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	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Olympic Rehabilitation of Sequim	1000 5th Avenue South Sequim, WA 98382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure residents were informed of the risks and benefits associated with proposed psychotropic medication therapy (medications capable of affecting the mind, emotions, and behavior), and obtain the residents'/resident representatives' consent prior to administering the medication for 2 of 6 residents (Residents 62 and 63) reviewed for unnecessary medications. This failure prevented residents from making an informed decision about the use of the proposed medication and precluded the resident from exercising their right to decline such treatment therapy and from exercising their right to refuse/decline the proposed medication. Findings included . <Resident 62> Resident 62 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/13/2024, showed the resident was cognitively intact, had diagnoses of depressive (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorders (repeated episodes of intense anxiety, fear or terror) and received antidepressant and antianxiety medications during the assessment period. Resident 62 had a 08/05/2024 order for mirtazapine (an antidepressant) daily at bedtime for major depression, and a 07/09/2024 order for Seroquel (an antipsychotic) daily at bedtime for unspecified dementia with other behavioral disturbances. Review of the July and August 2024 Medication Administration Records showed the resident was started on Seroquel on 07/09/2024 and the mirtazapine on 08/05/2024. Review of the electronic health record (EHR) showed no documentation was present to show the facility informed Resident 62 and/or their representative of the risks and benefits associated with the use of Seroquel and mirtazapine or that the resident/resident representative consented to their use. On 09/27/2024 at 11:18 AM, when asked if there was any documentation to show Resident 62 and/or their representative were informed of the risks and benefits associated with the use of Seroquel and mirtazapine and consented to their use, Staff N, Assistant Director of Nursing, said no. <Resident 63> (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 63 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented Resident 63 was cognitively intact. Resident had diagnoses including, generalized anxiety, major depressive disorder, hallucinations (an experience involving the apparent perception of something not present), panic disorder (unexpected and repeated episodes of intense fear accompanied by physical symptoms) and hydrocephalus (a condition in which fluid accumulates in the brain). Review of the EHR showed no documentation was present to show the facility informed Resident 63 and/or their representative of the risks and benefits associated with the use of sertraline (an antidepressant) or that the resident/resident representative consented to their use. On 10/01/2024 at 12 AM, when asked if there was any documentation to show Resident 62 and/or their representative were informed of the risks and benefits associated with the use of sertraline and consented to their use, Staff M, Resident Care Manager, said no. Reference WAC 388-97-0260

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview and record review, the facility failed to provide adaptive equipment for cutting food that reflected the unique physical needs and preferences for 1 of 1 resident (Resident 63) reviewed for accommodation of needs. The facility failed to implement a plan for the resident's living environment that was conducive to their unique physical limitations and that took into consideration their needs and preferences which placed them at risk for a diminished quality of life and increased dependence on staff. Findings included . Review of the resident's comprehensive assessment showed Resident 63 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, arthritis in left and right hands, malnutrition and hydrocephalus (fluid on the brain). The assessment showed Resident 63 required assistance to eat. The resident was alert, oriented and able to make their needs known. Review of Resident 63's Activities of Daily Living (ADL) care plan, revised on 09/16/2024, showed interventions including, resident requires full set up assist for her meal trays including cutting [their] food. During an interview on 09/23/2024 at 1:35 PM, Resident 63 stated, I need assistance with cutting my food. The Occupational Therapist (OT) came up with a great idea to use a pizza cutter, it worked great, but they took it away about two weeks ago, I don't know why. I liked the pizza cutter, I could cut my own food, I was independent. The resident said due to arthritis in both hands cutting food was very difficult and stated, my fingers are numb and freeze, I am unable to grip onto things. On 09/24/2024 at 8:35 AM, a breakfast tray was observed on Resident 63's bedside table. The pancake and two pork links were not cut. Resident 63 was propped up in bed, sleeping, and unable to reach the food. On 09/26/24 at 8:30 AM, Resident 63 was observed eating breakfast in bed and with uncut food. Resident 63 was observed eating waffles, fruit, and a meat patty with their hands. Resident 63 was unable to open a butter packet. By 8:45 AM, no assistance to set up meal or position the resident had been offered. During an interview on 09/26/2024 at 1:12 PM, Resident 63 was asked about breakfast and eating waffles with her hands. Resident 63 said they had worked in an elementary school and the kids were served waffle sticks, so I treated my waffle as a stick and dipped into the syrup. Resident 63 would like to be more independent and have the pizza cutter back. Resident 63 stated, Talk to [Staff R] in physical therapy, he knows about it. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff B, Director of Nursing (DNS), Staff M, Resident Care Manager (RCM) and Staff E, RCM on 09/26/2024 at 2:05 PM, Staff M stated, based on [their] cognition, we determined [Resident 63] was not safe using the pizza cutter. There was no documentation to show an assessment was completed to show Resident 63 was not safe. Staff E stated, we thought of other options, like a pair of child scissors. When asked for documentation of alternatives attempted to replace the pizza cutter with something else, none was provided. During an interview on 09/26/2024 at 2:22 PM, Staff R Occupational Therapy Assistant (OTA) stated, I work in therapy, so I tried to do functional adaptations for [Resident 63]. I gave [Resident 63] a pizza cutter to cut food. [Resident 63] was doing really well with it, and liked it. When asked for any documentation of Resident 63's ability to use a pizza cutter safely, Staff R provided a therapy progress note, dated 08/28/2024, Pt. [Patient] assessed using pizza cutter to cut food with good motor control and ability cutting simulated meat of red putty. During an observation on 09/27/2024 at 8:54 AM, Resident 63 was eating breakfast. The breakfast meat, a round patty, was not cut. On 10/01/2024 at 11:54 AM, Staff S, (OT) said the focus for Resident 63 in therapy had been self-feeding and positioning and said the most focus was spend on independent eating as it was most important to the resident. Staff S said Resident 63 was ecstatic about getting the pizza cutter but that he was told he needed to take it away from her and didn't know why. Staff S said they had asked Staff B for a reason but had never been provided with an answer as to why they needed to take the pizza cutter away. Reference WAC 388-97-0860(2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to address required documentation for advance directives (AD) for 2 of 5 residents (Residents 2 and 40) reviewed for advanced directives. This failure placed the residents at risk of losing their right to have their preferences/decisions honored for end-of-life care. Findings included . <Resident 2> The resident was admitted to the facility on [DATE]. A review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/27/2024, showed the resident was severely cognitively impaired. A Care Conference Review progress note, dated 08/13/2024, said advanced directives are established. A review of Resident 2's electronic health record (EHR) showed no copy of the AD. On 09/26/2024 at 9:23 AM, Staff D, Social Services Director, said, I don't have a copy of the AD and I should have asked in August during the care conference to make sure we had it. <Resident 40> The resident was admitted to the facility on [DATE]. A review of the Quarterly MDS, dated [DATE], showed the resident was severely cognitively impaired. A Care Conference Review progress note, dated 09/06/2024, said advanced directives are established. A review of Resident 40's electronic health record (EHR) showed no copy of the AD. On 09/26/2024 at 9:23 AM, Staff D, Social Services Director, stated, I should have followed up with the family and asked for copies of the AD. At 3:08 PM Staff B, Director of Nursing, said her expectation was that the staff attempt to get the AD and document it. Reference WAC 388-97-0300 (1)(b), (3)(a-c)

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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. 50392 Based on interview and record review, the facility failed to initiate and investigate grievances for resident concerns, maintain an accurate log of grievances and report grievances to the Administrator for review for 2 of 2 sampled resident (Residents 27 and 63) and 1 of 1 resident groups (Resident Council) reviewed for grievances. This failure to report, initiate, investigate, and log grievances placed residents at risk for not having grievances investigated, delayed or incomplete resolution to grievances and a diminished quality of life. Findings included . The facility policy titled, Grievance, revised 01/05/2000, showed the grievance communication form would be forwarded to the administrator and the administrator would review the grievance and then forward a copy to the appropriate department manager. <Logging Grievances> The following grievances were made during Resident Council meetings on 06/24/2024, 07/22/2024, and 08/30/2024. Resident Council Meeting minutes, dated 06/24/2024, showed an unidentified resident talked about there not being enough sandwich options in the snack fridge. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 06/24/2024, showed unidentified residents talked about leaves being piled up around the facility which were creating a possible fire hazard. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 06/24/2024, showed an unidentified resident talked about longer call light wait times and staff telling them they were short on the floor, reporting it was worse on weekends. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 06/24/2024, showed an unidentified resident talked about wanting more fresh fruit, not canned. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 06/24/2024, showed unidentified residents talked about how staff needed to stop throwing cigarette butts in the parking lot. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 07/22/2024, showed unidentified residents talked about reminding staff to knock before entering their rooms. Meeting minutes showed, turned in concern. This grievance was not on the grievance log. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Council Meeting minutes, dated 07/22/2024, showed unidentified residents talked about hearing staff talking in the hallways. Meeting minutes showed, turned in concerns/requests. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 07/22/2024, showed unidentified residents talked about how they would like staff to offer to cut up food at mealtimes. Meeting minutes showed, turned in concerns/requests. This grievance was not on the grievance log. Resident Council Meeting minutes, dated 08/30/2024, showed an unidentified resident said Certified Nursing Assistants (CNAs) were not offering drink options when delivering trays. Meeting minutes showed, grievances filled out with [Social Services] for concerns. This grievance was not on the grievance log. <Initiating Grievances> On 09/23/2024 at 10:40 AM, Resident 27 said Staff H, CNA, and Staff I, CNA were impatient with them during care and Resident 27 told staff they no longer wanted the CNA's to provide care to them. On 09/25/2024 at 8:26 AM, Staff A, Administrator, said he was aware of Resident 27's request to not have Staff H and Staff I care for Resident 27 anymore and he believed it was filed as a grievance. At 10:17 AM, Staff B, Director of Nursing (DNS), said she remembered that Resident 27 did not like Staff H and Staff I, but that she did not complete a grievance at the time because Resident 27 had only said they didn't like them. On 09/30/2024 at 2:46 PM, Staff B, DNS said a grievance should have been completed when Resident 27 said they did not like Staff H and Staff I. <Reporting Grievances to Administrator> On 10/01/2024 at 10:19 AM, Staff D, Social Services Director said it was her job to make sure grievances were put on the grievance log and all grievances should go on the grievance log. At 10:42 AM, Staff A said resident grievances should be logged onto the grievance log. At 1:31 PM, Staff A was informed Staff J, Activities Director, had been using Resident Response Forms for grievances instead of the Grievance form. Staff J, would provide Resident Response forms to Department Heads and once resolved the forms would be returned to Staff J, not providing Staff A the chance to review the grievance. When asked if not reviewing grievances met his expectations, Staff A said his expectation was he would review grievances and sign off on them and that had not been happening. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/2024 at 10:30 AM, when asked about Grievance forms, Staff J, said she always used Resident Response Forms for grievances rather than Grievance Forms and only used grievance forms if the concern was really bad. Staff J said, after grievances were documented on a Resident Response Form, they were sent to the department head, the department head would investigate the grievance, and the Resident Response form would be turned back into Staff J when resolved. When asked if the Resident Response Forms were given to the administrator for review, Staff J stated, maybe, some might not have. When asked if grievances should go on the grievance log, Staff J stated, of course I think grievances should go on the grievance log. <Resolution to Grievances> Review of Resident 63's Activities of Daily Living (ADL) care plan, revised on 09/16/2024, showed interventions that included, Resident requires full set up assist for her meal trays including cutting her food. Up for meals, lunch and dinner. On 09/18/2024, Resident 63 filed a grievance. Staff D, Social Services Director, assisted Resident 63 with writing the grievance which read, [Resident 63], food not being set-up, her food needs to be cut up. Also, not up and ready for lunch time. Staff M, on 9/18/2024, talked with Resident 63 about the grievance and documented, Interviewed [Resident 63], has no concerns the staff cuts up her food when she asks. The staff gets her up for lunch when she agrees. Resident 63 would like her pizza cutter back. The grievance report showed no documentation alternatives were explored with Resident 63 regarding her concerns. There was no evidence the facility critically reviewed the grievance and attended to the resident in order to reach a mutual resolution. Staff A signed the grievance 09/18/2024. Review of Resident 63's nursing progress notes showed no refusals of care. During an interview on 10/01/2024 at 11:54 AM, Staff S, Occupational Therapist, stated, I have not been able to get nursing to get her out of bed to eat, or to position her correctly in bed to eat, it has been difficult. I have decided to put it in communications (writing) because going to the nurse and aides is not working. During an interview on 10/01/2024 Staff M, stated, she did a grievance because she had talked with the resident. Reference WAC 388-97-0460

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview and record review, the facility failed to ensure allegations of abuse and neglect were reported to the state agency for 1 of 4 sampled residents (Resident 46) reviewed for abuse/neglect. This failure placed residents at risk for experiencing potential abuse and neglect and a diminished quality of life. Findings included . A review of the facility's policy, dated April 2021, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program showed to investigate and report any allegations within timeframes required by federal requirements. Resident 46 was admitted to the facility on [DATE]. A review of the Minimum Data Set (MDS, an assessment tool), dated 08/06/2024, showed the resident was cognitively intact. On 09/23/2024 at 2:14 PM, Resident 46 said a nurse at night, who's name the resident could not remember, would bring their pain medication late because the nurse was in control and because she was pissed at me. Resident 46 said the nurse would say that she didn't care if the resident reported her. Resident 46 said she thought she had reported it to Staff B, Registered Nurse and Director of Nursing (DNS) and that the nurse she was referring to was no longer working at the facility. On 09/23/02024 at 4:53 PM, Staff A, Administrator and Staff B were notified of Resident 46's statement. On 09/26/2024 at 3:08 PM, Staff B said she had already investigated the allegation in July and processed it as a grievance but did not log or report the allegation. On 09/27/2024 at 12:03 PM, Staff B, when asked again if she had reported or completed a formal abuse allegation investigation, said, I will start an investigation and report it to the state. On 09/27/2024 at 3:12 PM, the facility submitted the incident report to the state. On 10/01/2024 at 9:16 AM, Staff B said the incident could be considered abuse and if there was an allegation of abuse she would report it. Reference WAC 388-97-0640(5)(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review the facility failed to properly notify the Office of the State Long-Term Care Ombudsman of the discharge or transfer for 1 of 5 residents (Resident 40). This failure placed the residents at risk for diminished protection from being inappropriately discharged , lack of access to an advocate who can inform them of their options and rights, and to ensure that the Offices of the State Long-Term-Care Ombudsman is aware of facility practices and activities related to transfers and discharges. Findings included . Resident 40 was admitted to the facility on [DATE]. A review of the Quarterly Minimum Data Set, an assessment tool, dated 09/10/2024, showed the resident was severely cognitively impaired. A review of the Electronic Health Record showed no documentation of notification having been sent to the Ombudsman for Resident 40's transfer on 01/01/2024. On 09/26/2024 at 9:23 AM, Staff D, Social Services Director, said she did not have documentation the Ombudsman was notified of Resident 40's transfer. At 3:08 PM, Staff B, Director of Nursing, said her expectation was that the Ombudsman notification be documented and done. Reference WAC 388-97-0140 (1)(a)(b)(c)(i-iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure resident assessments accurately reflected their health status and/or care needs for 3 of 33 sample residents (Residents 11, 4 & 2) whose Minimum Data Sets (MDS, an assessment tool) were reviewed. The failure to accurately assess whether residents had a terminal diagnosis, that residents were receiving restorative therapy or were on a physician ordered planned weight loss program, placed residents at risk for unidentified and/or unmet care needs. Findings included . 1) Resident 11 admitted to the facility on [DATE]. Review of the 09/05/2024 Annual MDS showed the resident received hospice services during the assessment period, but did not have a terminal diagnosis. Review of the electronic health record (EHR) showed the resident went on hospice on 10/08/2021 and had remained on uninterrupted services since. A 10/08/2021 Hospice Certification and Plan of Care showed two physicians signed that the resident was terminally ill with a life expectancy of six months or less. Review of the following MDS assessments showed similar findings, in which Resident 11 received hospice services but did not have a terminal diagnosis: a) 08/13/2024 Quarterly MDS b) 02/26/2024 Quarterly MDS c) 12/01/2023 Quarterly MDS d) 09/11/2023 Annual MDS On 10/01/2024 11:54 AM, Staff N, Assistant Director of Nursing (ADON), confirmed Resident 11 had a terminal diagnosis documented in the EHR and said their terminal diagnosis should have been coded on the above referenced MDSs. 42960 2) Resident 2 was admitted to the facility on [DATE]. A review of the Quarterly MDS, dated [DATE], showed the resident was severely cognitively impaired. The MDS, selection O0500 read, Restorative Nursing Programs passive range of motion 4 days. Further review of the clinical record found no documentation of Resident 2 on a Restorative Program during that period for the MDS, dated [DATE]. On 09/30/2024 at 1:12 PM Staff Q, MDS coordinator, said I know I should not have captured those minutes for Section O Passive ROM [Range of Motion] for restorative therapy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/2024 at 9:16 AM Staff B, DNS, said Resident 2 was not on an actual restorative program and her expectation was that they would not code it. 46793 3) Resident 4 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 4 was severely cognitively impaired. Resident 4 was placed on hospice on 08/01/2024. The MDS, selection K0300, for Resident 4 read, Yes, on a prescribed weight loss regimen. The EHR documented no physician or registered dietitian orders for a prescribed weight loss regimen. Resident 4's diet was ordered as Regular diet, Minced & Moist texture, IDDSI [International Dysphagia Diet Standardization Initiative (IDDSI) created global standardized terminology and definitions for texture-modified foods and thickened liquids to improve the safety and care for individuals with swallowing difficulty] Mildly Thick consistency. On 09/26/2024 at 10:20 AM Staff E, Resident Care Manager (RCM)/Registered Nurse (RN), said Resident 4 was not on a weight loss program. At 11:24 AM, Staff B, DNS stated, Resident 4 was not on a weight loss program, it must have been human error. On 09/30/2024 at 11:55 AM, Staff C, Chief Medical Director, said he was not aware of Resident 4 being on a weight loss program. Staff C checked the EHR and said, there was no orders for a prescribed weight loss program, the medication contributing to the weight loss was not prescribed for weight loss, but to manage other health conditions and they would not place a hospice resident on a weight loss program. Staff C said the MDS coding was incorrect. Reference WAC 388-97-1000 (1)(b)

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	505327	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Olympic Rehabilitation of Sequim	1000 5th Avenue South Sequim, WA 98382

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(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** 46793 . Based on interviews and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions for 3 of 6 sampled residents (Residents 25, 63, and 171) reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 25> Resident 25 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS, an assessment tool), dated 07/15/2024, documented Resident 25 was cognitively intact. Resident 25 was diagnosed with generalized anxiety (mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), major depressive disorder (mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The Level I PASRR, dated 04/11/2024, documented Resident 25 was diagnosed with a Mood disorder, but did not specify which type and did not include the diagnoses of anxiety. In the comments section it documented Resident 25 also had a diagnosis of dementia. Record review documented Resident 25 was not diagnosed with dementia. On 09/26/2024 at 11:05 AM, Staff D, Social Services Director, stated the diagnosis of dementia in the comments should have been caught and addressed. Staff D said the diagnosis of anxiety should have been included on the Level I PASRR. At 11:24 AM, Staff B, Director of Nursing Services (DNS), said she did not deal with PASRR's, that was Social Services. When the missing anxiety diagnoses and incorrect diagnoses of dementia were mentioned, Staff B said that should have been caught and addressed when Resident 25 admitted . 50846 50945 <Resident 171> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Electronic Health Record showed Resident 171 was first admitted to the facility on [DATE], with a recent hospitalization on [DATE] and a readmission on 08/19/2024. Resident 171 had diagnoses including dementia and generalized anxiety disorder. The annual MDS, dated [DATE], recorded that Resident 171 had a psychotic disorder (a mental disorder with a disconnection from reality) and depression, and was severely cognitively impaired. Review of Resident 171's Level 1 Pre-Admission Screening and Resident Review, dated 08/18/2024, stated, The nursing facility is responsible for ensuring that the form is complete and accurate before admission. Review of the document showed Resident 171 did not have a serious mental illness indicator selected and did not require a level two PASRR form to be completed. During an interview on 09/30/2024 at 11:07 AM, Staff D, Social Services Director, said their process for screening PASRRs, when a resident goes to the hospital and has a new PASRR form completed, was that they reviewed it within one to two days of admission. Staff D stated they would have marked Resident 171 as having a mood disorder, and the level 1 PASRR form was not accurate. During an interview on 09/30/2024 at 2:18 PM, Staff B, DNS, said if there was a mistake with the PASRR, then Social Services was responsible for calling to get it fixed. Reference WAC 388-97-1915 (1)(2)(a-c)

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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** 37044 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 5 of 33 sampled residents (Residents 30, 10, 62, 42 & 54) reviewed for professional standards. The failure to follow and/or clarify incomplete physicians' orders, and to only sign for tasks that were completed, placed residents at risk for medication errors, complications of treatments, and other potential negative health outcomes. Findings included . 1) Resident 62 readmitted to the facility on [DATE], with orders for: a) Hydralazine (an antihypertensive) two times a day for high blood pressure, hold for a systolic blood pressure (SBP) below 110 b) Metoprolol (an antihypertensive) two times a day for high blood pressure, hold for a SBP below 110. Review of Resident 62's July and September 2024 Medication Administration Records (MARs) showed on the following occasions facility nurses administered the resident antihypertensive medications with a SBP less than 110, rather than holding the medications as ordered: -Hydralazine: 07/09/2024 evening dose SBP=104 = administered 07/16/2024 evening dose SBP= 108 = administered 09/05/2024 morning dose SBP= 104 = administered -Metoprolol: 07/16/2024 evening dose SBP= 108 On 09/27/2024 at 11:09 AM, Staff N, Assistant Director of Nursing (ADON), confirmed on the above referenced occasions, facility nurses administered Resident 62's metoprolol and hydralazine instead of holding the medications as ordered. 2) Resident 30 admitted to the facility on [DATE]. Review of the electronic health record (EHR) showed a 08/06/2024 order to apply knee-high compression stockings to both lower extremities in the morning, and remove them at bedtime for edema management. On 09/30/2024 at 1:24 PM, Resident 30 was observed in their room wearing bulky blue personal socks that bunched up around their ankles. The ordered compression stockings were not in place. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the September 2024 Treatment Administration Record (TAR) showed the nurse had signed that they applied the compression stockings that morning as ordered. On 09/30/2024 at 2:07 PM, Staff AA, Resident Care Manager (RCM), confirmed Resident 30's compression stockings were not applied as ordered, nor were a pair present in the resident's room. Staff AA said it was the expectation that nurses only sign for those tasks they completed or validated as completed. 3) Resident 10 admitted to the facility on [DATE]. Review of the EHR showed a 12/11/2020 order for nursing to apply toe spacers to all toes, on in the morning and off at bedtime to prevent tissue damage related to hallux valgus (overlapping toes). On 09/30/2024 at 11:46 AM, Resident 10 was observed to be fully dressed including footwear. When asked if their toe separators had been applied, Resident 10 reported they had not worn the toe separators for three months or so. The September 2024 TAR showed nursing had signed daily, including on 09/30/2024, that they applied the toe separators daily in the morning as ordered. On 09/30/2024 at 2:17 PM, Staff AA, RCM, confirmed Resident 10's toe separators had not been applied. When asked if nursing had signed that they applied the toe separators as ordered, Staff AA, RCM, stated, yes. 50392 4) Resident 42 was admitted on [DATE]. The Admission Minimum Data Set, (MDS/an assessment tool), dated 08/08/2024, documented Resident 42 was moderately cognitively impaired. On 09/26/2024 at 8:46 AM, Staff O, Registered Nurse, said she had not seen behaviors of Resident 42 going into other residents' rooms, but she had received information in report from other nurses and read Resident 42's history, which indicated Resident 42 had attempted to elope (leave the building) and got close to the door in the past. Staff O said, so we put a Wanderguard (a wander management system to keep residents from wandering) on her wheelchair. Physician's orders from 09/26/2024 documented there was no order in place for a Wanderguard device for Resident 42. At 9:53 AM, Staff M, RCM, said that an order was required for a Wanderguard and she could not locate one in the EHR for Resident 42. Staff M said her expectation was the order should be there. 5) Resident 54 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 54 was cognitively intact and had a Stage 4 Pressure Ulcer (severe type of pressure ulcer involving full thickness skin loss that extends into muscle, bone, and tendon, or joint) to the right buttock. A Physician's Order, dated 07/29/2024, documented Resident 54's wound vac (a treatment that uses suction to help heal wounds) was to be changed every Tuesday and Thursday. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/06/2024, a progress note in the EHR documented w-d dsg [wet to dry dressing] done this AM on R ischial wound [right lower part of hip bone]. Will apply Wound Vac to R ischial wound when supplies arrive later this AM. Review of Physicians Orders for 09/06/2024 documented no order was in place for the wet to dry dressing placed on Resident 54's wound on 09/06/2024. On 09/26/2024 at 12:59 PM, Staff M, RCM, said when supplies were not available for wound vac dressing change, the facility would get an order from the doctor to temporarily use a dressing such as wet to dry. When asked if an order was in place for Resident 54's wet to dry dressing that was placed on 09/06/2024, Staff M said they didn't see an order and would expect staff to get a doctor order to apply a wet to dry dressing until wound care supplies arrived. Reference WAC 388-97- 1620(1)(5)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37044 Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 1 of 3 residents (Resident 58) reviewed for ADLs. Failure to provide assistance with oral care to residents who were dependent on staff for such care, placed the residents at risk for unmet needs, poor hygiene, diminished self-image, and decreased quality of life. Findings included . 1) Resident 58 admitted to the facility on [DATE]. Review of the 01/24/2024 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had limited functional range of motion to both upper extremities, natural teeth, was dependent on staff for personal hygiene, and demonstrated no behaviors or rejection of care. An ADL self-care deficit care plan, revised 05/21/2024, showed the resident required one-to-two-person assistance with personal hygiene. On 09/24/2024 at 10:51 AM, Resident 58 stated, I don't have good care of my teeth. [Staff] don't brush them at all, and my arthritis is too bad to do it myself. On 09/27/2024 at 12:27 PM, Resident 58 reported her teeth still had not been brushed, and alleged only one male nursing aide that was seldom assigned to their care, and one male therapist had brushed their teeth since admission. Resident 58 stated, I use my fingernail to scratch the plaque off. That's embarrassing. I have never told anyone that. The resident then ran a fingernail down a tooth and held it out for inspection. A yellowish/white debris was noted caked under the fingernail. Additionally, observation of Resident 58's oral cavity showed yellowish white food debris along the resident's upper gum line. Resident 58 indicated they brushed their teeth twice a day at home, but would be ok with oral care once daily while at the facility, and said they had no preference about whether it was done after breakfast or after dinner as long as it occured. On 09/30/2024 at 11:49 AM, Resident 58 indicated staff had brushed their teeth and stated, they did yesterday and today, two days in a row. On 09/30/2024 at 3:35 PM, Resident 58 reported their concerns about staffs' failureto consistently assist with oral care to Staff AA, Resident Care Manager. Staff AA was unable to confirm the yellowish/white debris along the resident's upper gum line as oral care had since been provided. Reference WAC 388-97 -1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure 4 of 15 sample residents (Residents 30, 10, 62, and 63) received the necessary care and services in accordance with their comprehensive person-centered plan of care. The facility's failure to ensure residents received the care and services they were assessed to require related to edema management (Resident 30), treatment and monitoring of non-pressure skin issues (Resident 10 and 62), and positioning (Resident 63) placed residents at risk for wound decline and/or prolonged wound healing times, poorly controlled edema (swelling), delays in treatment, unmet care needs and decreased quality of life. Findings included . Review of the facility's Wound Management Guidelines policy, revised 08/25/2020, showed if a resident had a new skin alteration the licensed nurse would investigate the potential cause and develop and implement interventions. The licensed nurse would document in the resident's record the location, size, wound description, drainage type/amount, and appearance of the surrounding tissue. Non-ulcer skin impairments (e. g. skin tears, abrasions, bruises etc.) were to be monitored and documented on the Treatment Administration Record (TAR). 1) Resident 30 admitted to the facility on [DATE]. Review of the 06/19/2024 Admission Nursing Database showed the resident had no edema upon admission. A 07/31/2024 provider note documented Resident 30 had 2+ pitting edema to the left foot and lower leg, and 1+ pitting edema to the right foot. A 08/06/2024 order was obtained to apply knee-high compression stockings to both lower extremities in the morning and remove at bedtime for edema management. On 09/30/2024 at 1:24 PM, Resident 30 was observed in their room wearing bulky blue personal socks which were bunched up around the ankles. No compression stockings were in place. Resident 30 indicated they did not know the last time the compression hose had been applied. Resident 30 allowed writer to look in their closet, drawers and bathroom for their compression hose but none were found. Review of the September 2024 TAR showed the nurse signed (on 09/30/2024) that they had applied the compression stockings as ordered. On 09/30/2024 at 2:07 PM, Staff AA, Resident Care Manager (RCM), confirmed Resident 30's compression stockings were not applied as ordered, nor was a pair present in the resident's room. 2) Resident 10 admitted to the facility on [DATE]. Review of the electronic health record showed a 12/11/2020 order for nursing to apply toe spacers to all toes, on in the morning and off at bedtime to prevent tissue damage related to Hallux valgus (overlapping toes). On 09/30/2024 at 11:46 AM, Resident 10 was observed to be fully dressed including footwear. When asked if their toe separators had been applied, Resident 10 reported they had not worn the toe separators for three months or so. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September 2024 TAR showed nursing had signed daily, including on 09/30/2024, that they applied the toe separators daily in the morning as ordered. On 09/30/2024 at 2:17 PM, Staff AA, RCM, confirmed Resident 10's toe separators had not been applied as ordered. 3) Resident 62 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS/an assessment tool), dated 07/13/2024, showed the resident was cognitively intact and received antiplatelet medication (medications that prevent blood clots from forming.) On 09/23/2024 at 3:00 PM, Resident 62 was observed with a one by two-inch bruise under their left eye. The resident reported they fell recently and likely sustained the bruise at that time. A 08/24/2024 nurses' note documented Resident 62 fell in the bathroom and struck their head. On 09/27/2024 at 2:01 PM, 09/30/2024 at 2:41 PM, and 10/02/2024 at 7:33 AM, Resident 62 still had a visible bruise under the left eye. On 10/02/2024 at 1:57 PM, Staff B, Director of Nursing (DNS), confirmed the brownish/purple discoloration under Resident 62's left eye, but indicated they believed it was not a bruise related to the fall, rather discoloration related to the resident picking at their eye. When asked if there was any documentation to show facility staff had been assessing/monitoring the area as directed in the facility's wound management guidelines policy, Staff B, DNS, stated, No. 50846 4) Review of Resident 63's MDS, dated [DATE], showed the resident was admitted to the facility on [DATE] with diagnoses including arthritis in left and right hands, malnutrition and hydrocephalus (fluid accumulation on the brain). The resident was able to make their needs known. Review of Resident 63's Activities of Daily Living (ADL) care plan, dated 09/16/2024, showed interventions to include assistance with positioning for Resident 63 to eat while in bed. Keep the plate and height of bedside table no higher than chest and about one foot max from her mouth. Please position resident upright and midline in bed when eating to ensure safe swallow. Resident requires full set up assist for her meal trays including cutting her meat, providing a straw for her liquids with covered cup, placement of her tray no further than one foot away from her mouth and the use of a shirt saver. If in bed please prop right upper arm/elbow to assist resident in getting the food safely and independently to her mouth. On 09/24/2024 at 8:35 AM, Resident 63's breakfast tray was observed on the bedside table out of reach for Resident 63 to eat. The head of Resident 63's bed was raised to 80 degrees; Resident 63 was slumped down in the bed. Food items on the breakfast tray included a pancake and two pork links which were uncut. At 3:19 PM, Staff DD, Certified Nursing Assistant (CNA), said Resident 63 was fully dependent on staff for positioning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/2024 at 8:15 AM, Resident 63 was observed in her room, head of bed elevated to 80 degrees, resident slumped down in bed with her head resting on the bed cane (positioning bar). Breakfast was observed in front of Resident 63 on the bedside table nearing the foot of the bed, out of reach for Resident 63. Breakfast was uncut eggs, ham, and salsa spread over the eggs. No assistance with positioning to eat was observed. On 9/26/2024 at 8:30 AM, Resident 63 was observed eating breakfast in bed with her hands. On 9/27/2024 at 9:00 AM, Resident 63 was observed slumped in bed, breakfast on the bedside table, unable to reach their food. At 1:08 PM, Staff M, Resident Care Manager (RCM) stated, we put in the care plan to have staff cut up her meal. She frequently declines to have staff cut up the food. At 9:00 AM, Resident 63 was observed slumped in bed, breakfast on the bedside table, unable to reach their food. On 9/30/2024 at 12:12 PM, Resident 63 was observed in bed for lunch. The meal on the bedside table was not within her reach. The resident's head of bed was at 80 degrees. Resident 63 was slumped down in bed. On 10/01/2024 at 11:54 AM, Staff S, Occupational Therapist (OT), said the focus for Resident 63 in therapy had been self-feeding and positioning and said the most focus was spend on independent eating as it was most important to the resident. Staff S said they would like resident up in chair for all meals and Resident 63 had left shoulder pain that could inhibit positioning but that the resident does fine with eating if she is proper up right. Staff S said he'd had difficulty getting nursing to get her out of bed to eat or position her correctly in bed so she could eat. At 12:39 PM, Staff M, RCM, when asked about Resident 63's positioning for meals, stated, If I am able, I do not stand there and watch all day. When asked if the RCM talked with the CNA's about resident 63's positioning to eat or if she had noticed positioning issues, Staff M, said she had not noticed Resident 63 not being positioned in bed to eat. Staff M said they had not specifically talked with OT about positioning Resident 63 to eat. Staff M stated, yes if they [OT] send notes and we put it in the care plan, we follow up as best as we are able. It is an ongoing situation, she is positioned, she resists and goes back into a position she prefers. Review of the nursing progress notes on 10/01/2024, showed during the time frame 09/01/2024-09/24/2024, revealed no documentation of Resident 63's refusals to get out of bed. On 10/01/2024 at 1:21 PM, during an interview with Staff B, DNS and Staff N, Assistant Director of Nursing, Staff N stated, if I were a floor nurse I would definitely go and talk to the resident and ask her to go and get up and talk with her. Reference WAC 388-97-1060 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to provide pressure ulcer care consistent with professional standards of practice to prevent and treat pressure ulcers for 1 of 3 sampled residents (Resident 4) reviewed for pressure ulcers. This failure placed residents at risk for developing pressure ulcers, worsening pressure ulcers, increased pain, and a diminished quality of life. Findings included . Resident 4 was admitted to the facility on [DATE] with diagnoses including disorder of arteries and arterioles, unspecified (a disease that affects your arteries, the vessels that carry oxygen-rich blood away from your heart to your body's tissues) and osteoporosis (a condition in which bones become weak and brittle). The Significant Change Minimum Data Set, (MDS, an assessment tool), dated 08/13/2024, documented Resident 4 was severely cognitively impaired. Resident was documented to have two pressure ulcers, one of which was present upon admission. Resident 4 was documented as being at risk for pressure ulcers. Resident 4 was placed on hospice on 08/01/2024. Resident 4's Skin Care Plan, dated 06/10/2024, included the following interventions: bruise monitoring, encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, keep skin clean and dry/use lotion on dry skin, Licensed Nurse (LN) to complete weekly skin assessment, monitor/document location, size and treatment of skin injury, report any new skin impairment to LN immediately, and treatment per physician orders. A physician's order, dated 06/11/2024, showed, skin prep [quick drying liquid that can add layer of protection against friction and pressure] to bilateral heels BID (two times a day), notify provider of any changes. The order was discontinued on 07/28/2024. Resident 4's July 2024 weekly skin audits showed skin audits were completed on 07/06/2024, 07/13/2024, 07/20/2024 and 07/27/2024 with no new skin issues noted. Resident 4 was placed on alert charting on 07/28/2024, due to an unstageable pressure ulcer on the right heel. Administrative order's note, dated 07/28/2024, showed, right heel is open and needs to have a wound cleaning/dressing changing schedule. A physician's order, dated 07/28/2024, showed, right heel ulcer-wound wash, pat dry, cover with dressing - float heel. The order was discontinued 07/29/2024. A physician's order, dated 07/29/2024, showed, right heel ulcer-wound wash, pat dry, apply calcium alginate [moisture wicking dressing] and skin prep edges then cover with boarder dressing. Put blue booty on and float heel. Resident 4's August 2024 weekly skin audits showed skin audits were completed on 08/03/2024, 08/10/2024, 08/24/2024 and 08/31/2024 with no new skin issues. The 08/17/2024 audit was missing entry. (continued on next page)

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Avamere Olympic Rehabilitation of Sequim	1000 5th Avenue South Sequim, WA 98382

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/26/2024 at 10:20 AM, Staff E, Resident Care Manager (RCM)/Registered Nurse, said interventions to prevent pressure ulcers included turning, repositioning, nutritional assessments, floating heels, skin prep, and pressure relieving devices. When asked about Resident 4's facility acquired pressure ulcer, Staff E said she was not in the facility during that time, but believed it was caused by the resident's heels rubbing. When shown the missing weekly audits documenting no new skin issues, Staff E said the audits should have been documented correctly. When asked what interventions where in place for Resident 4 to prevent pressure ulcers, Staff E said wearing the blue boots. At 11:24 AM, Staff B, Director of Nursing Services (DNS) said the facility normally placed the typical interventions when a resident was at risk for pressure ulcers. Staff B said there were no interventions in place for Resident 4 to prevent new pressures ulcers. Staff B said on 08/05/2024, moon boots and floating heels were added to the interventions. Staff B said the weekly skin audits should have documented a new skin issue when it was identified. See F692 Reference WAC 388-97-1060 (3)(j)(viii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure restorative nursing programs (RNPs) to increase, maintain and/or prevent decline in range of motion (ROM), strength and mobility were provided for 16 of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) reviewed, who were assessed to require them in December 2023, when the facility stopped providing restorative services due to staffing issues. Additionally, after the facility reimplemented restorative nursing services, they failed to provide a restorative range of motion program at the frequency the resident was assessed to require for 1 of 1 resident (Resident 2) reviewed. These failures placed residents at risk for a decline in strength, range of motion, contracture formation, increased dependence on staff for activities of daily living (ADLs), and decreased quality of life. Findings included . On 09/26/2024 at 12:25 PM, Staff N, Assistant Director of Nursing (ADON)/ Restorative Nurse, reported the facility had dropped their restorative nursing services six to eight months prior (December 2023), because the Restorative Nurse transferred to another position and the Restorative aide left. When asked what happened to the residents who had been assessed to require restorative service at that time, Staff N said some of the restorative programs were transitioned to functional maintenance programs (FMP) and were assigned to the floor aides to perform while assisting residents with ADL care. On 09/26/2024 at 12:37 PM, a list of all residents who were receiving restorative services in December 2023 was requested, to include: a) The specific restorative programs each resident was assessed to require. b) Each residents' restorative nursing flowsheet. c) Each residents' restorative evaluation that assessed the programs were no longer required. d) A copy of the initial evaluation and FMP that each resident had implemented when their restorative programs were no longer provided. Staff N, ADON/ Restorative Nurse said no assessments/evaluations were done when the facility stopped providing restorative services due to staffing. On 09/27/2024 at 1:44 PM, the above requested restorative documents were again requested, this time from Staff B, Director of Nursing (DNS). No records were provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/2024 at 5:32 PM, Staff B, DNS, provided a list of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) who were on restorative services prior to the facility's restorative nursing program at the time the facility stopped providing them due to a lack of staff. The list provided did not identify what specific RNPs each resident was assessed to require. Staff B, DNS, said they were still unable to locate the restorative binders which contained each resident's specific programs and associated documentation. No further documentation was provided. 42960 <Resident 2> Resident 2 was admitted to the facility on [DATE] with a diagnosis of dementia and osteoarthritis (a chronic disease that breaks down the cartilage and other tissues in the joints). A review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/27/2024, showed the resident was severely cognitively impaired and was dependent on staff for activities of daily living. A physical therapy summary, dated 04/05/2022 - 05/30/2022, showed physical therapy had discharged Resident 2 from their program and recommended restorative services. A Restorative Referral form, dated 05/14/2022, said Resident 2's diagnosis and reason for referral were contracture management and prevention. The goals were a range of motion program for all joints and all planes of motion with a frequency of three to five times a week. A review of Resident 2's care plan, initiated on 06/10/2022, said patient has and is at risk for contractures/impaired functional range of motion of BUE [bilateral upper extremities] and BLE [bilateral lower extremities] related to Osteoarthritis and impaired mobility. The listed goal, revised on 04/11/2024,showed, patient will maintain range of motion of affected joints(s) BUE and BLE: Shoulder, elbows, wrist, fingers, hips, knees, ankles, toes. On 09/26/2024 at 11:32 AM Staff N, Assistant Director of Nursing, said Resident 2 was not getting Restorative Therapy and they were in the process of reinstating restorative therapy to all the residents again. On 09/30/2024 at 12:01 PM Staff X, Restorative Aide, said she had been the restorative aide for two weeks. Staff X said she was not familiar with Resident 2 and they were not on her list. On 10/01/2024 at 9:16 AM Staff B, Director of Nursing said she would have liked Resident 2 to have received RT but they did not until a Restorative Aide was hired. Reference WAC 388-97-1060 (3)(d), (j)(ix)

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(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** 46793 Based on observation, interview, and record review, the facility failed to accurately document, monitor and assess resident fluid intake, to follow physician orders to obtain weights, implement nutritional interventions, and reevaluate the effectiveness of the interventions for 2 of 5 sampled residents (Resident 4 & 62) reviewed for nutrition/hydration. These failures placed residents at risk for fluid volume overload, fluid and electrolyte imbalances, unplanned significant weight loss, nutritional complications and a diminished quality of life. Findings included . <Resident 4> Resident 4 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated 08/13/2024, documented Resident 4 was severely cognitively impaired. Resident 4 was placed on hospice on 08/01/2024. Resident 4's Nutritional Care Plan, dated 06/10/2024, documented Resident 4 was at nutritional risk related to diagnoses of Chronic Obstructive Pulmonary Disease (COPD, is an ongoing lung condition caused by damage to the lungs) and diagnoses of dysphagia (difficulty swallowing). Interventions included diet as ordered, fortified extra sauces/gravies/butter with meals, monitor and record daily meal consumption, Registered Dietitian to evaluate and make dietary recommendations as needed and obtain weights per orders. A Malnutritional Risk Identification assessment, dated 06/13/2024, documented Resident 4 was at risk for malnutrition. A Physician's order, dated 06/10/2024, documented weights were to be obtained every shift for three days (06/11/2024-06/14/2024. A Physician's order, dated 06/10/2024, documented weights were to be obtained every Sunday for four weeks (06/10/2024-07/14/2024). Weights should have been obtained on 06/16/2024, 06/23/2024, 06/30/2024 and 07/07/2024. Resident 4's weights were obtained on the following dates: 06/10/2024 137.0 Lbs (pounds) 06/12/2024 136.6 Lbs 06/25/2024 128.0 Lbs 07/09/2024 121.6 Lbs 07/22/2024 121.6 Lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/12/2024 109.5 Lbs 09/22/2024 100.6 Lbs Resident 4's weight records showed missing weights on 06/11/2024, 06/16/2024, 06/23/2024, 06/30/2024 and 07/07/2024. Resident 4's weight record showed weights were only being obtained every 13-14 days, instead of weekly. On 06/10/2024, Resident 4 weighed 137.0 lbs. On 07/10/2024, Resident 4 weighed 121.6 pounds which was a -11.24 % loss in 30 days. A progress note, dated 07/10/2024, documented Resident 4's weight as 121.6 pounds. The Electronic Health Records (EHR) documented no follow up, including progress notes, physician's review /orders or dietary evaluation/assessments for the significant weight loss. Resident 4 was placed on hospice on 08/01/2024. A Nutritional Assessment, dated 08/13/2024, documented Resident 4's weight on 08/12/2024 as 109.5 pounds. On 06/10/2024, Resident 4 weighed 137 lbs. On 08/12/2024, Resident 4 weighed 109.5 pounds, which was a -20.07 % loss in 60 days. On 09/26/2024 at 10:20 AM Staff E, Resident Care Manager (RCM)/Registered Nurse, said when a resident was identified as losing weight, the resident would be placed on the Nutrition At Risk (NAR) list, to be discussed at the next NAR meeting. At the NAR meeting the team discusses concerns and makes recommendations, including reassessing and developing new interventions to address the weight loss. Staff E said the facility notifies the doctor and the family of the concerns and recommendations. Staff E said significant weight loss was over five percent loss in less than a month and more than 10 percent loss in six months. When shown Resident 4's weight loss record, Staff E said she should have put a note in the EHR but failed to do so, stating that the weights were not obtained because the family asked the facility to not disturb Resident 4. At 11:24 AM, Staff B, Director of Nursing Services (DNS) said when a resident loses weight, the resident was placed on the weekly NAR meeting to discuss the concerns. The family and doctor would be notified. When shown Resident 4 weight loss record, Staff B, said Resident 4's weight should have been caught and addressed. At 1:28 PM, Staff E, RCM, said no nutritional assessments were complete for Resident 4, due to the Registered Dietitian being out of the building for an extended period. 37044 <Resident 62> (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 62 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnoses of heart failure and kidney disease, and received diuretic (pulls excess fluid off the body) medication during the assessment period. A chronic kidney disease care plan, revised 09/17/2024, showed Resident 62 was on an 1800 milliliter per day fluid restriction (1800 ml/day). The kitchen was to provide 240 ml with each meal for a total of 720 ml/day, and nursing was to provide 360 ml of fluid each shift for a total of 1080 ml. On 09/25/2024 at 11:10 AM and 09/30/2024 at 1:41 PM, Resident 62 was observed with two 300 ml plastic cups with blue lids sitting on their bedside table. Both cups contained a clear liquid. Review of Resident 62's EHR showed their fluid intake with meals was recorded on the meal monitor in point of care (computer program), and fluids provided by nursing were recorded on the Medication Administration Record (MAR). Review of the August 2024 MAR showed nurses were recording the amount of fluid they provided each shift, but there was no direction or spot provided for nursing to reconcile the fluid intake recorded on the meal monitor with the fluid intake recorded on the MAR to calculate the resident's 24-hour fluid intake total. On 10/27/2024 at 11:19 AM, Staff N, Assistant Director of Nursing (ADON), explained the purpose of the fluid restriction was to manage the resident's fluid volume status due to chronic kidney disease. Staff were to record the resident's fluid intake and then assess whether the resident was adherent or non-adherent with the restriction. If the resident was non-adherent, nursing would educate the resident to the risks and benefits and notify the physician. Reconciliation of Resident 62's recorded intake on the August 2024 meal monitor and MAR from 09/01/2024 - 09/22/2024, showed the resident exceeded the 1800 ml fluid restriction on six of 22 days. Review of the EHR showed no documentation was present to show staff had identified the resident frequently exceeded the 1800 ml fluid restriction. On 09/27/2024 at 11:25 AM, when asked if there was any documentation to show facility staff were calculating Resident 62's 24 hour intake total, Staff N, ADON, stated, No. Staff N then confirmed, that the failure to calculate the resident's 24 hour total fluid intake, resulted in the failure to identify Resident 62 had exceeded the restriction on multiple occasions, detracted from identifying the resident's educational needs elated to the risks and benefits of non-adherence, as well as the need for physician notification. Reference WAC 388-97-1060 (3)(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37044 Based on interview, and record review, the facility failed to ensure there were sufficient qualified nursing staff to provide restorative nursing services for 16 of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) reviewed for restorative nursing. Additionally, review of Resident Council Minutes for June, July and August 2024, showed 3 of 3 months contained resident complaints related to staffing. The failure to have sufficient qualified nursing staff to respond timely to resident call lights and care needs, and that ensured the provision of restorative nursing programs (RNPs) residents had been assessed to require, placed residents at risk for a decline in strength, range of motion, contracture formation, increased dependence on staff for activities of daily living (ADLs), unmet care needs and decreased quality of life. Findings included . <Facility Assessment> Review of the facility's assessment, dated 07/10/2024, showed residents' ADLs were supported by restorative aides who helped residents with ROM, contractures, and splint application as needed. The facility would ensure staff training/competency/skill sets that were necessary to provide the level and types of care needed for the resident population. When determining staffing needs the facility would assess the specific needs of each resident unit in the facility and adjust as necessary. <Resident Council> August 2024 The Resident Council minutes showed residents reported concerns about call lights being responded to in a timely manner. Call light audits performed in response to the complaint showed the following: - A 09/01/2024 call light audit showed 13 call lights were activated during the audit, with the longest response time being 22 minutes. - A 09/03/2024 call light audit showed four call lights were activated during the audit, with the longest response time being 65 minutes. - A 09/04/2024 call light audit showed seven call lights were activated during the audit, with response times of 38, 49, and 29 minutes recorded for 3 of the 7 lights activated. July 2024 The Resident Council minutes showed a resident had complaints about care. Review of the Resident Council Department Response Form, dated 07/22/2024, showed a resident complaint of staff members telling residents they would return but failing to do so. Thus, the resident (s) were Left hanging. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Resident Council minutes showed resident complaints of long call light response times and staff informing them they are working short on the floor. Review of the Resident Council Department Response Form, dated 06/24/2024, recorded the issues identified by residents as: - Not receiving their restorative program(s) - Long call light wait times - Staff telling resident(s) they are working short. Weekends were identified as being worse. <Restorative Services> On 09/26/2024 at 12:25 PM, Staff N, Assistant Director of Nursing (ADON) and Restorative Nurse, reported the facility stopped providing restorative nursing services six to eight months prior (December 2023) because the Restorative nurse transferred to another position and the Restorative aide left. When asked what happened to the residents who had been assessed to require restorative services Staff N indicated some of the restorative programs transitioned to functional maintenance programs (FMPs) that the assigned aide perform during activity of daily living care. When asked how therapy referrals for restorative services were addressed Staff N indicated they had not received restorative referrals from therapy until recently, after the facility had hired a restorative aide. On 09/25/2024 at 2:23 PM, Staff FF, Occupational Therapy Assistant (OTA), said when they were hired in August 2023 the facility did not have Restorative Nursing from then until around March 2024. Staff FF said they did not make restorative referrals during that time because there were no restorative staff. On 09/26/2024 at 12:37 PM, a list of all residents who were on restorative services in December 2023 was requested, to include each residents' specific programs, restorative nursing assessments that showed each resident no longer required restorative services, each residents associated restorative flowsheets and initial evaluations for each residents who was started on FMPs. No records were provided On 09/30/2024 at 5:32 PM, Staff B, DNS, provided a list of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) who were on restorative services when the facility stopped providing them due to lack of restorative staff. Staff B, DNS, said they were unable to locate the restorative binders, which contained each resident's specific programs and associated restorative flowsheets. On 10/01/2024 at 9:16 AM, Staff B, DNS, confirmed the facility stopped providing restorative services due to staffing issues, and acknowledged there were residents that should have RNPs, but said [the facility] could not [provide RNPs] until they hired someone. Reference WAC 388-97-1080 (1)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure that cognitively impaired residents had social services to assist with obtaining a legal representative, for 1 of 21 sampled residents reviewed (Resident 171). This failure placed residents at risk for not being able to provide informed consent, confusion, unidentified and unmet care needs, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 171 was first admitted to the facility on [DATE]. Resident 171 had diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) and generalized anxiety disorder (repeated episodes of intense anxiety, fear or terror). The Annual Minimum Data Set assessment, dated [DATE], showed Resident 171 was severely cognitively impaired, with no ability to recall. Review of document titled, Health Care Decision Declaration, dated [DATE], showed Resident 171 had a surrogate health care decision maker, which expired on [DATE]. On [DATE] at 3:46 PM, Collateral Contact reported Resident 171, appeared to have been in custodial care dating back to, at least 2022, and there had not been an advance directive in place and no apparent efforts towards obtaining any sort of guardianship or establishing a legal decisionmaker. There is a concern that [Resident 171] is a complex patient and now there are no criteria for [Resident 171's] return to [the nursing home facility]. During an interview on [DATE] at 11:07 AM, Staff D, Social Services Director, stated that Resident 171's ex-wife was involved in care, and that if the facility were to pursue guardianship it would take a long time. Staff D stated that since being employed at the facility for a little over a year, there had been no efforts to obtain guardianship for Resident 171. Staff D stated that Resident 171 had a health care declaration form. Staff D reviewed the expiration date, stated the form was no longer valid, the individual listed on the form was no longer able to make any decisions as of [DATE], and that Resident 171 was unable to make their own decisions. During an interview on [DATE] at 2:18 PM, Staff B, Director of Nursing Services, stated Social Services was responsible for obtaining a power of attorney or guardian, and that Resident 171 should have someone to speak on their behalf. Reference WAC [DATE] (1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to document observed behavioral monitoring related to the use of psychotropic (affecting the mind) medications for 4 of 6 current sampled residents (Residents 25, 62, & 372) and 1 of 6 discharged sampled residents (Resident 171) reviewed for behavior monitoring. The facility's failure to monitor behaviors and side effects observed related to use of a psychotropic medications placed residents at risk for adverse side effects, medical complications and a diminished quality of life. Findings included . <Resident 25> Resident 25 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/15/2024, documented Resident 25 was cognitively intact. Resident 25 was diagnosed with generalized anxiety (mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), major depressive disorder (mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The September 2024 Medication Administration Records (MAR) and the September 2024 Treatment Administration Record (TAR) documented Resident 25 was having anxiety behaviors on 09/07/2024 day shift and was missing entries on 09/13/2024 and 09/19/2024. Resident 25 was documented to have anxiety behaviors on 09/07/2024, 09/09/2024, 09/14/2024, 09/19/2024, 09/21/2024 and 09/24/2024, evening shift. Resident 25 was documented to have depressant behaviors on 09/07/2024, 09/09/2024, 09/14/2024, 09/19/2024, 09/21/2024 and 09/24/2024, evening shift. Resident 25 was documented to have psychotic behaviors on 09/07/2024, 09/09/2024, 09/14/2024, 09/19/2024, 09/21/2024 and 09/24/2024, evening shift. The MAR and TAR do not document what behaviors were being observed by staff. The Electronic Health Records (EHR) documented no progress notes on dates when behaviors were observed. (continued on next page)

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Avamere Olympic Rehabilitation of Sequim	1000 5th Avenue South Sequim, WA 98382

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/2024 at 10:20 AM, Staff E, Resident Care Manger/Registered Nurse, said behavior monitoring was documented in PCC [electronic documentation/charting] under behaviors, but not all medications require monitoring. When shown the symbols on the MAR/TAR, Staff E said the check marks mean a behavior was observed for that resident. When asked if the specific behaviors observed should be documented, Staff E said yes, there should have been a note documenting what behaviors staff were observing, and acknowledged it was somthing that needed to be addressed. At 11:24 AM, Staff B, Director of Nursing Services (DNS), said this concern was brought to her attention the day prior and agreed the behaviors observed by staff should be documented in the system. 37044 <Resident 62> Resident 62 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 07/13/2024, showed the resident was cognitively intact, had diagnoses of depressive (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorders (repeated episodes of intense anxiety, fear or terror) and received antidepressant and antianxiety medications during the assessment period. Review of Resident 62's electronic health record (EHR) showed the following psychotropic medication orders: a) 08/05/2024 order for mirtazapine (an antidepressant) daily at bedtime for major depression. b) 07/09/2024 order for Seroquel (an antipsychotic) daily at bedtime for unspecified dementia with other behavioral disturbances. Review of the EHR showed no documentation to show an Abnormal Involuntary Movement Scale (AIMS, a test to measure involuntary movements known as tardive dyskinesia, a disorder that sometimes develops as a side effect of long-term treatment antipsychotic medications) test had been performed on Resident 62 with the initiation of seroquel or since. Additionally, no consent was found for the use of Seroquel or mirtazapine. On 09/27/2024 at 11:16 AM, Staff N, Assistant Director of Nursing (ADON), explained when residents get an order for a psychotropic medication before initiation the nurse must explain the risks and benefits of the medication and obtained the resident's consent for its use. If the medication was an antipsychotic, then an AIMS test would also be conducted, upon initiation of the medication therapy and then repeated every six months. On 09/27/2024 at 11:18 AM, when asked if there was documentation to show facility staff obtained the resident's consent prior to initiating the mirtazapine and Seroquel, and whether an AIMS test was conducted with the initiation of Seroquel Staff N, Assistant Director of Nursing, stated, No. A behavior monitor care plan, revised 07/16/2024, showed the Target Behaviors (TB)s identified for the use of mirtazapine and Seroquel were as follows: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Seroquel TBs - Verbal aggression, hallucinations/delusions, refusal of care and physical aggression. b) Mirtazapine TBs - tearfulness, negative statements and social isolation/decreased social engagement. c) Lorazepam (discontinued on 09/06/2024 but received greater than 30 days after the initiation of Seroquel) TBs - refusal of care, agitation and verbal aggression. Review of the EHR showed no documentation or indication to support Resident 62 had experienced hallucinations or had a history of hallucinations, which was an identified TBs for the use of Seroquel. On 10/01/2024 at 12:04 PM, when asked if there was any documentation to support Resident 62 had ever had hallucinations Staff D, Social Services Director (SSD), explained that the TBs identified for staff to monitor for each medication were just behaviors that staff should look, not necessarily behaviors that the resident had demonstrated. When asked why a medication would be initiated to treat a behavior the resident had never demonstrated, no response was provided. On 10/01/2024 at 12:18 PM, Staff N, ADON, confirmed that the TBs should be the demonstrated behavior(s) by the resident that the medication was initiated to treat (target). Staff N indicated monitoring whether there was a decrease, increase, or no change in the frequency/prevalence of the identified TB after invitation of treatment, helped staff evaluate the effectiveness and need for continued use of the medication. 50846 <Resident 63> including, generalized anxiety, major depressive disorder, hallucinations (an experience involving the apparent perception of something not present), panic disorder (unexpected and repeated episodes of intense fear accompanied by physical symptoms), attention and concentration deficit and hydrocephalus (a condition in which fluid accumulates in the brain.) During the time frame 09/01/2024 - 09/24/2024, Resident 63 was prescribed four different psychotropic medications (affecting how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). These medications included a stimulant, antianxiety and antidepressant medication. No behavior monitoring to ensure the effectiveness and or side effects of these medications was in place. During the time frame 09/01/2024 - 09/24/2024, Resident 63's Behavior Monitor Plan, showed Resident 63 was having anxiety behaviors on September 2, 3, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, day shift. Resident 63 was documented to have anxiety behaviors on September 4, 5, 6, 7, 11, 12, 13, 14, 18, 19, 20, 21, 23, evening shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 63 was documented to have anxiety behaviors on September 2, 3, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, night shift. Resident 63's MAR and TAR did not document what behaviors were being observed by staff. The EHR documented no progress notes on dates when behaviors were observed by staff. During the time frame 09/01/2024 - 09/24/2024, Resident 63's Behavior Monitor Plan, showed Resident 63 was having symptoms of depression on September 5, 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, day shift. Resident 63 was documented to have symptoms of depression on September 2, 3, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, evening shift. Resident 63 was documented to have symptoms of depression on September 2, 3, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, night shift. Resident 63's MAR and TAR did not document what behaviors were being observed by staff. The EHR documented no progress notes on dates when behaviors were observed by staff. <Resident 372> Resident 372 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 372 had moderate cognitive impairment. Resident 372 was diagnosed with major depressive disorder, anxiety disorder, dementia with psychotic disturbance (a condition that occurs when a person with dementia experiences hallucinations or delusions.) During the time frame 09/11/2024 - 09/24/2024, Resident 372 was prescribed three different psychotropic medications. These medications included a stimulant, an antianxiety and antidepressant medication. No behavior monitoring to ensure the effectiveness and or side effects of these medications was in place. During the time frame 09/11/2024 - 09/24/2024 Resident 372 Behavior Monitor Plan, showed Resident 372 was having anxiety behaviors on September 17, 18, 19, 20, day shift. Resident 372 was documented to have anxiety behaviors on September 17, 18, 19, 20, 21, 23, evening shift. Resident 372 was documented to have anxiety behaviors September 16, 17, 18, 19, 22, 23, 24, night shift. Resident 372's MAR and TAR did not document what behaviors were being observed by staff. The EHR documented no progress notes on dates when behaviors were observed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the time frame 09/01/2024 - 09/24/2024, Resident 372's Behavior Monitor Plan, showed Resident 372 was having symptoms of depression on September 12, 13, 14, 17, 18, 19, 20, day shift. Resident 372 was documented to have symptoms of depression on September 11, 12, 13, 14, 18, 19, 20, 21, 23, evening shift. Resident 63 was documented to have symptoms of depression September 11, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24, night shift. Resident 372's MAR and TAR did not document what behaviors were being observed by staff. The EHR documented no progress notes on dates when behaviors were observed. On 09/25/24 at 2:00 PM, during an interview, Staff M, Resident Care Manager, was asked to show the surveyor how to interpret the facility's behavior monitoring record for Resident 63. Staff M was unable to explain how to read the sheets. Staff M said she would get clarification from Staff N, ADON. At 2:10 PM, Staff M, said she was confused, and would show the surveyor on Point Click Care (PCC). Staff M could not show on PCC what behaviors were being monitored for Resident 63, what interventions were in place to mitigate anxious or depressed behaviors, nor, if the interventions the facility had in place were effective. At 3:45 PM, Staff D, Social Services, said with their behavior monitor tracking system there was no way to track the intervention, there was no way to say this the interventions theyt tried prior to administering the medication. Staff S said, I do not know how nursing would monitor slight agitation as opposed to moderate to severe. Staff D stated, Unfortunately, we need a new system for behavior monitoring, bottom line we can't tell. At 4:00 PM, Staff B, Director of Nursing, with Staff D present, stated, I will look at it, the expectation is nursing needs to try non-pharmalogical interventions before giving medications. They need to make a progress note of anxiety or depressive symptoms. They need to monitor for side effects. If there is a multiple medication amount there needs to be a scale to determine dose. They should be documenting behaviors in the progress notes. The behavior monitoring sheets are not working. 50945 <Resident 171> Review of the EHR showed Resident 171 was first admitted to the facility on [DATE], with a hospitalization on [DATE] and a readmission to the facility on [DATE] and subsequent transfer back to the hospital on 08/22/2024 where the resident remained at this writing. Resident 171 had diagnoses including dementia and major depression. The Annual MDS, dated [DATE], recorded Resident 171 was severely cognitively impaired. Review of Resident 171's medications, for August 2024, showed Resident 171 returned from the hospital on 08/19/2024 with an order for Trazadone (an antidepressant). An order for behavior monitoring for the antidepressant was not found. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/30/2024 at 2:18 PM, Staff E, RCM/RN, when asked for documentation of behavior monitoring for Resident 171's antidepressant medication, and after reviewing the EHR, stated the provider must not have put in a new order and there should have been. During an interview on 09/30/2024 at 2:18 PM, Staff B, DNS, stated Resident 171 needed to have depression behavior tracking, and it did not meet expectations that Resident 171 was readmitted without an order for antidepressant monitoring. Reference WAC 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50945 Based on observation, interview, and record review, the facility failed to label and store drugs and biologicals used in the facility in accordance with current accepted professional principles for 2 of 3 medication carts ([NAME] & Dungeness) and 1 of 3 medication rooms (One) reviewed for medication storage and labeling, and 1 of 21 rooms for sampled residents (Resident 27). This failure placed residents at risk for decrease effectiveness of medication, worsening symptoms, unidentified complications, and a diminished quality of life. Findings included . <Medication Room> During an observation and interview of medication room one on [DATE] at 3:25 PM, a vial of Tuberculin Purified Protein (proteins used for the tuberculin skin test for diagnosis of tuberculosis) was observed to be opened without a date listed. Staff N, Assistant Director of Nursing (ADON), stated that the vial was opened, not dated, and should have been dated. Observation of a vial of Insulin Lispro (medication used to control blood sugars for people with diabetes) showed it was opened without a date listed. Staff N stated it was opened, not dated, should have been dated. Record review on [DATE] showed that Tuberculin Purified Protein should have been discarded 30 days after opening, and Insulin Lispro should be discarded after 28 days of use. During an observation of the [NAME] medication cart on [DATE] at 3:47 PM, a Fluticasone-Salmeterol Advair Diskus Inhalation medication (an inhaler with combination medication to help open the airways of the lungs) was observed to have an opened date of [DATE]. Record review on [DATE] showed that Fluticasone-Salmeterol Advair Diskus Inhalation medication was only good for one month after opening. During an observation and interview on [DATE] at 10:29 AM, Staff K, Infection Nurse/ Registered Nurse (RN), reviewed the pharmacy binder and medication cart, and stated that since the Fluticasone-Salmeterol Advair Diskus Inhalation medication was opened on [DATE], it had been opened for more than one month, was expired, and needed to be removed from the medication cart. During an interview on [DATE] at 10:41 AM, Staff B, Director of Nursing Services (DNS), stated that the Tuberculin Purified Protein and Insulin vials should have been dated if opened, and staff should have looked at the date on the Fluticasone-Salmeterol Advair Diskus Inhalation medication. Staff B stated these observations did not meet expectations. 37044 <Dungeness Medication Cart> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An audit of the Dungeness hall medication cart on [DATE] at 3:40 PM showed the following: a) Resident 6's Fluticasone propionate aerosol inhaler had an open date of [DATE]. b) Resident 39's Fluticasone propionate aerosol inhaler was opened and undated. c) Resident 62's Humolog insulin had an open date of [DATE]. Review of the pharmacy's medication storage quick reference guide showed fluticasone propionate aerosol inhalers were to be discarded 30 days after opening, and Humolog insulin 28 days after opening. On [DATE] at 3:47 PM, Staff BB, Registered Nurse, confirmed the above referenced medications were opened and undated, or past the discard date. 50392 <Resident 27> Resident 27 was admitted to the facility [DATE]. The Admission Minimum Data Set, (MDS an assessment tool), dated [DATE] indicated Resident 27 was cognitively intact. A Physicians Order, dated [DATE], documented Resident 27 was ordered Nystatin External Powder, 100, 000 UNIT/GM (gram), Nystatin (Topical), Apply to Under Abdominal folds topically two times a day for rash. On [DATE] at 9:19 AM, a bottle of medication was observed on top of Resident 27's dresser in their room. The label on the bottle read Nystatin Topical Powder (an antifungal powder used to treat rash) with Resident 27's name on it. At 9:27 AM, Staff L, Registered Nurse, said, to have a medication in a resident's room you needed MD approval and an order for self-administration. When brought to Resident 27's room and shown the bottle of medication, Staff L said, the bottle of Nystatin had been left there by Staff L in the morning, and it should not have been. On [DATE] at 10:49 AM, Staff M, Resident Care Manager, when asked what her expectation was for keeping medications at bedside, she said, we do not keep medications in a resident room unless the resident had gone through an assessment and had been supplied a lock box and key. When informed Nystatin had been found at the bedside of Resident 27 and asked if that met her expectation she stated, of course not, it is a medication, so I would expect it is not in the room. Reference WAC [DATE](2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure residents' medical records were complete accurate and readily accessible for 16 of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) reviewed for restorative services and for 1 of 1 Resident (Resident 11) reviewed for Hospice services. The facility failed to maintain documentation of the provision of restorative nursing services for residents who were assessed to require them. Additionally, the facility failed to maintain hospice documentation inlcuding details regarding coordination with hospice services, hospice recertification and details regarding visits by hospice staff. These failures resulted in residents' health records being incomplete and/or inaccurate and placed residents at risk for unmet care needs and potential negative health outcomes. Findings included . <Hospice Documentation> Resident 11 admitted to the facility on [DATE]. Review of the [DATE] Annual Minimum Data Set (MDS, an assessment tool), showed the resident had severe cognitive impairment and received hospice services Review of the Hospice Comprehensive Assessment and Plan of Care showed it was expired. It was for the certification period of [DATE] - [DATE]. A current hospice plan of care was not found. On [DATE] at 12:49 PM, Staff CC looked through Resident 11's paperwork and stated hospice had not provided the residents current coordinated plan of care yet, and indicated they would request it. Review of Resident 11's electronic health record (EHR) showed there was no documentation present to show what hospice staff had visited, when they visited, what they assessed and/or what care they provided. On [DATE] at 3:32 PM, the last six weeks of Resident 11's hospice visit notes, from all disciplines, was requested from Staff B, Director of Nursing. On [DATE] at 2:10 PM, Staff N, ADON, confirmed Resident 11's facility electronic health record (EHR), had no documentation present that showed what hospice staff had visited, when, or what occurred during the visit. When asked what disciplines had visited Resident 11 in the past two weeks, how many times, and what was done during the visits Staff N said they did not know because the information was not present in the Resident 11's EHR. The last six weeks of hospice visit notes, from all disciplines, was again requested but not provided. On [DATE] at 11:45 AM via telephone, Staff B, Director of Nursing, said they had requested Resident 11's hospice visit notes four to five times, but hospice had not provided anything yet. <Restorative Documentation> (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:25 PM, Staff N, Assistant Director of Nursing (ADON), reported the facility stopped providing restorative nursing services six to eight months prior because the Restorative nurse transferred to another position and the Restorative aide left. When asked what happened to the residents who had been assessed to require restorative service Staff N indicated some of the restorative programs transitioned to functional maintenance programs (FMP) that the assigned aide performed during activity of daily living care. On [DATE] at 12:37 PM, a list of all residents who were on restorative services in [DATE] was requested, to include each residents' specific programs, restorative nursing assessments that showed each resident no longer required restorative services, each residents associated restorative flowsheets and initial evaluations for each residents who was started on a FMP. On [DATE] at 1:44 PM, the above requested restorative documents were again requested, this time from Staff B, Director of Nursing (DNS). No records were provided. On [DATE] at 5:32 PM, Staff B, DNS, provided a list of 16 residents (Residents 41, 28, 21, 29, 20, 23, 26, 34, 9, 18, 33, 48, 2, 172, 39 and 10) who were on restorative services prior to the facility's restorative nursing programs being discontinued due to staffing. Staff B, DNS, said facility staff were unable to locate the restorative binders, which contained each resident's specific programs and associated flowsheets. On [DATE] at 11:53 AM, Staff B said the facility was still unable to locate the requested restorative documentation for the 16 residents the facility identified as being on restorative nursing services at the time they were discontinued due to staffing issues. No restorative documentation was provided. Reference WAC [DATE] (1)(a)(i-iv)(b) See F688 See F849

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to have a system in place that ensured effective communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 1 resident (Resident 11) reviewed for hospice services. The facility failed to obtain and/or maintain a copy of a resident's current hospice coordinated plan of care, to have documentation in residents' electronic health records that showed what hospice disciplines (e.g. registered nurse, chaplain, certified nursing assistant, massage therapist) had visited, when they visited, and what care was provided. These failures detracted from staffs' ability to effectively collaborate, communicate and coordinate care with the Hospice provider and placed residents at risk for not receiving necessary care and services and/or unmet care needs. Findings included . Resident 11 admitted to the facility on [DATE]. Review of the [DATE] Annual Minimum Data Set (MDS, an assessment tool), showed the resident had severe cognitive impairment and received hospice services. Review of the Hospice Comprehensive Assessment and Plan of Care showed it was expired. It was for the certification period of [DATE] - [DATE]. A current hospice plan of care was not found. On [DATE] at 11:09 AM, Staff N, Assistant Director of Nursing (ADON), confirmed Resident 11's coordinated hospice plan of care was from the previous benefit period and indicated Staff CC, Medical Records Director, may have the current hospice plan of care and not scanned it in yet. On [DATE] at 12:49 PM, Staff CC looked through Resident 11's paperwork and said hospice had not provided the resident's current coordinated plan of care yet, and indicated they would request it. Review of Resident 11's electronic health record (EHR) showed there was no documentation present to show what hospice staff had visited, when they visited, what they assessed and/or what care they provided. Review of the facility's hospice contract showed the interdisciplinary team (IDT) member identified as the facility's hospice liaison was Staff D, Social Services Director (SSD). On [DATE] at 2:13 PM, when asked about their role in facilitating communication and coordination of care with hospice, Staff D, SSD, said they made the initial hospice referrals to the hospice, but had no further role related to the communication and coordination of hospice services. On [DATE] at 3:32 PM, the last six weeks of Resident 11's hospice visit notes, from all disciplines, was requested from Staff B, Director of Nursing. (continued on next page)

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	505327	A. Building B. Wing	10/01/2024

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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:04 PM, when asked where hospice staff signed in for visits and the location of their notes Staff N, ADON, said hospice staff did not leave visit notes for residents' records at the facility. When asked how the facility knew which hospice staff had visited, when, what was assessed, and what care, if any, was provided, Staff N, ADON, said the hospice staff spoke with the floor nurse prior to leaving to have them sign. When asked if the facility nurse had to read the visit note and then sign that they did, Staff N, ADON, laughed and said, no, the hospice nurse just sticks out their pad and you sign to show they were present in the building. On [DATE] at 2:10 PM, Staff N, ADON, confirmed Resident 11's facility EHR, had no documentation present that showed what hospice staff had visited, when, or what occurred during the visit. When asked what disciplines had visited Resident 11 in the past two weeks, how many times, and what was done during the visits, Staff N said they did not know. The prior six weeks of hospice visit notes, from all disciplines, was again requested but not provided. On [DATE] at 11:45 AM via telephone, Staff B, Director of Nursing, said they had requested Resident 11's hospice visit notes four to five times, but hospice had not provided anything yet. No Associated WAC

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review, the facility failed to maintain essential equipment in working condition for 1 of 5 refrigerators in the facility's kitchen and 2 of 4 resident nourishment refrigerators (A & B) at each nursing station. Additionally, the facility failed to maintain hot water temperatures at safe levels in 4 of 7 occupied resident rooms (102, 123, 214 & 203) and 1 of 2 dining rooms ([NAME]) reviewed for functional essential equipment. These failures placed residents at risk for food borne illness or for serious burns and decreased quality of life. Findings Included <Facility's Kitchen Refrigerator> During an interview with Staff W, Kitchen Manager, on 09/25/2024 at 11:40 AM, the digital thermometer of one refrigerator (A) read 47 degrees Fahrenheit (F) The potentially hazardous foods inside Refrigerator (A) were temped: - 3 of 10 Chef Salads for lunch this day, 55 degrees F. - 1 of 1 Ham Sandwich temped at 56 degrees F - Dessert, ambrosia, at 46 degrees F - Nutritious shakes at 43 degrees F - Cottage cheese at 43 degrees F - Yogurt at 43 degrees F Staff W said the ham was pulled out of Refrigerator B at 11:00 AM - 11:15 AM. The sandwiches and salads were made at this time and placed back into Refrigerator A to chill. The problem was, they are not cooling. At 1:00 PM, Refrigerator A was rechecked to determine proper cooling. The digital thermometer on the outside of the refrigerator registered at 49 degrees F. The thermometer located inside was 42 degrees F. The temperature of a pitcher of water was temped at 45 degrees F inside the refrigerator. Staff W said this was unusual and thought the refrigerator was broken. All foods were removed. <Resident Personal Food at Each Nursing Station and Resident Nourishment Refrigerator> On 09/27/2024 at 9:33 AM, during an interview, Staff W, Dietary Manager, stated, there is one nourishment refrigerator directly outside the [NAME] Dining Room. The kitchen staff is responsible for cleaning and temperature control. At the three nursing stations, there are refrigerators for resident food, nursing is responsible for cleaning and temperature control of these refrigerators. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:25 AM, on Unit Two's nursing station, the facility's temperature log titled, Temperature Log for Refrigerator and Freezer - Fahrenheit, for September, showed during the time frame of 09/01/2024 to 09/27/2024, nursing staff logged in the refrigerator temps fifty times. The safe temperature range indicated on the form for the refrigerator was 36 degrees F to 46 degrees F. Thirty seven of the entries indicated the refrigerator was 42 degrees F or higher. Potentially hazardous food (yogurt) was observed in the refrigerator. During an interview at 10:30 AM, Staff T, Licensed Nurse (LN), said the refrigerator was used to keep residents' food, and the night shift monitored and cleaned the refrigerators. At 10:45 AM, on Unit Three's nursing station, the facility's temperature log titled, Temperature Log for Refrigerator and Freezer - Fahrenheit during the time frame of 09/01/2024 to 09/27/2024, nursing staff logged in the refrigerator temps fifty times. The safe temperature range indicated on the form for the refrigerator was 36 degrees F to 46 degrees F. Thirty two of the entries indicated the refrigerator was 42 degrees F or higher. Potentially hazardous food (yogurt and cheese) was observed in the refrigerator. During an interview at 10:50 AM, Staff U, LN, said the refrigerator was used to keep residents' food. Staff U discarded the food in the refrigerator. On 9/29/2024 at 2:00 PM, during an interview with Staff B, Director of Nursing, when showed the temperature logs, said the temps were within range. The facility's temperature monitoring forms used at the nursing stations indicate an appropriate range of 36-46 degrees F. The intended use of these forms was specific for monitoring COVID 19 vaccines and not potentially hazardous foods. Staff B stated we need new forms <Water Temperatures> On 9/30/2024 at 3:30 PM, the water temperature in resident room [ROOM NUMBER] was temped at 120.5 degrees F. Additional water temperatures were taken in areas residents' access. - 09/30/2024 3:56 PM room [ROOM NUMBER] -117.5 degrees F - 09/30/2024 3:58 PM [NAME] Dining Room (DR) - 120.6 degrees F - 09/30/2024 4:00 PM room [ROOM NUMBER] -120.6 degrees F - 09/30/2024 4:01 PM room [ROOM NUMBER] -121 degrees F - 09/30/2024 4:03 PM room [ROOM NUMBER] - 117.5 degrees F - 09/30/2024 4:05 PM room [ROOM NUMBER] - 119.3 degrees F At 4:15 PM, Staff V, Maintenance Director, accompanied surveyors checking water temperatures and the following were tempted with Staff V's thermometer (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 09/30/2024 4:16 PM [NAME] dining room - 122.1 degrees F - 09/30/2024 4:18 PM Cypress court DR - 119.3 degrees F - 09/30/2024 4:20 PM Shower Room West- Sink- 116.0 and then shower water - 107.4 - 09/30/2024 4:24 PM room [ROOM NUMBER] - 120.2 degrees F - 09/30/2024 4:27 PM room [ROOM NUMBER] - 118 degrees F - 09/30/2024 4:30 PM room [ROOM NUMBER] - 115.8 degrees F At 4:30 PM, the boiler setting was observed to be set at 118 degrees F. Staff V provided the facilities temperature log and instructions for water temperature testing, there was no facility policy. A water temperature log for the previous 13 weeks was documented on a three by five card. Staff V stated, each handwritten one by one box on the card reflected the weekly temperatures. The temperature log revealed the sink in resident room [ROOM NUMBER] had a temperature of 120 -128 degrees F six (6) of the past 13 weeks temperatures were documented. There were no dates to indicate when the temperatures were taken. Staff V said the Maintenance Assistant documented the temperatures and since he was not available, he really could not speak to it. On 10/01/2024 at 10:05 AM, Staff V said he called Brother's Plumbing, to check on all the check valves as that was the only other thing he could think of for the discrepancies because the water temps should not be higher that the boiler was set at. Reference WAC 388-97-2100