

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Avamere Olympic Rehabilitation of Sequim		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5th Avenue South Sequim, WA 98382	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to identify and prevent an allegation of neglect, failed to suspend staff members alleged to have neglected residents and failed to initiate the investigation and assess and monitor residents in a timely manner for three of three residents (Residents 1, 2 and 3) reviewed for neglect. These failures placed residents at risk for continued neglect and a diminished quality of life. Findings included . Review of the Washington State Department of Social & Health Services Nursing Home Guidelines -The Purple Book (guidelines to assist nursing homes with compliance of the State and Federal requirements for the prevention, identification, reporting, and investigating incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, exploitation, and misappropriation of nursing home residents), dated October 2015, showed the facility must begin an immediate investigation of alleged violations in order to collect accurate data and take immediate action to protect residents from possible reoccurrence. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation, revised September 2022 showed that if abuse or neglect was suspected it should be reported immediately, (defined as 2 hours if abuse or severe injury, or within 24 hours if it did not involve abuse or serious injury) to the administrator and other officials according to state law. Upon hearing the allegation, the administrator will determine the needed steps to protect the residents. Review of the Facility Grievance Communication Form, dated 07/19/2025, showed Staff E, Nursing Assistant, filled out the form which was also signed by Staff H, Registered Nurse (RN), and three additional nursing assistants (NA). The form described the condition in which Staff H, and the other NAs found the residents on Unit 1, on the morning of 07/19/2025 and showed, 80 percent of the residents were found dripping wet in their own waste. Details were written on the back of the form which showed out of 17 residents listed, 7 residents were described as soaking wet with urine to include the bed linens, and four residents were noted to have fecal matter in brief, on their linens and or on their hands. One resident had no linens on the bed and no call light within reach, and five were noted to be okay. Review of the facility investigation showed no documentation that the investigation was initiated prior to 07/23/2025, four days after the alleged incident. The facility investigation identified Staff F, NA and Staff G, NA as the identified staff members responsible for the residents on Unit 1. The facility investigation found the allegation against Staff F to be substantiated, and the employee was terminated. Allegations against Staff G were unsubstantiated. Review of Staff Schedule for 07/19/2025 through 07/21/2025 showed Staff G worked the night shift again on 07/19/2025 into 07/20/2025. Staff F worked two additional night shifts after the allegation of neglect was made; 07/19/2025 into 07/20/2025 and again 07/20/2025 into 07/21/2025. The shifts were confirmed with review of payroll records. &lt;Resident 1&gt;Resident 1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 05/27/2025, showed the resident had severe cognitive impairment, was unable to make her needs known, always incontinent of bowel and bladder and was dependent on staff for all activities of daily living (ADL's). Review of the care plan dated 08/15/2013 and revised on 02/10/2025 included interventions for toileting that included the resident was incontinent of bowel and bladder and required frequent check and changes. The care plan showed resident 1 was not able to use her call light and required frequent rounds for needs and safety. Review of Resident 's Progress notes from 07/16/2025 through 07/26/2025 showed the resident was placed on alert for allegation of neglect on 07/23/2025. &lt;Resident 2&gt;Resident 2 was admitted to the facility on [DATE]. The quarterly MDS showed Resident 2 had moderate cognitive impairment, was able to make needs known, was frequently incontinent of bowel and bladder and required substantial to maximal assistance from staff for toileting needs. Review of the care plan interventions, initiated on 06/28/2024, showed the resident was not always aware of his toileting needs and staff were to offer toileting frequently to prevent incontinence. Review of Resident 2's progress notes from 07/16/2025 through 07/26/2025 showed the resident was placed on alert for allegations of neglect on 07/23/2025. &lt;Resident 3&gt;Resident 3 was admitted to the facility on [DATE]. The quarterly MDS showed Resident 3 was cognitively intact, and able to make needs known, frequently incontinent of bladder and always incontinent of bowel and dependent on staff for toileting needs. Review of the care plan interventions, initiated 01/19/2024, showed the resident used briefs for bowel and bladder incontinence and was to be checked and changed frequently. Review of Resident 3's progress notes from 07/16/2025 through 07/26/2025 showed the resident was placed on alert for allegation of neglect on 07/23/2025. On 08/07/2025 at 5:45pm Staff F, Nursing Assistant (NA) said that failing to check on residents</p>		