monitored the severity of, or documented the degree of edema (for example 2+ or 3+), or notified the provider. In an observation and interview on 07/28/2025 at 9:19 AM, Staff I (Registered Nurse) assessed the resident with 3+ edema on both feet. Staff I was asked why Resident 28 was not wearing compression socks per the “Physician Order.” Staff I stated Resident 28 did not like to wear compression socks and staff documented the refusals. Staff I stated they did not notify the provider about the refusals and did not document the resident's refusals in Resident 28's record. In an interview on 07/28/2025 at 12:59 PM, Staff B (Director of Nursing) reviewed Resident 28's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record and stated it was very important to monitor fluid overload for residents with heart failure. Staff B stated there was no documentation the facility staff assessed or monitored Resident 28 for edema of the lower legs, did not follow the physician order to weigh the resident three times a week, and did not notify the provider of the resident's refusals for compression socks. Staff B stated staff should monitor the resident for edema and document the degree of edema in record and notify the provider to provide better care for the resident, but they did not. <Resident 1> According to a 04/24/2025 admission MDS, Resident 1 admitted to the facility on [DATE]. Resident 1 had diagnoses of, but not limited to, heart failure and shortness of breath. The MDS showed Resident 1 was receiving diuretic medications (helped the body eliminate excess fluid by increasing urine production) during the assessment period. In an observation and interview on 07/22/2025 at 11:49 AM, Resident 1's representative stated Resident 1 was on diuretic therapy because they often presented with “bad” swelling in their lower legs due to fluid retention. Resident 1 pulled their pant legs up and their representative stated the swelling was really bad the other day. In an interview on 07/28/2025 at 12:44 PM Staff E (Resident Care Manager) stated they expected staff to monitor and document signs of fluid retention to ensure the resident did not go into Congestive Heart Failure exacerbation. Staff E was unable to provide documentation that the facility was monitoring Resident 1's fluid retention/edema. In an email on 07/28/2025 at 11:57 AM Staff A (Administrator) stated the facility did not have an Edema Management policy. In an interview on 07/29/2025 at 10:41 AM Staff B stated they expected staff to monitor for signs of fluid retention/edema. Staff B was unable to provide documentation of staff monitoring Resident 1 for fluid retention/edema. REFERENCE: WAC 388-97-1060(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review facility failed to maintain an environment that was free from accident hazards. The failure to secure chemicals in 1 of 3 soiled utility rooms and 1 of 2 storage rooms placed residents at risk for accident hazards, and diminished safety.Findings included .<2nd Floor>Observation on 07/22/2025 at 8:40 AM showed the door to the second floor soiled utility room was unlocked. One bottle of a bleach urine stain/odor remover was unsecured. The warning label on the bottle showed the chemical was an eye irritant. The bottle was one quarter full. The soiled utility room also contained a bag of fingernail polishes and a bottle of nail polish drying spray. The drying spray had a warning label that cautioned the user to prevent contact with the skin and eyes. The soiled utility room also contained a a bottle of rapid dissolving disinfectant spray with a caution warning on the front label to keep away from children.Observation on 07/22/2025 at 8:42 AM showed second floor storage room near room [ROOM NUMBER] was unlocked. The storage room led through another door to a bathroom. In the bathroom there was a bottle of bacterial drain and trap cleaner for slow drains that had a quarter of its contents remaining. The warning label on the bottle showed it was harmful if swallowed.In an interview on 07/29/2025 at 9:39 AM Staff E (Resident Care Manager) stated the soiled utility room and storage rooms should be locked and closed for resident safety. REFERENCE: WAC 388-97-1060(3)(g).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor and report on nutritional care, provide weight monitoring, and obtain supplements as ordered for 3 (Resident 79, 26, & 1) of 11 residents reviewed for nutrition. The failure to offer meal replacements and monitor residents who consumed less than 50% of their meals and collect timely and accurate weights as ordered and per facility policy, placed residents at risk for nutrition-related complications, unplanned weight fluctuations, inaccurate assessments and delayed interventions of nutritional status, fluid overload, and other negative health outcomes.Findings included .<Facility Policy>According to the facility's revised 2017 Nutrition Impaired/Unplanned Weight Loss-Clinical Protocol policy, staff would monitor and document weight and intake of resident's in a format which permitted comparison over time and the provider would be notified of any abrupt or persistent change from baseline appetite or food intake. The policy showed staff would identify pertinent interventions based on identified causes and treatments and responses to interventions. <Resident 79> According to a 07/14/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 79 had multiple diagnoses including malnutrition, was on a mechanically altered diet, and had no natural teeth. In an interview on 07/23/2025 at 10:04 AM, Resident 79 stated they were concerned about weight loss and stated staff did not weigh them recently. Review of a 07/17/2025 Nutritional Status care area assessment showed staff documented Resident 79 was at nutritional risk and had weight loss of 7.6 percent noted in seven months. Staff documented Resident 79 had inadequate intake due to age and other medical conditions, was seen by the dietician, and would proceed to the Care Plan (CP) to assure the facility met the resident's nutritional needs while preventing dehydration and reducing the risk of weight loss. Review of a revised 07/09/2025 nutritional CP showed the goal for Resident 79 was to have no significant weight loss through the next review and gave directions to staff to obtain weights per physician orders. Review of Resident 79's July 2025 Treatment Administration Record showed a 07/08/2025 order to obtain new admit weights for three days. Staff documented only two of the three days of weights were completed as ordered. Review of Resident 79's physician orders showed a 07/15/2025 order to weigh the resident every week and notify the provider of gain or loss of five Pounds (lbs) or more from previous weight. According to a 07/15/2205 progress note, staff documented the weight scheduled for 07/15/2025 was not completed due to the resident being on contact precautions (an infection control measure used to prevent the spread of infectious agents). According to Resident 79's weight summary report, the resident's weight was 179.2 lbs on 07/08/2025 and the next documented weight was 162.0 lbs on 07/24/2025, a loss of 9.6 percent in 16 days. In an interview on 07/29/2025 at 11:11 AM, Staff CC (Registered Dietician -RD) stated it was their expectation staff obtain weights daily for three days when a resident admits to the facility to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	establish an admission baseline weight, then weekly as ordered to monitor for changes. Staff CC stated if the weights were not obtained, the residents would not show up on the reports they run to monitor for weight changes. When asked if they would expect a resident at nutritional risk to be weighed as ordered and while they were on contact precautions, Staff CC stated “yes, we would want to try and get a weight on everyone.” <Resident 26> According to the 06/08/2025 modified Quarterly MDS, Resident 26 had diagnoses including dementia, mood disorder, cognitive communication deficit, malnutrition and diabetes. Review of the revised 10/22/2024 Nutritional Problem CP showed Resident 26 had potential nutritional problems related to their mood disorder. The goal listed on the CP showed Resident 26's weight would remain stable. Interventions on the CP showed staff were to provide the prescribed diet as ordered, explain consequences of refusals to Resident 26, check their weight monthly, and get snacks from the kitchen or vending machine. Review of Resident 26's records showed on 06/01/2025, the resident weighed 129 lbs. On 07/28/2025, the resident weighed 116 pounds which was a -10.08% loss in weight. Record review showed an 07/17/2025 physician order for an appetite stimulant medication. There were no instructions provided on what to do if Resident 26 did not eat their meals or ate less than 50% and did not show when the provider was to be notified of missed meals or increased loss in weight. Review of the July 2025 caregiver task sheet showed staff documented on 07/17/2025, 07/19/2025, 07/22/2025 and on 07/25/2025, Resident 26 ate none to less than 25% of their meal. The July 2025 task sheet showed when Resident 26 ate less than 50% of their meals to offer them a meal replacement and record the percentage of supplement meal offered. On 07/17/2025, 07/19/2025, and on 07/25/2025 no percentage was noted for meal replacement as shown on the task sheet. Review of a 07/23/2025 nutrition assessment showed the RD ordered a supplement twice a day, to offer Resident 26 a liberalized diet and to closely monitor weight for additional loss. Staff CC documented they were unclear of the root cause of Resident 26's poor appetite and Resident 26 weight was now at their baseline weight on admission. Staff CC documented Resident 26 was put on medication to help with their appetite and Resident 26 would like to have ramen type noodles. In an interview on 07/28/2025 at 1:29 PM Staff CC stated residents were put on a Nutrition at Risk (NAR) list when there were significant changes in their nutritional condition. For high-risk residents, Staff CC stated they documented monthly on the status of the interventions and revised them if needed and helped to determine the root cause of the weight loss. Staff CC stated Resident 26 was added to the NAR list and they monitored Resident 26's weight but did not evaluate if current interventions on the CP were sufficient. Staff CC stated they recommended updating Resident 26 from a diabetic diet to a regular diet on 07/24/2025 but did not update this in Resident 26's record and did not order the ramen noodles yet. Staff CC stated Resident 26 received supplements as a part of their regular meals, but Resident 26 did not like the dairy based supplements, and they did not order a juice base alternative as a supplement yet. Staff CC stated they were responsible for making recommendations in the nutrition CP but did not update Resident 26's CP yet. In an interview on 07/29/2025 at 9:47 AM Staff E (Resident Care Manager) stated the staff did not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report to them or the provider when Resident 26 did not eat their meals and why a replacement meal was not offered but should have. Staff E stated ramen noodles were not being provided by the kitchen currently and Resident 26 did not like dairy based supplements. Staff E stated, interventions should be checked for their effectiveness and Resident 26's nutrition CP should include interventions for refusals of meals such as offering alternatives or honoring Resident 26's preferences such as noodles or supplements but did not include these interventions on Resident 26's nutrition CP. In an interview on 07/29/2025 at 12:48 PM Staff B (Director of Nursing) stated staff should notify the provider and document when Resident 26 refused their meals. Staff B stated interventions should be assessed for effectiveness and Resident 26's CP should be personalized with preferences. Staff B stated the nutrition CP should provide instructions on when the provider should be notified, when to report weight changes and should show effective interventions specific for Resident 26, such as offering alternatives such as noodles and supplements but were not. <Resident 1> According to a 04/24/2025 admission MDS Resident 1 admitted [DATE]. The MDS showed Resident 1 had diagnoses of, but not limited to, Malnutrition and Diabetes's (unstable blood sugar). Review of a 04/21/2025 Nutrition Assessment showed an RD evaluation of poor intake with a house supplement to be offered twice daily for a goal of increased caloric intake and blood sugar management. Review of Resident 1's physician orders showed the house supplement was not initiated until 06/05/2025, over one month later. In an interview on 07/28/2025 at 12:44 PM Staff E stated the RCM assigned to the resident at that time should review the RD recommendations and implemented them at that time but did not. Staff E stated it was important to review these evaluations to ensure recommendations were implemented immediately to ensure proper interventions for poor intake. In an interview on 07/29/2025 at 10:41 AM Staff B stated they expected the RD recommendations to be implemented at time of evaluation. Staff B stated Resident 1's house supplement order was implemented on 06/05/2025 but should be implemented on 04/21/2025. REFERENCE: WAC 388-97-1060 (3)(h).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were discarded when expired, and/or returned to the pharmacy upon a resident's discharge for 1 of 3 medication rooms (First Floor Unit) observed. The facility failed to ensure resident rooms were free of unsecured medication for 1 of 19 sample residents (Resident 31) observed. The failure to ensure unneeded medications were returned to the pharmacy, discarded when expired, and were stored securely, placed residents at risk for receiving unauthorized, compromised, and/or ineffective medications.Findings included.<Facility Policy>According to the facility's Revised November 2020 Storage of Medications policy, drugs and biologicals must be locked with only authorized persons given access. The policy showed discontinued and outdated drugs must be returned to the dispensing pharmacy or destroyed.<First Floor Unit Medication Room> Observations of the First Floor Unit Medication room on 07/23/2025 at 9:18 AM with Staff AA (Licensed Practical Nurse) showed the following expired medications: -a bottle of fish oil which expired “3/25”. -two bottles of a stool softener medication that expired “4/25”. -two-gallon sized storage bags full of different medication bottles, all of which showed they were expired. In an interview on 07/23/2025 at 9:18 AM, Staff AA stated there was a risk for staff to use the expired medications if they remained in the medication room supply. Staff AA confirmed the medications were expired and stated the medications should be removed from the medication room and discarded. Observations of the First Floor Unit Medication room on 07/23/2025 at 9:18 AM with Staff AA (Licensed Practical Nurse) showed medications still present in the medication room for the following discharged residents: -Resident 107 who discharged [DATE], over five months previously. -Resident 109 who discharged [DATE], over two months previously. -Resident 108 who discharged [DATE], almost two months previously. -Resident 102 who discharged [DATE], over a month previously. -Resident 105 who discharged [DATE], over a month previously. In an interview on 07/23/2025 at 9:18 AM, Staff AA stated discharged residents' medications should be sent with the resident or returned to the pharmacy after discharge. In an interview on 07/29/2025 at 12:03 PM, Staff B (Director of Nursing) stated it was their (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation medications of discharged residents, and all expired medications should be removed from the medication room promptly to decrease the chance of medication errors. <Resident 31> Observation on 07/25/2025 at 10:30 AM showed Staff Y (Certified Nursing Assistant) providing incontinence care to Resident 31. Staff Y opened Resident 31's nightstand drawer, removed a bottle of antifungal powder from the drawer, and applied it to the resident. Staff Y placed the antifungal powder back in Resident 31's drawer. In an interview on 07/25/2025 at 10:51 AM, Staff E (Resident Care Manager) stated antifungal powders should be secured and not kept at the resident's bedside. REFERENCE: WAC 388-97-1300(1)(b)(ii), (2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an effective Antibiotic (ABO) Stewardship Program to promote appropriate use of ABO's, reduce the risk of unnecessary ABO use, and decrease the development of an ABO resistance for 2 of 3 residents (Resident 9 & 53) reviewed for ABO Stewardship.<Policy>According to the facility policy titled, ABO Stewardship, dated December 2016, ABOs would be prescribed and administered to residents under the guidance of the facility's ABO Stewardship Program. The policy showed when an ABO was prescribed to a resident the primary care practitioner would assess the resident within 72 hours. The policy showed diagnostic results would be communicated with the resident's primary care provider to determine if ABO therapy should be continued, modified, or discontinued. Findings included.In an interview on 07/28/2025 at 9:19 AM Staff D (Infection Preventionist) stated the facility used the McGeers criteria (a tool used for infection surveillance activities and management of ABO usage). Staff D stated when a resident admitted to the facility with an infection, the staff were expected to obtain, from the hospital, the appropriate diagnosis for the prescribed ABO, start and stop date of ABO's, supporting lab results, and data to ensure the resident meets the McGeers criteria. Staff D stated when a resident acquired an infection in house, the staff were expected to ensure the resident's symptoms met the McGeers criteria, the prescribed ABO was appropriate and needed, lab results were communicated to the prescriber to ensure the least invasive ABO was prescribed, the order was complete with the appropriate ABO, dose, and length of course with the appropriate diagnosis.<Resident 9>Review of Resident 9's health records showed a June 2025 physician order for an ABO course to treat a Urinary Tract Infection. Resident 9's health records showed a 07/16/2025 urinalysis test reporting no infection present.<Resident 53>Review of Resident 53's health records showed a 07/07/2025 Infection Screening Evaluation reporting a recent chest xray consistent with pneumonia results. Review of Resident 53's History and Physical (H&P) Report showed a 07/01/2025 chest xray result negative for pneumonia.In an interview on 07/28/2025 at 9:19 AM Staff D reviewed the ABO Stewardship June line listing and stated Resident 9's ABO was not reviewed and was missed. Staff D reviewed Resident 53's records and stated they were aware of the H&P 07/01/2025 negative chest xray result. Staff D stated the hospital physician prescribed the ABO for pneumonia according to the H&P so they went with that. Staff D stated they were expected to communicate the conflicting hospital documentation with the facility physician, Resident 53's primary physician, but did not. Staff D stated they did not conduct an ABO Timeout (process used by providers to reevaluate the need for continuation of an ABO course) for Resident 53 per expectations of facility ABO Stewardship program. Staff D stated Resident 53's ABO was not on the ABO line listing for June 2025 and Staff D had not initiated the July 2025 ABO line listing for the facility yet.REFERENCE: WAC 388-97-1060(3)(k)(i).