STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Olympic Rehabilitation of Sequim	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 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 interview and record review, the facility failed to provide bowel care in accordance with provider orders and the facility's bowel protocol for 2 of 4 residents (Resident 1 & 2) reviewed for bowel management. This failure placed residents at risk for abdominal pain/discomfort, decreased appetite and other potential health complicationsFindings included. Review of the undated facility policy titled, Bowel Protocol for Constipation, showed that additional interventions would be initiated on Day 3 for a resident not having a recorded bowel movement (BM). Interventions included use of a stool softener or stimulant laxative, if no results on day 4, MiraLAX or Milk of Magnesia would be initiated, day 5 use of a suppository and day 6 administration of an enema. Resident 1Resident 1 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 01/24/2026, showed Resident 1 had severe cognitive impairment, required substantial to maximum assistance for transfers to the toilet, and was frequently bowel incontinent. Review of the bowel and bladder evaluation, dated 10/27/2025, showed Resident 1 was not aware of his toileting needs, incontinent of stool on a daily basis, and required the assistance of two staff for toileting. Review of Resident 1's Bowel record for January 2026 showed no recorded Bowel Movement on 01/25/2026, 01/26/2026, 01/27/2027 and 01/28/2028. Review of Resident 1's Medication Administration Record (MAR) for January 2026 showed no as needed bowel medications were administered on 01/27/2026 or 01/28/2026. Resident 1 discharged to home with spouse on 01/28/2026. Review of the discharge instructions showed no documentation of the need for, or education to the spouse regarding Resident 1's constipation.Review of the Hospital admission record for Resident 1, dated 01/29/2026 showed the resident was admitted to the hospital with admitting diagnosis including small bowel obstruction, constipation, and other impaction of the intestine. On 04/14/2026 Resident 1's spouse said the resident discharged home and about an hour later started puking, the next day he was admitted to the hospital and he was impacted. The facility never told me he was constipated and had not had a BM. Resident 2Resident 2 was admitted to the facility on [DATE]. The admission MDS showed the resident was cognitively intact, required partial to moderate assistance for toileting, was continent of bowel and constipation was present. Review of the bowel and bladder evaluation, dated 04/17/2026, showed Resident 2 was always continent of bowel and required two staff to assist with toilet transfers. Review of Resident Bowel record for 04/18/2026 through 05/16/2026 showed no documentation of a bowel movement for 05/07/2026 through 05/16/2026. Resident 2 discharged home on [DATE].Review of Resident 2's May 2026 MAR, showed no as needed bowel medications were documented as given during the last 10 days of their stay. On 05/19/2026 at 2:02 pm, Staff E, Nursing Assistant (NA), said residents were monitored for constipation by documenting BMs in the PCC (the electronic health record -EHR) task record. If a resident does not have a BM in 3 days, the nurse is alerted and they make a BM list for the nursing assistants. On 05/19/2026 at 3:00 pm, Staff D, Licensed Practical Nurse (LPN), said the NA's notify the nurse if a resident has not had a BM in 3 days as well as there is a dashboard alert if there has not been one documented, although that can sometimes be false if a resident is independent with toileting; staff would need to ask the resident so it can be logged. If a resident has not had a BM in 3 days they can give a variety of things such as (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Olympic Rehabilitation of Sequim	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prune juice, various bowel medications, a suppository or an enema. Staff D said if a resident has not had a BM in 3 days and was discharging home with spouse on day 4, they would expect they would have received some medication to assist with constipation or sent home with them and the spouse to be informed, stating, Yes, definitely, I don't think an impaction would be very comfortable.On 05/19/2026 at 3:12 pm, Staff C, Resident Care Manager, Registered Nurse (RN) said, Residents are monitored for constipation with the NA's documenting in PCC and the nurses will get an alert on their dashboard if they have not had a BM in 3 days, they would initial bowel protocol. Staff C said they would expect a resident discharging on day 4 of no BM to be given something prior to discharge, if they received meds prior to discharge, and the spouse to be educated regarding. On 05/19/2026 at 3:39 pm, Staff B, Director of Nursing, RN, said they monitor residents for constipation by NAC staff documenting bowel movements in the EHR. If there were no bowel movements documented, it alerts the nurse. Staff B said it was harder to keep track with residents who were self-directed and take themselves to the toilet. Staff B said the bowel protocol was different for each shift and included MiraLAX, colace and enemas and would be documented in the MAR if administered. Staff B said they would expect a resident who had not had a BM in over 3 days and discharging home on day 4, to receive medication for constipation and their spouse to be informed. Reference WAC 388-97-1060