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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** Based on observation, interview and record review, the facility failed to adequately and consistently assess developing/worsening skin conditions/breakdown, follow the care/treatment plan and interventions as ordered, and report changes to medical provider in a timely manner for 1 of 1 sampled resident (Resident 24) reviewed for pressure ulcers. Resident 24 experienced harm when their Moisture Associated Skin Damage (MASD, inflammation and erosion of the skin caused by prolonged exposure to moisture) on their coccyx (tailbone) that was present on admission to the facility worsened and developed into two unstageable pressure ulcers (PU - a type of wound where the depth cannot be determined due to the presence of dying tissue or eschar, making it difficult to assess the extent of tissue damage) over the coccyx and left buttocks, which showed signs of infection and caused an increase in pain levels and a diminished quality of life. Findings included .The facility's policy titled Skin and Wound Management, dated November 2025, documented: .2) the Nurse Manager and/or designee will evaluate any new skin integrity and document findings in the clinical record. 6) skin checks are completed by the Licensed Nurse weekly. 7) if a Resident is identified to have a new skin alteration the Licensed Nurse will document in the resident record the evaluation of the wound, provider notification and obtain treatment orders. 8) Skin documentation of wounds or pressure injury identification is complete in the resident's record. An assessment will be complete for each area. Areas include, but not limited to pressure injuries.10) Actual pressure injuries. wounds will have weekly documentation that included measurements and how the wound is progressing (improvement, worse unchanged).On 12/01/2025 at 1:13 PM, Staff W, Receptionist, emailed to the department, the full resident Matrix (list of all residents and identified care concerns). The Matrix, dated 12/01/2025, documented that no one in the facility had any pressure ulcers, either admitted with or facility acquired. Resident 24 was admitted to the facility on [DATE]. The admission Minimum Dat Set, (MDS, an assessment tool) dated 11/19/2025, documented Resident 24 was cognitively impaired, was dependent on staff for all cares and admitted with an unstageable pressure ulcer on the right heel and MASD on their coccyx.Resident 24's skin integrity care plan, dated 11/13/2025, documented Resident 24 had an open area buttocks (sacrum) 1.5 cm [centimeters] x 0.5 cm and also made note of a right heel concern with measurements documented. Care plan interventions included: .-Encourage good nutrition and hydration in order to promote healthier skin. -Follow facility protocol for treatment of injury. -LN [Licensed Nurse] to complete weekly skin assessment.-Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx [signs and symptoms] of infection, maceration [breakdown] etc. to MD [Medical Director].-Obtain blood work such as CBC with Diff [Complete Blood Count with Differential is a comprehensive blood test that provides valuable information about the different components of your blood], Blood Cultures and C&S [culture and sensitivity] test, a laboratory procedure used to identify specific microorganisms, such as bacteria or fungi, responsible for an infection and to determine their susceptibility to various treatments] of any open wounds as ordered by Physician.-Patient has a LAL [low air loss - used for reducing moisture and pressure] mattress to protect the skin while in bed. Check settings every shift. [no setting parameters were documented/ordered]-[Resident 24] has pressure relieving/reducing (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	wheelchair cushion to protect the skin whileup in chair.A physician's order, dated 11/13/2025, documented to cleanse the buttocks with wound cleanser, pat dry, and apply foam dressing, to change daily for skin care and PRN [as needed] for soilage/loosening and to notify the provider of any changes. A physician's order, dated 11/15/2025, documented weekly skin assessment to be completed, with a ?N' for no new skin issues and ?Y' for new skin issues.A physician's order, dated 11/15/2025, documented weekly skin assessment to be completed, with staff to check a ?N' for no new skin issues and ?Y' for new skin issues on the form.A Weekly Skin audit, dated 11/15/2025, showed a right elbow skin tear marked as being noted with no other skin conditions documented.A physician's order, dated 11/17/2025, documented a LAL mattress for skin care and for staff to check pressure and settings every shift for safety was ordered. No LAL mattress settings were included in the order.A Daily Skilled progress note, dated 11/19/2025, documented Resident 24's skin was intact and had no wounds present.A Weekly Skin audit, dated 11/22/2025, had skin irregularities marked as being noted, but no new irregularities. Documentation included a skin tear to the right elbow, right hip incision and right heel blister. There was no documentation regarding condition of skin of the coccyx.A Weekly Skin audit, dated 11/29/2025, had skin irregularities marked as being noted, but no new irregularities. There was no additional documentation about Resident 24's skin conditions. A Daily Skilled progress note, dated 11/30/2025 at 7:41 PM, documented resident has a pressure injury, wound with no signs and symptoms of infection present with small amount of drainage, physician orders in place for daily dressing change. This was the first documentation that showed a change from MASD to pressure injury. The electronic health record (EHR) showed no documentation the MD had been notified of a change in Resident 24's skin condition.On 12/01/2025 at 2:52 PM, Resident 24 was observed seated in their wheelchair and said they had been waiting two hours for staff to come and get them back in bed. Resident 24 said they were in pain, from sitting in the wheelchair for so long, due to having a pressure ulcer on their buttock. At this point staff walked into the room and transferred Resident to the bed. An additional observation was made of a standard foam mattress on Resident 24's bed, no LAL mattress was in place.On 12/01/2025 at 3:33 PM, Resident 24 was observed lying in bed on their back.On 12/02/2025 at 8:22 AM, Resident 24 was sitting in bed at a 45-degree angle. Resident 24 said they had a pressure ulcer on their buttock, felt it was getting worse, and it had been causing more pain. Resident 24 said they had been waiting for the new air mattress to arrive to help relieve the pressure on their buttock. Resident 24 was observed on a standard foam mattress. No Low Air Loss (LAL) mattress was in place. Daily observations from 12/01/2025 through 12/04/2025 showed Resident 24 had a standard foam mattress pad on their bed. Review of two Wound Evaluations, completed by facility (in house) wound team staff, both dated 12/02/2025, documented Resident 24 had 1. MASD located in the middle of coccyx 3.5 cm x 0.7cm x 0.2cm (larger then when admitted), 2. MASD located Right inner buttock 2.3cm x 0.8 cm x 0.2cm, serous (a type of fluid that comes out of a wound with tissue damage) and the area was now two distinct areas, documented as caused from MASD which would be followed weekly by [in facility] wound team until resolved. The EHR documented the areas were identified as pressure injuries three days prior, on 11/30/2025. The EHR showed no documentation the MD had been notified of these evaluations/change in skin condition. During observation of Resident 24's wound and wound care on 12/04/2025 at 10:53 AM by Staff T, Registered Nurse (RN) and Staff R, Infection Preventionist (IP), Staff T removed the old foam dressing and said the wound(s) smelled like fish. Staff T said there were now two distinct open areas on the coccyx/buttock.On 12/05/2025 at 8:50 AM, Resident 24 was sitting up in bed, at a 45-degree angle, with a bedside table across their lap. Resident 24 said they received the LAL mattress the day prior and they were not sure if it was relieving any pressure because their buttock was still painful. The LAL mattress was observed with a control box attached to the end of the bed. The settings on control box were marked at 75 pounds. On 12/05/2025 at 9:45 AM, Staff T, RN, said when there was a change in a resident's skin condition(s) the facility would monitor for redness, if it was non-blanchable or there were open areas they would notify the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	physician, resident care manager (RCM), and wound team [an in-house team]. Staff T said if it was a new skin condition, staff would document it in a progress note, complete a skin incident worksheet, update the resident's record and notify the RCM, Assistant Director of Nursing Services (ADNS), and Director of Nurse Services (DNS). Staff T was asked about the wound(s) on Resident 24's buttock. Staff T said Resident 24 had two wounds on their buttock, that they would assess them to be Stage 2 pressure ulcers; one on the coccyx and another on the left buttock, both with a wound base of 90% slough (dead tissue that appears in wounds and can hinder healing). When asked about staging and 90% slough on the wound beds, Staff T said they did not stage/assess wounds, that was the responsibility of the wound care team. When asked if the wounds would be considered MASD, Staff T stated, no, they are pressure ulcers. Staff T was asked to review the 12/02/2025 Wound Evaluations. When asked if the evaluations were correct, Staff T said no, the wounds were not MASD, they were pressure ulcers, the wound evaluation was incorrect. Staff T said Resident 24 had one pressure ulcer upon admit (on the heel) and now had three (one on the heel, one on the coccyx and one on the left buttock). On 12/05/2025 at 11:15 AM, Staff K, Residential Care Manager (RCM), said when a staff member has identified a new or change in an old skin condition, they were to notify the RCM, ADNS and DNS, who would evaluate the wound and notify the MD. Staff K said themself and Staff C, Assistant Director of Nursing Services made up the wound care team. The resident would then have weekly skin assessments and would be followed by the wound care team. Staff K was asked about Resident 24's admitting skin conditions. Staff K said Resident 24 had red, flaky skin on his coccyx, it was assessed as MASD and a large blister on the heel assessed as an unstageable deep tissue injury, due to not being able to assess what was beneath the wound. When asked about Resident 24's current wound(s), Staff K said the coccyx wound now had two wounds, but they had not reviewed the wound care treatment report and did not have any further information. When asked about slough, Staff K said there was no slough in prior assessments and did not know if there was slough currently. Staff K was unable to provide update or documentation about the wound observation on 12/04/2025. On 12/05/2025 at 12:11 PM, when asked about Resident 24's change of mattress, Staff T, RN, said they were not aware Resident 24 had a mattress change. Staff U, Certified Nursing Assistant (CNA) sitting at the nursing station, said they had changed the mattress out the previous day (12/04/2025), due to the old mattress malfunctioning. When asked how long the bed had been malfunctioning, Staff U said less than 24 hours. Review of Resident 24's November and December 2025 Treatment Administration Record (TAR), showed staff documented three times a day from 11/17/2025 through 12/05/2025, that they had checked the pressure and inflation setting on Resident 24's LAL mattress. Resident 24 had a standard mattress until 12/04/2025 when the LAL mattress arrived. A Weekly Skin audit, dated 12/06/2025, documented skin irregularities noted, but no new irregularities. Notes documented No new skin issues noted or reported. R [right] elbow has dry scab where old skin tear was. R elbow scab left open to air. R heel blister w serosang dng [serosanguinous drainage - mixed blood and serum] to old dressing of sm-mod [small to moderate] amount. Dsg [dressing] to R heel changed per order. Coccyx open area-wnl [within normal limits], L buttock open area wnl. This was the first weekly skin audit to document all of Resident 24's current skin conditions. A Daily Skilled progress notes, dated 12/06/2025 at 7:52 AM, documented resident has a pressure injury, wound with no signs and symptoms of infection wound bed with slough. physician orders in place for daily dressing change. The EHR showed no documentation the MD had been notified of the change in Resident 24's skin condition.On 12/08/2025 at 10:42 AM, Staff V, Maintenance Director, said he was informed about a request for an order form for a new bed for Resident 24. Staff V said he reviewed all the TELs requests for room [ROOM NUMBER] and the only order request found was from 10/12/2025 (one month prior to Resident 24' admit), regarding concerns that a bed would not go up and down. Staff V said the Maintenance Assistant replaced the control handle and sprayed the bed down to help with the bed going up and down and there had been no other problems reported with that bed since. Staff V said they had no order for a new LAL mattress on/about 11/17/2025, there were no reports of a (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	broken control box or broken LAL mattress for Resident 24, and they had never installed a new LAL mattress until 12/04/2025. On 12/08/2025 at 10:46 AM, Staff B, DNS, said when there was a change in a resident's skin condition, they expected staff (if CNA) to notify the nurse, who would notify the RCM, ADNS, DNS, who then would notify the provider. When asked about Resident 24' skin conditions, Staff B said Resident 24 admitted with a pressure ulcer on their heel and MASD on the coccyx. Staff B said they were made aware that a second wound had developed on the coccyx area. Staff B was asked to review the Wound Evaluations and daily skilled progress notes. When asked about what the wounds were currently identified as (per the documentation), Staff B said they did not know because each report called them something different and they would have to look into it further. When asked what interventions were in place to prevent worsening or development of new pressure ulcers, Staff B said good nutrition, pressure-relieving boots, weekly skin assessments, LAL mattress, report skin conditions, pressure reliving cushion for chair, treatments as ordered and use caution to prevent striking arms and legs. When Staff B was asked about Staff T, RN, and Staff R IP, who completed the wound treatment, assessment of both wounds to be Stage 2's with 90% slough. Staff B said with 90% slough, the wounds would not be stageable and should have been documented as unstageable. When asked if there were any reports of Resident 24 reporting an increase in pain, Staff B said they did not know if there was an increase in Resident 24's pain. Staff B was asked to review the LAL mattress order and confirmed Resident 24 had an order for a LAL mattress on 11/17/2025 and for staff to check the LAL every shift. Staff B reviewed the EHR and found no documentation a LAL had ever been installed on 11/17/2025 and said they would have to check with maintenance. When Staff B was asked about the interview with Staff V who stated they had no order for a new LAL mattress on/about 11/17/2025. there were no reports of a broken control box or broken LAL mattress for Resident 24 and they had never installed a new LAL mattress until 12/04/2025, Staff B said they did now know Resident 24 did not have a LAL mattress and staff should not have been signing for a task they could not complete and stated, that was not acceptable.On 12/08/2025 at 1:04 PM, Staff K, RCM, was asked about the smell of fish reported during the wound care treatment. Staff K said that kind of smell would have been an indication of an infection, like Pseudomonas (a common cause of wound infections, particularly in immunocompromised patients, and can lead to serious complications if not treated promptly). Staff K said the only way to determine if it was an infection was to complete a culture test. When asked about notification to the provider about the change in Resident 24's skin conditions, Staff K said they had informed the provider on 12/02/2025 (two days prior to wound care treatment observation), in stand up (a clinical meeting). When asked to show documentation that the provider was notified, Staff K said they had no record the provider was notified. The EHR showed no documentation the provider was notified about Resident 24's change of skin condition as of this date, 12/08/2025 (four days after the wound care treatment observation). On 12/08/2025 at 1:22 PM, Staff R, IP, was asked about the smell reported during the wound care treatment on 12/04/2025. Staff R said the only way to identify the infection was to complete a culture of the wound. When asked if a culture had been ordered or completed, Staff R reviewed the record and confirmed no culture had been ordered or completed. On 12/09/2025 at 12:02 PM, when asked if they had been made aware of the concerns related to Resident 24' pressure ulcer, Staff A, Administrator, said they were told about the concern with the LAL mattress. It was explained that Resident 24 was documented to have a LAL mattress since 11/17/2025, but did not receive the LAL mattress until 12/04/2025, but staff had been signing off they were checking the setting three times a day. Staff A said signing for things staff did not actually complete was not acceptable. When Staff A was asked about the inconsistency in documentation regarding the diagnoses/staging of the skin conditions and the matrix, some of the documentation noting there were no wounds at all, the overall development and worsening of the pressure ulcers and no documentation that the MD had been notified were reported, Staff A said they were not aware of the concerns and said, that was not acceptable.Reference WAC 388-97-1060 (3)(b)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were sent to the hospital with the required and necessary information to assure the safe transition of care for 3 of 3 residents (Residents 52, 81, & 1) reviewed for hospitalization. This failure placed residents at risk of incomplete emergency care, lack of services, lack of advocacy, and a diminished quality of care.Findings included. Review of the policy titled Transfer or Discharge, Preparing a Resident for, revised 12/2016, showed the policy did not include what documents were required to ensure the facility communicated appropriate and necessary information to the hospital when a resident was transferred. The policy documented, 1. When a resident is scheduled for transfer or discharge, the business office will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented. 2. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. Further review showed the policy's last point outlined nursing services was responsible for preparing the discharge summary and post-discharge plan, and for providing this to the resident or their representative. The policy did not mention any information on requirements for documentation to be provided to the hospital; it outlined steps related to scheduled transfers or discharges but did not outline the steps required for an emergent or emergency transfer. Resident 52 Resident 52 was admitted to the facility on [DATE] and had diagnoses of benign prostatic hyperplasia (prostate gland enlarges, which can cause difficulty urinating and a weak stream), retention (bladder holds on to) of urine, calculus of ureter (hard mineral deposits in the urinary tract, also known as kidney stones), obstructive and reflux uropathy (blockage in the urinary system that prevents normal urine flow), and dementia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/02/2025, showed Resident 52 was severely cognitively impaired, impaired with decision making, and dependent on staff for cares. Review of the electronic health record (EHR) showed before 10/25/2025, Resident 52 had a suprapubic catheter (an incision that was medically made through the abdomen which allowed a thin tube to drain the bladder) that would become clogged and needed regular irrigation. Resident 52 would sometimes refuse irrigation or changing of the catheter. Review of Resident 52's Treatment Administration Record for 10/18/2025 to 10/24/2025, showed Resident 52 had their suprapubic catheter changed on 10/19/2025, and the resident allowed staff to irrigate, with sterile water, the suprapubic catheter 12 out of 14 times. Review of Resident 52's nursing progress notes, dated 10/25/2025, showed nursing staff documented Resident 52 was sent to the Emergency Department (ED) for catheter placement. Nursing staff documented when they started their shift, Resident 52 was in extreme discomfort, they were unable to flush the (suprapubic) catheter, they bladder scanned the resident who had 179 milliliters (mls) of urine in their bladder and they removed the (suprapubic) catheter. The nurse documented, Not attempting re-cathing due to history of failed attempts. Further review of the EHR, dated 10/25/2025, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	showed no documentation of a report or handoff being called to the Emergency Department (ED) by the facility Review of Resident 52's ED Encounter showed the ED provider documented, Per EMS [emergency medical services] report, the patient's Foley catheter [conflicting with facility documentation] was discontinued this morning after staff determined it was not functioning properly. Since removal, no urinary output has been noted. Facility staff sent the patient to the ED for evaluation and possible placement of a suprapubic catheter. Patient is alert and oriented x4, GCS 15 [Glasco coma score, a tool used to determine level of consciousness, a score of 15 is the highest it goes indicating the resident had eye, verbal, and motor responses], and denies abdominal or flank pain, fever, chills, nausea, or vomiting. No history of trauma. Reports similar issues with catheter function in the past. Further review showed the provider documented, Discussed with patient that placement of a suprapubic catheter is not feasible in the emergency department on a Saturday night, as it is a planned procedure typically requiring sterile technique and urology involvement as it has been greater than a month since the last suprapubic has been in. Patient was initially hesitant to have a Foley catheter [also called indwelling urinary catheter - a thin tube that goes through the penis tip and into the bladder] replaced, expressing anxiety about the procedure. After discussion, 1 mg [milligram] IV [intravenous] Versed [a calming/ antianxiety medication] was administered for anxiolysis [anxiety relief]. Foley catheter was then placed with immediate return of clear yellow urine, confirming retention. Additionally, the provider documented the historians used were the patient and the chart. The provider documented Resident 52 would need a follow up appointment with urology for consideration of long-term suprapubic catheter. Review of Resident 52's After Visit Summary (AVS), dated 10/25/2025, showed the ED had scheduled a urology appointment for 07/10/2026 (9 months out) Review of Resident 52's nursing progress notes, dated 10/26/2025, showed nursing staff documented the ED called to give them report prior to transfer of Resident 52 back to the facility. The nurse was told that the suprapubic catheter could not be replaced due to the prolonged amount of time it was removed for, reported by EMS of over a month, and urology would need to see the patient. The nurse was informed that Resident 52 had a penile Foley catheter placed in the ED, and there was slight bleeding noted to the penis. The facility filled out a SNF/NF [Skilled nursing facility/nursing facility] to Hospital Transfer form (a document used by nursing homes to provide receiving facilities with the required information for transition of care) for 10/25/2025, which showed a creation date of 10/28/2025 (three days after initial hospitalization, after the resident was already back at the facility). This form had included information the facility was to provide the hospital at the time of transfer. Under the information for transfer section, staff documented, Other: catheter placement. Respiratory rate (taken 10/24/2025), temperature (taken 10/18/2025), and oxygen saturation (taken 10/24/2025) were documented from vitals taken on days prior to the day of transport on 10/25/2025, showing a complete set of vitals was not obtained before transfer. Under the resident/patient decision making capacity section, staff documented, Requires proxy and under mental status, documented, alert, disoriented, but can follow simple instructions. The form had information with contact information for Resident's 52's representative, contact information for who to call at the facility to get questions answered, and facility provider contact information. Under the report called in by (facility staff) and report called in to (ED staff) section, the fields were blank (no names were filled in). The form did not show any information on the size or type of catheter (suprapubic catheter) the resident had. There was a box on the form that was checked that selected urinary catheter. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the EHR showed Resident 52's prior two hospitalizations, dated 04/25/2025 and 06/14/2025, showed the SNF/NF to Hospital Transfer forms were completed late, on 04/29/2025 and 06/16/2025 respectively. Review of nursing progress notes after the hospitalization, from 10/26/2025 to 12/04/2025, showed Resident 52 had complications with the penile Foley catheter, such as refusals for staff to change the penile Foley catheter, blood in the urine, and penile erosion (breakdown and loss of tissue on the penis, can cause sensitivity). The penile Foley catheter was also noted to have gone through the suprapubic site. A nursing progress note, dated 11/03/2025, documented moderate leaking and bleeding was observed under the monitor for signs of penial erosion. Another note on 11/03/2025, documented nursing found the tip of the penile Foley catheter was slightly protruding through the opening of the suprapubic catheter site (the Foley catheter went through the opening in the penis, up into the bladder, and out the hole in the abdomen), the penile Foley catheter was retracted (pulled back from the suprapubic hole and into the bladder), and urine began flowing again. On 11/06/2025, nursing documented there was signs of stress showing at the meatus (tip) of the penis, and wrote, would do better with SP [suprapubic] replaced. On 11/10/2025, blood was noted to be coming from the meatus. At this time, Resident 52's penile Foley catheter was removed and Resident 52 would not allow a new penile Foley catheter to be placed and held firmly onto his penis. Documentation showed Resident 52 had 7/10 (typically on a scale of 0-10, with zero being no pain and ten being the worse pain) suprapubic pain from urinary retention, which the provider explained would not go away until they replaced the penile Foley catheter, then Resident 52 agreed. On 12/04/2025, nursing documented there were signs of erosion to the underside of penis, with yellow/green discharge from the penis and continued bloody urine that appeared to be increasing. During an observation on 12/01/2025 at 11:17 AM, Resident 52's penile Foley catheter tubing was noted to have blood-tinged sediment in the tubing. During an observation and interview on 12/03/2025 at 11:59 AM, Resident 52's penile Foley catheter tubing was noted to have dark red drainage in 75% of tubing that was visualized. At 12:02 AM, Staff F, Registered Nurse (RN), said since Resident 52 had switched to the penile Foley catheter (no longer had the suprapubic), the output had been mucous like and bloody since. Staff F lifted the tubing in attempt to drain it and it was slow moving from the tubing into the drainage bag. The drainage bag was visualized with similar thick dark blood drainage. During an interview on 12/03/2025 at 1:51 PM, Staff E, Resident Care Manager/RN, said Resident 52 had dementia and did not have great cognition, he was able to know who he was and where he was but was not fully aware of the situation. Staff E said Resident 52 was not a candidate for a transurethral resection of the prostate (TURP, a procedure that trims away extra prostate tissue blocking urine flow) due to cardiac issues. During a follow up interview at 3:42 PM, Staff E said the facility did not have a way to accurately monitor and record hematuria (blood in the urine), and Resident 52 would need a urology appointment (scheduled for 07/10/2026) for a suprapubic catheter replacement. During an interview on 12/05/2025 at 12:41 PM, Staff D, Medical Doctor when asked next steps for Resident 52's catheter needs, said they expected urology to put the suprapubic catheter back, and it would be up to the urologist if they fixed or put in a new suprapubic ostomy (new opening), but most likely it would be a new suprapubic ostomy. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/08/2025 at 12:08 PM, Staff C, Assistant Director of Nursing (ADON)/RN, said they normally send residents to the hospital with a face sheet, the medication administration record, order to evaluate and treat, and usually that was all that was sent. Staff C said they sometimes included the treatment administration record but did not say this was provided for every resident. When asked for documentation of what was sent to the hospital about Resident 52's suprapubic catheter, Staff C, said there was no record of what was sent. When asked about the process for providing information, if it was only reported to EMS, Staff C said it was dependent on how busy staff were, and their expectation was for staff to call and give the ED a heads up. When asked about the SNF/NF to Hospital Transfer form, Staff C said nurses did not fill those out but that they personally filled out the form after residents went to the ED. Staff C said they had recently sent a few residents out to the ED, and they were not caught up with this form. When asked if they knew of anything being communicated to the ED about Resident 52's anxiety, refusals with catheter changes, or mental status, Staff C said no. During an interview on 12/08/2025 at 1:53 PM, Staff B, Director of Nursing Services (DNS), said their expectation regarding information from this facility to the hospital during hospitalization, was for residents to be sent with information of why they are being sent, their symptoms, and the transfer sheet. Staff B was told of Resident 52's hospitalization on 10/25/2025, that no documentation was found by staff that the facility provided the ED with pertinent information of the situation. Staff B said their expectation was that documentation should have been sent with the resident to the hospital. Resident 1 Resident 1 was admitted to the facility on [DATE]. Review of the Discharge MDS, dated [DATE], showed Resident 1 was transferred to the hospital, return anticipated. A 12/04/2025 7:47 AM nurse's note documented Resident 1 had increased confusion, a weight gain of 10 pounds in two days, adventitious (abnormal) lung sounds and was sent to the hospital for further evaluation. There was no documentation present to show facility staff provided required information to the receiving health care institution. Review of the EHR showed a SNF/NF to Hospital Transfer Form, dated 05/06/2025, two days after Resident 1 discharged . Resident 81 Resident 81 was admitted to the facility on [DATE]. The 5 Day MDS, dated [DATE], indicated Resident 81 had some difficulty making decisions regarding tasks of daily life in new situations only. Record review showed Resident 81 was transferred to the hospital on [DATE]. Review of the form titled, A Skilled Nursing Facility/Nursing Facility to Hospital Transfer, showed it was created on 09/08/2025, two days after resident 81 transferred to the hospital. On 12/09/2025 at 1:06 PM, Staff C, Assistant Director of Nursing/RN, when asked what documentation was sent with a resident when they were transferred to the hospital, Staff C said normally a Medication Administration Record, the Treatment Administration Record if pertinent, a face sheet, an order, and copy of the Physician Orders for Life Sustaining Treatment. Staff C said she had never sent a transfer form. When asked what is done with the Skilled Nursing Facility/Nursing Facility to Hospital Transfer form, Staff C said, the form was filled out after a resident left for the hospital, and the facility was not sending it with residents. Reference WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080, -0140 (1)(a)-(c)(i)-(iii)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview the facility failed to provide appetizing and palatable food for 7 of 24 sampled residents (5, 17, 24, 11, 84, 10, and 28) and 1 of 1 test tray sampled for food quality. The facility also failed to prepare pureed foods for residents following the written recipe to ensure the nutritional value was maintained. These failures placed residents at risk for a decline in nutrition and a diminished quality of life. Findings included .Resident Food1) On 12/01/2025 at 1:15 PM, Resident 5 said the food was cold.2) On 12/01/2025 at 12:38 PM, Resident 17 said they were the last to get their food on this hallway and sometimes it was cold. Resident 17 stated, I had a cold burger, and I sent it back.3) On 12/02/2025 at 8:37 AM, Resident 24 said the pasta was not thoroughly cooked and it did not taste good. 4) On 12/01/2025 at 1:06 PM, Resident 11 said they do not like fish but still gets it on their tray.5) On 12/02/2025 at 8:19 AM, Resident 84 said they have had burnt cake for dinner and sometimes the breakfast was cold.6) On 12/01/2025 at 2:57 PM, Resident 10 said the food was overcooked and they once got a grill cheese that was burnt.7) On 12/04/2025 at 9:47 AM, Resident 28 was observed with three burnt chicken tenders that were blackened on the outside. Resident 28 stated, I ate what I could around the burnt part.Test TrayOn 12/03/2025 at 1:50 PM, the shrimp on the test tray tasted dry and had a rubbery texture. On 12/03/2025 at 2:23 PM, Staff CC, Dietary Services Manager, stated we encourage visitors and families to try the food and let us know.On 12/08/2025 at 10:29 AM, Staff BB, Registered Dietician, said they heard about the burnt chicken tenders and the staff were educated on what was appropriate to serve the residents. Staff BB said her expectation was that the staff were managing temperatures on the tray line and making sure the food was palatable throughout the tray line. Staff BB said they have also educated the staff to pass the meals to the residents timely once the trays were out on the hallways.Pureed Food PreparationOn 12/03/2025 at 11:00 AM, Staff DD, Cook, was observed making pureed green beans in the blender. Staff DD added vegetable base and water to the green beans before starting the blender. When asked if the water and vegetable base were on the recipe, Staff DD said no. Staff CC, Dietary Services Manager, said to Staff DD, do what it tells you, it is supposed to be god's words.On 12/03/2025 at 11:13 AM, Staff DD said they had found faults in the recipes and measurements. Staff DD stated, I don't always measure everything.On 12/03/2025 at 12:44 PM, Staff DD was observed adding pump liquid thickener to the gravy while on the serving line. Staff DD pumped twice and mixed the gravy, then pumped twice and mixed it again. Staff DD pumped another two times and mixed the gravy again. On 12/03/2025 at 2:23 PM, Staff CC, Dietary Services Manager, when asked if the recipes were followed stated, I know what you are getting at. Staff CC said the vegetable base and water were not in the recipe for pureed green beans. Staff CC was asked if there was a recipe for the gravy and she said they do not usually use the liquid pump on the serving line. Staff CC said they did not know the measurements on the liquid pump, Staff CC stated, It could be a long pump or a short pump. I can't say. Staff CC said they would prefer the staff to use the powder thickener and mix it while on the counter. Reference WAC 388-97-1100 (1), (2)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure Minimum Data Sets (MDS, an assessment tool) accurately reflected residents' health status and care needs for 5 of 22 sample residents (Residents 7, 26, 2, 8 & 12) whose assessments were reviewed. These failures placed residents at risk for unidentified and/or unmet care needs and decreased quality of life.Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, version1.20.1, m October 2025, showed Respiratory therapy services included coughing, deep breathing, treatments, assessing breath sounds and mechanical ventilation, which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training. Providers should record services for Respiratory Therapy when the following criteria are met: The therapy was ordered by the physician. The physician's order included a statement of frequency, duration, and scope of treatment. The services must be directly and specifically related to an active written treatment plan that was based on an initial evaluation performed by qualified personnel. The services were required and provided by qualified personnel. The services must reasonable and necessary for treatment of the resident's condition. When developing the plan of care, the therapist or qualified personnel must determine the mode(s) of therapy and the amount of time the resident will receive. The therapist or qualified personnel should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. Only medically necessary therapies, ordered by a physician, based on a qualified therapists assessment and treatment plan, that were documented in the resident's record, care planned, and periodically evaluated to ensure the provision and effectiveness of the treatment plan, should be coded. MDS personnel should review the resident's therapy evaluation and treatment records and consult with each qualified care provider to collect the information required for this item. Resident 7 Resident 7 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set, (MDS, an assessment tool), dated 10/21/2025, showed Resident 7 required the use of an indwelling urinary catheter (a thin, flexible tube inserted into the bladder for continuous urine drainage), and did not have a diagnosis of neurogenic bladder (a condition where nerve damage to the brain, spinal cord, or peripheral nerves disrupts the signals controlling bladder function, leading to loss of control, incontinence, urinary retention, or incomplete emptying). The hospital Discharge summary, dated [DATE], documented Resident 7 had a diagnosis of neurogenic bladder with chronic suprapubic catheterization (catheter inserted through abdominal wall into bladder). On 12/09/2025 at 11:29 AM, Staff H, MDS Coordinator, said Resident 7's MDS was inaccurate and neurogenic bladder should have been coded as an active diagnosis. Resident 26 Resident 26 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed the resident had diagnoses of stroke, heart dysrhythmias (an abnormal or irregular heartbeat) and asthma, and received anticoagulant medication and Respiratory Therapy services during the assessment. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment showed Resident 26 did not receive antiplatelet medication. Review of the November 2025 Medication Administration Record (MAR) showed Resident 26 received aspirin (an antiplatelet medication) on six of seven days during the assessment period. During an interview on 12/09/2025 at 11:29 AM, Staff H said Resident 26's MDS was inaccurate and needed to be modified to include antiplatelet medication. Record review showed Resident 26 had a physician order, dated 11/14/2025, that directed staff to provide incentive spirometry (IS, a handheld device to help you take slow, deep breaths, improving lung function, clearing mucus, and preventing complications like pneumonia, especially after surgery or with lung conditions) four times a day for asthma. The nurse was to document the total minutes it took to set up the incentive spirometer, perform patient education, and to complete pre and post respiratory evaluations. The order did not include the duration the therapy was to be provided for. Review of the comprehensive care plan, initiated 11/14/2025, showed no care plan that addressed Resident 2's respiratory therapy, the goals of treatment, the frequency, duration, or scope of treatment had been developed or implementedReview of the electronic health record (EHR) showed no documentation that Resident 26's had an initial evaluation performed by a respiratory therapist or trained respiratory nurse or that a written treatment plan was developed. Review of the IS treatment on the December 2025 MAR, showed for the pre- and post-respiratory evaluations staff were provided a space to document the following six assessments:a) Under IS staff documented the volume of air the resident was able to inhale into their lungs during a deep breath. b) Under Lung [sounds] staff documented either a Y [yes] or N [No]. The documentation on the TAR did not identify what the lung sounds were, if they were adventitious (abnormal lung sounds that are heard over a patient's lungs and airways utilizing a stethoscope. These sounds include fine and coarse crackles, wheezes, pleural rubs and stridor, which provide important clues used for diagnosing numerous cardiac and pulmonary conditions) or if the post treatment lung sounds had improved, worsened or were unchanged after the treatment. c) Under Min staff documented the minutes it took to set up the IS, perform patient education, and perform the pre and post lung evaluations, which was documented as 5 minutes for every treatment provided.d) The last three assessed items that were documented were the resident pulse, respiratory rate and oxygen saturation (SpO2). Review of the EHR showed Resident 26's pre and post IS treatment lung sounds were not documented.Review of the pre and post treatment respiratory evaluation documentation for the 9:00 AM and 1:00 PM treatments from 11/15/2025 - 11/30/2025, showed the pre and post pulse, respiratory rate and minutes to provide the treatment were the same for 32 of 32 reviewed. The residents pre and post treatment SpO2 was the same for 31 of 32 reviewed. On 12/09/2025 at 9:13 AM, when asked if the nurses came daily to instruct them on how to use the IS (one was located on Resident 26's overbed table) Resident 26 stated, No, why would they tell me how to use it or watch. I know how to use it. I know how. I use it when I need to. I have to use it every time I go to the Hospital. Resident 2 Resident 2 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident had a diagnosis of chronic congestive heart failure (CHF, a chronic condition where the heart muscle weakens and can't pump enough oxygen-rich blood to meet the body's needs, leading to fluid buildup (congestion) in the lungs, legs, and other organs, causing symptoms like shortness of breath, fatigue, and swelling) and received RT services during the assessment period. A physician order, dated 11/21/2025, directed staff to provide incentive spirometry four times a day for CHF. The nurse was to document the total minutes it took to set up the incentive spirometer, (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perform patient education, and to complete pre and post respiratory evaluations. The order did not include the duration the therapy was to be provided for. Review of the comprehensive care plan, initiated 07/1/2025, showed no care plan that addressed Resident 2's respiratory therapy, the goals of treatment, the frequency, duration, or scope of treatment had been developed or implemented. Review of the electronic health record (EHR) showed no documentation that Resident 2's had an initial evaluation performed by a respiratory therapist or trained respiratory nurse or that a written treatment plan was developed. Review of the IS treatment on the December 2025 MAR, showed for the pre- and post-respiratory evaluations staff were provided a space to document the following six assessments:a) Under IS staff were to document the volume of air the resident was able to inhale into their lungs during a deep breath. b) Under Lung the trained respiratory nurses documented a Y or N. The documentation identify what the residents lung sound were, if they were adventitious, or if the post treatment lung sounds had improved, worsened or were unchanged, to indicate if the IS treatment was effective.c) Under Min staff documented the minutes it took to set up the IS, perform patient education, and perform the pre and post lung evaluations, which was documented as 5 minutes for every treatment provided.d) The last three assessments were the resident's pulse, respiratory rate and SpO2. Review of the EHR showed Resident 2's pre and post IS treatment lung sounds were not documented in the record. During an interview on 12/09/2025 at 12:00 PM, Staff MM, MDS Coordinator, explained if a resident had an IS respiratory therapy program, each day during the assessment period where 15 minutes or more was documented would be coded as Respiratory therapy on the MDS When asked if they spoke with the qualified staff who provided the IS treatments, or ensured the services were directly and specifically related to an active written treatment plan that was based on an initial evaluation performed by qualified personnel. Staff MM, MDS Coordinator, said no, and indicated the respiratory therapy collected on the above reference MDSs, met the RAI criteria for respiratory therapy and were accurately coded. Resident 8 Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE] showed Resident 8 was cognitively intact. Review of Resident 8's electronic health record (EHR), showed they had a fall on 6/23/2025 that resulted in bruising. Review of Resident 8's Quarterly MDS, dated [DATE], showed no fall had been recorded. During an interview on 12/5/2025 at 8:44 AM, Staff H, MDS Coordinator/ Registered Nurse (RN), said both minor and major injuries were recorded on the MDS. Staff H reviewed minor injury criteria and said they recorded how many falls since admission or prior assessment. Staff H said a bruise from a fall would be considered a minor injury. When asked about Resident 8's fall on 6/23/2025 that resulted in bruises, which MDS this should have shown up on, Staff H said the Quarterly MDS done on 8/28/2025 and confirmed this was not coded as a fall. Resident 12 Resident 12 was admitted to the facility on [DATE] and had a diagnosis of dementia. The Quarterly MDS, dated [DATE], showed they had severe cognitive impairment, had two or more falls with no injury, had one fall with minor injury, and did not use a wander/elopement alarm. Review of Resident 12's orders showed they had a wander guard (wander/elopement alarm) ordered (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	since 5/22/2025. During an observation on 12/3/2025 at 11:15 AM, a wander guard was seen on Resident 12's wheelchair. Review of Resident 12's EHR and fall investigations, showed they had two recent falls with injury, on 11/4/2025 that resulted in bruising, and 11/14/2025 that resulted in a laceration. During an interview on 12/5/2025 at 8:49 AM, Staff H, MDS Coordinator/ RN, said for elopement alarms, section p of the MDS assessment specifically asks whether the residents have an alarm. Staff H reviewed the 11/19/2025 MDS, confirmed the wander guard was not coded and said it should have been. Staff H also confirmed the two falls with injury should both have been recorded on the 11/19/2025 MDS and acknowledged it was not accurately recorded. During an interview on 12/8/2025 at 1:53 PM, Staff B, Director of Nursing Services, said their expectation for MDS assessments was for them to be accurate. Reference WAC 388-97-1000(4)(b)(5)(a)(e)(i)-(iii) .

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' care plans were comprehensive and person centered for 7 of 22 sampled residents (Residents 52, 54, 12, 1, 7, 73 & 9) reviewed for care plans. This failure placed residents at risk of lack of services or cares, and a diminished quality of life.Findings included.Resident 52 Resident 52 was admitted to the facility on [DATE], with diagnoses of depression and urinary retention (bladder holds on to urine). Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/02/2025, showed Resident 52 was severely cognitively impaired. The most recent Comprehensive MDS, dated [DATE], showed Resident 52 was considered to have serious mental illness, requiring a level II Preadmission Screening and Resident Review (PASRR). Review of Resident 52's level II PASRR, dated 02/26/2020, documented recommendations for plan of care. Under mental health services, it recommended the facility provide mental health counseling and psychiatric assessment and medication evaluation for depressive disorder. Under recommendation for nursing facility, recommendations were given for the environment, staff approaches/training, activities, and other. For environment, there was an intervention of monitoring the relationship between them and their roommate to make sure it would be amicable with volume of the television and verbal sounds. For staff approaches/training, there were interventions such as supporting Resident 52's self-esteem by focusing on their strengths and unique qualities, identifying with the resident coping skills, and providing them with Crisis Telephone numbers so they had someone to converse with when needed. For activities, they recommended assisting Resident 52 with televised snow skiing events. For other, they recommended that if Resident 52 was resistant to mental health services, that they should remind them that being seen once does not mean they have to continue with ongoing services or follow recommendations made, and to explain that this was an opportunity to process anything distressing with the hope of some resolve. Review of Resident 52's care plans on 12/03/2025, showed they did not have a level II PASRR care plan and the other care plans did not include a comprehensive list of interventions from the level II PASRR evaluation, nor did they document the effectiveness of the recommendations. Resident 52 had a potential for psychological well-being problem care plan, revised on 06/16/2025, with a goal to utilize effective coping mechanism without listing what they were, and had generic interventions such as Initiate referrals as needed or increase social relationships: (e.g. [example] Pastoral Care, Social Services, Psych Services) without listing if any had been used, attempted, or helpful in the past. This specific intervention also did not specify the recommendations for what to do when Resident 52 was resistant to being seen by a mental health provider. During an interview on 12/05/2025 at 8:08 AM, Staff X, Social Services Director, said for level II PASRR recommendations, they and the resident care managers review them, and update the care plans as needed. When asked if they put recommendations on the care plan, Staff X said yes, if it pertains to the care plan. Staff X said Resident 52 had no current credible suspicion for needing mental health counseling at the time and Resident 52 was not currently seeing a mental health counselor. When asked about Resident 52's care plans, Staff X said they did not make a section for level II PASRRs, but Resident 52 did have a depression and psychosocial well-being care plan. When asked about recommendations from the level II PASRR and if they were on the care plan, Staff X was unable to find the Crisis Telephone numbers or the mental health counseling recommendations but (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the recommendation for mental health counseling would likely fall under referrals as needed. Review of Resident 52's electronic heath record showed they were hospitalized on [DATE], and they returned on 10/26/2025 without their suprapubic catheter (an incision that was medically made through the abdomen which allowed a thin tube to drain the bladder) replaced, and now had a penile indwelling urinary catheter (also called a Foley, a thin tube that goes through the penis tip and into the bladder). Review of Resident 52's Foley catheter care plan, revised on 10/30/2025, showed they had prior interventions that had not been removed, Please change suprapubic catheter every 3 weeks (21 Days) and Resident has occasional urinary incontinence, even with suprapubic [.]. The care plan did not have information specific to the suprapubic catheter site, such as the date it was last accessed and the interventions being done post removal or of any monitoring. The care plan also did not mention Resident 52 was being monitored for penile erosion, related to the penile Foley catheter. Review of Resident 52's enhanced barrier precautions [special precautions taken when a resident has a MDRO -multidrug resistant organisms] care plan, dated 04/03/2025, showed they had a history MDROs of methicillin-resistant Staphylococcus aureus (MRSA) and carbapenem-resistant Enterobacterales (CRE). The goal was listed as the risk of spreading MDRO infection or potential infection will be minimized. This care plan did not list where the MDROs had been detected on Resident 52 (possible examples: urine, skin, wound infection). Review of Resident 52's orders, showed Resident 52 had an order that was initiated 10/27/2025 for cleaning the old suprapubic site with wound wash, to pat dry, and cover with boarder dressing every dayshift. The most recent version of this order, ordered on 11/20/2025, showed staff were also applying Hydrocortisone 1% cream to the site. During an interview on 12/08/2025 at 12:08 PM, Staff C, Assistant Director of Nursing (ADON)/Registered Nurse (RN), regarding their expectation for updating care plans after hospitalization, said for new orders, they expected them to be put on the care plan. Staff C confirmed Resident 52's care plan did not have any mention of penile erosion being monitored and said there should be. Staff C confirmed there was no information on Resident 52's prior suprapubic catheter site, and said there should have been documentation of monitoring it, what they were doing about it, and how they were addressing it. When asked about Resident 52's care plans, if they had any mention of their blood or mucous in their urine, or how long they had had these symptoms, Staff C said there was a history of chronic urinary tract infection, a monitor for checking for blood in the urine, and for a urology consult as needed. Staff C confirmed Resident 52's care plan on enhanced barrier precautions did not have the location of where the MDROs were found on Resident 52. Resident 54 Resident 54 was admitted to the facility on [DATE], and had diagnoses including muscle weakness, difficulty walking, limitations of activities due to disability, and need for assistance with personal care. The Annual MDS assessment, dated 10/7/2025, showed Resident 54 was cognitively intact, and received a range of motion and a dressing/grooming restorative program for six days of the week. During an interview and observation on 12/01/2025 at 11:51 AM, Resident 54 showed they put their feet on a step stool and placed a weight on their leg, to work on straightening their legs. They reported they did this two to three times a day by themself. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 54's care plans on 12/04/2025, showed there was not a care plan with their self-directed leg strengthening details. During a joint interview on 12/05/2025 at 9:16 AM, Staff G, Director of Rehabilitation, and Staff H, MDS Coordinator/Registered Nurse, were interviewed. Staff G said Resident 54 was working on hamstring stretching, Resident 54 had requested it, and the daughter was okay with the program, which encouraged Resident 54 to stretch their legs. Staff G said they do not normally tell nursing about this kind of program. When asked if there was anything specific about Resident 54 doing these hamstring exercises in the care plan, Staff H said no. Resident 12 Resident 12 was admitted to the facility on [DATE], with a diagnosis of dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/2025, showed Resident 12 was severely cognitively impaired. Review of Resident 12's fall care plan, revised 11/20/2025, showed 14 falls were listed. One of the interventions listed was added on 10/18/2025, for 30-minute checks. This intervention did not have any other details, such as how long this intervention was being implemented for. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, ADON/RN, and Staff J, Resident Care Manager/Licensed Practical Nurse, were asked about Resident 12. Staff C said the order for 30 minute checks was no longer in effect, and said this intervention should not be on the care plan. During an interview on 12/08/2025 at 1:53 PM, Staff B, Director of Nursing Services (DNS), when asked their general expectation for care plans, said everything should be care planned. Staff B provided examples, such as activities of daily living, skin, falls, wounds, blood thinners, fluid restrictions, and psychotropic medications. Staff B said any kind of cares should be included, it should be individualized per resident. Resident 1 Resident 1 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF, a condition where the heart muscle doesn't pump blood as well as it should and blood and fluid often backs up and fluid can build up in the lungs and lower extremities). Review of Situation Background Assessment and Recommendation forms (SBAR, a form used to communicate changes in residents conditions to the provider), dated 11/01/2025 and 12/01/2025, documented Resident 1 had weeping edema (swelling caused by too much fluid trapped in the body's tissues that leaks or weeps out through the skin) to both lower extremities. Record review showed Resident 1 had the following orders, dated 10/25/2025, for Lasix (a diuretic) twice daily for CHF and daily weights. Review of Resident 1's comprehensive care plan, initiated 10/25/2025, showed a care plan to address the resident's CHF, diuretic use, need for daily weights and weeping edema to bilateral (both) lower extremities had not been developed or implemented. During an interview on 12/05/2025 at 12:01 PM, when asked if Resident 1's CHF, diuretic use, daily weights, and weeping lower extremity edema should have been care Staff B stated Yes. Resident 7 Resident 7 was admitted to the facility on [DATE]. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed 10/23/2025 orders to apply TED hose (compression stocking) daily for edema management and to start Lasix (a diuretic) 20 milligrams daily. Review of Resident 7's comprehensive care plan, initiated 10/17/2025, showed no plan was developed or implemented that addressed the resident's edema, use of diuretics and need for TED hose to be applied daily. On 12/05/2025 at 12:01 PM, when asked if a care plan addressing Resident 7's edema, diuretic use and need for TED hose daily should have been developed/ implemented, Staff B, said yes, but she did not see one. Resident 73 Resident 73 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident had a diagnosis of sepsis (a serious condition in which the body responds improperly to an infection, and the infection-fighting processes turns on the body, causing the organs to work poorly), and received intravenous (IV) antibiotics via a central catheter during the assessment period. The Avaadmission Nursing Database, dated 11/04/2025, showed Resident 73 had a Peripherally Inserted Central Catheter (PICC, a long, thin, flexible tube inserted into a small arm vein and threaded to a large central vein near the heart) to the right upper arm. The November 2025 Medication and Treatment Administration Records (MAR/TAR) showed Resident 73 received Cefepime IV infusions every 12 hours for right lower extremity cellulitis (skin infection). Review of Resident 73's comprehensive care plan, initiated 11/04/2025, showed staff failed to develop and implement a care plan that addressed the resident's PICC line and treatment with IV antibiotics with identified goal and interventions. During an interview on 12/05/2025 at 11:45 AM, when asked if a care plan should have been developed and implemented for the resident's PICC line and IV antibiotics that identified goals and interventions for the care and maintenance of the PICC, Staff B stated, Yep, and I don't see any. Resident 9 Resident 9 was admitted to the facility on [DATE]. Review of the Modification of Quarterly MDS, dated [DATE], documented Resident 9 was severely cognitively impaired. Resident 9 had a diagnosis of dementia with psychotic disturbance (involves symptoms of hallucinations [seeing things not there] and delusions [fixed false beliefs].) Review of Resident 9's comprehensive care plan on 12/02/2025, showed no care plan was present for dementia. On 12/08/2025 at 10:57 AM, Staff K, Resident Care Manager/RN, when asked if a resident had dementia should they have a care plan for dementia, Staff K said yes. On 12/08/2025 at 12:59 PM, Staff B, DNS, when asked if a resident had a dementia diagnosis should they have a care plan for dementia, Staff B said yes. Regarding Resident 9, staff B confirmed they had a dementia diagnosis and did not have a dementia care plan and said one should be there. Reference WAC 388-97-1020(1), (2)(a)(b) Reference F690

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards were met related to following provider orders, medication administration practices, provider notification of weight variances, and/or accurate documentation practices, for 7 of 22 sampled residents (Resident 73, 1, 31, 12, 74, 9 & 24). This failure placed residents at risk of not receiving services being signed off on, lack of monitoring, medication complications, and a diminished quality of life. Findings included .Resident 73 Resident 73 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 11/10/2025, showed the resident had a diagnosis of heart failure, and received supplemental oxygen during the assessment period. Record review showed an order, dated 11/04/2025, for oxygen 1-2 liters via nasal canula as needed for shortness of breath, with direction to notify the physician when resident was placed on oxygen. On 12/02/2025 at 11:57 AM and 12/04/2025 at 5:57 AM, 8:34 AM and 9:37 AM, Resident 73 was observed receiving oxygen at 2 liters per minute via nasal canula. Review of the December 2025 Medication and Treatment Administration Records (MAR/TAR) showed that no nurses had signed the administered oxygen to Resident 37 during the month. On 12/04/2025 at 9:37 AM, Staff KK, Registered Nurse (RN), confirmed Resident 37 was receiving oxygen at two liters per minute via nasal canula and said the resident required oxygen use daily. When asked if there was documentation on the December 2025 TAR that showed Resident 37 was administered oxygen, Staff KK stated, No. On 12/04/2025 at 9:45 AM, Staff B, Director of Nursing Services (DNS), said they were familiar with Resident 37 and acknowledged the resident received oxygen therapy. When asked if there was any documentation on the TAR that Resident 37 had been administered oxygen in December 2025, Staff B said no, it was the expectation that nurses sign for all medications administered. Resident 1 Resident 1 was admitted to the facility on [DATE]. Record review showed an order, dated 11/05/2025, for hydralazine (blood pressure medication) three times daily, with direction to hold the medication for a systolic blood pressure (SBP) less than 120. The November 2025 MAR showed, on 11/27/2025 at 3:00 PM, Resident 1 had a SBP of 116, and hydralazine was administered instead of being held for a SBP less than 120 as ordered. On 12/04/2025 at 9:28 AM, Staff B, DNS, said Resident 1's hydralazine was administered outside of the physician ordered parameters and should have been held. Resident 31 Resident 31 was admitted to the facility on [DATE]. Record review showed the resident had the following pain management orders, dated 09/24/2025:-acetaminophen 650 milligrams (mg) every four hours as needed, for a pain level of 1-3 on a scale to 10.-oxycodone 2.5 mg every six hours as needed, for a pain level of 4-6 on a scale to 10.-oxycodone 5 mg every six hours as needed, for a pain level of 7-10 on a scale to 10. Review of the October 2025 MAR, showed the following:- On 10/20/2025 at 5:12 PM, Resident 31 had a pain level of 5 and was medicated with acetaminophen 650 mg, rather than oxycodone 2.5 mg as ordered.- On 10/27/2025 at 6:28 PM, Resident 31 had a pain level of 5 and was medicated with acetaminophen 650 mg, rather than oxycodone 2.5 mg as ordered. Review of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	electronic health record (EHR), showed no documentation that Resident 31 requested acetaminophen be administered instead of the ordered oxycodone 2.5 mg for a pain level of 5. On 12/05/2025 at 11:33 AM, when asked if Resident 37's pain medication was administered in accordance with the physician ordered parameters, Staff B, DNS, stated, No. Resident 12 Resident 12 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 12 was severely cognitively impaired. Review of Resident 12's orders, showed they had an order for orthostatic blood pressures (when blood pressure readings were taken laying, sitting, and then standing, to assess if there was positional low blood pressure) to be taken every 28 days, because they were taking an antipsychotic medication. Review of Resident 12's September 2025 TAR, showed orthostatic blood pressures was not completed on 09/10/2025 for sitting, standing, or laying. Review of Resident 12's November 2025 TAR, showed only the sitting position had a blood pressure reading, and there was not a blood pressure reading for standing or laying. Review of Resident 12's MAR from 11/01/2025 to 12/07/2025, showed nurses had been administering Resident 12's lidocaine patch for 24 hours (unless refused/hospitalized). For November, Resident 12 had 23/30 days, that they wore a lidocaine patch for twenty-four hours. For December, Resident 12 had 5/7 days, that they wore a lidocaine patch for twenty-four hours. The order had a start date of 07/25/2025, and nursing had not questioned the order since then (for about four months). During an interview on 12/03/2025 at 8:44 AM, Staff Q, Licensed Practical Nurse (LPN), confirmed Resident 12 was wearing their lidocaine patch for twenty-four hours a day. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/RN, and Staff J, Resident Care Manager (RCM)/LPN, were asked about Resident 12. Staff C said Resident 12 required orthostatic blood pressures to be taken once a month, to monitor for side effects of their antipsychotic medication. When asked their expectation for when a nurse was unable to get orthostatic blood pressures on Resident 12, Staff C said they could not understand why the nurse would not be able to, as Resident 12 was able to stand, sit, and lie. Staff C reviewed the September 2025 for orthostatic blood pressure documentation and said they could not find a note on why it was not completed. Staff J reviewed November 2025 for orthostatic blood pressure documentation and said they found documentation the nurse was unable to perform safely. Staff J said they could understand that sometimes standing could be unsafe but could not say the same for lying down. Staff J said if the nurse truly thought it was unsafe, then there should have been a note put in that they talked to the doctor. Staff C said their expectation was that nursing would have reapproached on another day and tried again. When asked how long a lidocaine patch can be on a resident, both Staff C and Staff J said twelve on and twelve off. Resident 74 During a medication administration observation on 12/02/2025 at 11:38 AM, Staff J, RCM/LPN, gave (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 74 their long-acting insulin (a type of insulin that provides a steady release of insulin over an extended period of time, to help manage blood sugar levels) that was due at 8:00 AM. Staff J had said Resident 74 did not eat breakfast and their earlier blood sugar reading was 73, but now it was 223. Staff J said their nursing judgment told them when to hold the medication, if under 100 they would wait until above. Staff J said they had given Resident 74 orange juice that morning, but they had not rechecked Resident 74's blood sugar level after the orange juice was consumed. Review of a medication progress note on 12/02/2025 at 9:08 AM, showed staff were to notify the provider if blood sugars were below 60 or above 400. The nurse had documented OJ provided and consumed. During an interview on 12/08/2025 at 1:53 PM, Staff B, DNS, said short acting insulin was immediate and long-acting insulin was for the life of the specific insulin, which would maintain glucose levels throughout the day. When asked if Resident 74's insulin order had parameters for holding, Staff B said yes and no, that on the order itself it did not, but there was an order to hold for below 60 and to notify the provider. When told of Resident 74's blood sugar reported to be 73, Staff B said the order did not say to hold it so it should not have been held. When asked if Resident 74 should have been reassessed after they were documented at 9:08 AM to have consumed their orange juice, Staff B said yes. Staff B said it did not meet expectations, that the recheck blood sugar level, provider notification, and administration did not occur until about 11:38 AM. Resident 9 Resident 9 was admitted to the facility on [DATE]. Review of the Modification of Quarterly MDS, dated [DATE], documented Resident 9 was severely cognitively impaired. Resident 9's EHR showed they had a Power of Attorney (POA, a person assigned authority to make decisions on behalf of another person) for healthcare. On 12/01/2025 at 1:52 PM, Resident 9's POA said she had wanted to talk with the doctor regarding Resident 9's medications and she had talked to Staff E, RCM/RN, and Staff E had said he would get back to them. On 12/08/2025 at 9:03 AM, Staff E, when asked their expectation of staff when a POA requested to talk with a doctor about a resident's medications, Staff E said they would get communication to the doctor. Staff E said if they could not directly find the doctor, they would do an SBAR (SBAR, a form to communicate to providers that outlines situation, background, assessment, and request) to request the doctor speak with the family. Staff E said they would try and follow up to make sure the doctor was going to get back to the family. When Staff E was asked if Resident 9's POA had requested to talk with the doctor about Resident 9's medications, Staff E said there were a few times the POA had requested this. Staff E said to their knowledge the doctor had seen them. Staff E said they themselves were able to answer some of the POA's questions about medications, but there was a period of transition from one provider to another and the initial request fell through the cracks. Staff E said they had requested the doctor to speak with the POA about medications, but he was not sure if the doctor had met with the POA or not. Record review of Resident 9's SBAR communications, from 06/11/2025 through 12/08/2025, showed no SBAR communications regarding Resident 9's POA request to talk with the doctor. On 12/08/2025 at 2:53 PM, Staff E said the request by Resident 9's POA to speak with the doctor (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not that long ago, the last request had been maybe a month prior. When told review of SBAR communications did not show any communication regarding POA's request, Staff E said he knew it had been mentioned to the doctor a few times, but moving forward an SBAR would be good so it would be clear that the doctor had been communicated with. Resident 24 Resident 24 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 24 was cognitively impaired, was dependent on staff for all cares and admitted with an unstageable pressure ulcer on the right heel and moisture associated skin damage (MASD) on their coccyx (tailbone). On 12/01/2025 at 2:52 PM, a standard foam mattress was observed on Resident 24's bed, without a low air loss (LAL) mattress in place. Daily observations, from 12/01/2025 through 12/04/2025, showed Resident 24 had a standard foam mattress pad on their bed. Resident 24's skin integrity care plan, dated 11/13/2025, documented Resident 24 had a LAL mattress to protect the skin while in bed. Resident 24's order, dated 11/17/2025, documented to check settings every shift. Review of Resident 24's November and December 2025 TAR, showed staff documented three times a day from 11/17/2025 through 12/05/2025, that they had checked the pressure and inflation setting on Resident 24's LAL mattress (Resident 24 had a standard mattress until 12/04/2025 when the LAL mattress arrived). On 12/05/2025 at 8:50 AM, Resident 24 said they received the new LAL mattress the day before. A new LAL mattress was observed, with a control box attached to the end of the bed. On 12/08/2025 at 10:42 AM, Staff V, Maintenance Director, said he reviewed all the TELs requests for the room in which Resident 24 resided and the only order request found was from 10/12/2025 (one month prior to Resident 24' admit), and there had been no other problems reported with that bed since. Staff V confirmed they had no maintenance order for a new LAL mattress on or around 11/17/2025 (Resident 24's order for nursing to perform LAL checks), there were no reports of a broken control box or broken LAL mattress for Resident 24, and they had not installed a new LAL mattress until 12/04/2025. On 12/08/2025 at 10:46 AM, Staff B confirmed Resident 24 had an order for a LAL mattress on 11/17/2025 and for staff to check the LAL mattress ever shift. Staff B reviewed the EHR and found no documentation a LAL mattress had ever been installed on 11/17/2025 and said they would have to check with maintenance. When the interview with Staff V was explained, Staff B said they did not know Resident 24 did not have a LAL mattress and staff should not have been signing for a task they could not complete, that was not acceptable. On 12/09/2025 at 12:02 PM, when asked if they had been made aware of the concerns related to Resident 24' pressure ulcer, Staff A, Administrator, said they were only told about the concern with the LAL mattress. It was explained that Resident 24 was documented to have a LAL mattress since 11/17/2025, but did not receive the LAL mattress until 12/04/2025, but staff had been signing off they were checking the setting three times a day. Staff A said signing for things staff did not actually complete was not acceptable. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference F686, F756 Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to provide restorative services at the assessed frequency, for 2 of 2 residents (Residents 52 & 54) reviewed for restorative services. This failure placed residents at risk of decreased range of motion, loss of abilities to complete daily activities, and a diminished quality of life.Findings included.Review of the facility policy titled Restorative Nursing Services, with an approval date of 10/2025, documented the facility would provide restorative nursing care as needed to help promote optimal safety and independence for the residents. Resident 52Resident 52 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/02/2025, showed Resident 52 was dependent on staff for cares, and received a passive and an active range of motion restorative program for six days of the week. Review of Resident 52's 2025 September, October, November, and December (up to 12/03/2025) restorative charting, in the electronic health record (EHR), showed Resident 52 was not receiving restorative programs consistently at six days a week. For September, six days of restorative were recorded for the month. For October, eight days were recorded. For November, five days were recorded. For December, no documentation was found of restorative between 12/01/2025 to 12/03/2025. Review of the Restorative Quarterly Review, dated 10/30/2025, documented Resident 52 was participating in the programs and pain was not an issue. Recommendations were made to continue current programs, and to continue monitoring participation and progress.Resident 54Resident 54 was admitted to the facility on [DATE], and had diagnoses including muscle weakness, difficulty walking, limitations of activities due to disability, and need for assistance with personal care. The Annual MDS assessment, dated 10/07/2025, showed Resident 54 was cognitively intact, and received a range of motion and a dressing/grooming restorative program for six days of the week. Review of Resident 54's 2025 October, November, and December (up to 12/04/2025) restorative charting, showed Resident 54 was not receiving restorative programs consistently at six days a week. After the first week in October, Resident 54 had their programs about five days a week. In November, they received their programs Sunday through Thursday, which came out to five days a week. For December, no restorative program had been completed from 12/01/2025 to 12/04/2025 (all 4 days).During a joint interview on 12/05/2025 at 9:34 AM, Staff I, Restorative Aide, was interviewed with Staff G, Director of Rehabilitation, and Staff H, MDS Coordinator/Registered Nurse, present. Staff I confirmed Resident 52 was assessed to need restorative services six times a week. Staff I provided additional paper records, for Resident 52, to be reviewed during the interview. Staff G assisted with the review and confirmed that for the previous 30 days (11/06/2025 to 12/05/2025), only five refusals had been documented (either in the EHR or on the papers reviewed) and Resident 52 only received restorative services four times. Staff G said their expectation was that in the restorative meeting, if there was a pattern of missed opportunities or refusals, then there would be a discussion to discontinue or reevaluate on if a new program should be developed. During this interview, Staff I confirmed Resident 54's program was written for six days a week for range of motion and activities of daily living. Staff I said Resident 54 was on their partner's schedule, whose work schedule was only Sunday through Thursday, so Resident 54 was only getting five days of their program. During an interview on 12/08/2025 at 1:53 PM, Staff B, Director of Nursing Services, when asked their expectation for restorative programs being done at the frequency they were assessed to be done, said they should be done. Reference WAC 388-97-1060 (3)(d)(j)(ix)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff monitored and accurately recorded fluid intake for 1 of 1 resident (Resident 3) reviewed for hydration. These failures placed residents at potential risk for medical complications, fluid overload, and a diminished quality of life.Findings included . The facility's policy titled, Encouraging and Restricting Fluids, dated 10/2010, said The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids.General Guidelines 1. Follow specific instructions concerning fluid intake or restrictions. Be accurate when recording fluid intake.Resident 3 was admitted was admitted to the facility on [DATE] with a diagnosis of edema (swelling caused by excess fluid trapped in your body's tissues). The admission Minimum Data Set (an assessment tool), dated 11/01/2024, documented the resident was cognitively intact.Resident 3's diet restrictions care plan, dated 10/27/2025, documented, Fluid Restriction 1800ml [milliliters]/24 hours, Kitchen 240ml per meal tray, Nursing 360ml per shift.Resident 3's orders, ordered on 10/27/2025, showed:-Fluid restriction 1800ml/24 hours - record total fluid intake every shift. Include intake with meals.-Fluid Restriction: Total 24-hour intake every night shiftResident 3's Point of Care (POC) response history for task: amount eaten for Fluid intake in mls, dated 11/03/2025 - 12/01/2025 had entries documented one to three times a day.Resident 3's November and December 2025 Treatment Administration Record (TAR) showed documentation of the fluid intake for every shift: day evening and night in mls and documentation of the total 24-hour intake in mls.On 12/04/2025 at 10:48 AM, Staff C, Assistant Director of Nursing/ Registered Nurse, said the nurses were supposed to be calculating the day, evening and night shift totals for 24 hours in the TAR. Staff C stated while looking at the POC, I don't know what the aides were charting. Staff C said they were supposed to have sheets at the nurse stations to document on, and she would look for those sheets.On 12/04/2025 at 11:38 AM, Staff C provided fluid restrictions sheets for 10/30/2025, 11/01/2025, 11/02/2025, 11/03/2025, 11/04/2025, 11/10/2025, and 11/11/2025. When asked if she had fluid restriction sheets for the most recent 30 days, Staff C said she would have to look.On 12/04/2025 at 11:51 AM, Staff C, provided additional fluid restrictions sheets for 10/30/2025, 10/31/2025, 11/01/2025, 11/02/2025, and 11/12/2025 and stated, this is all I've got.On 12/08/2025 at 12:33 PM, Staff B, Director of Nursing Services, said regarding the POC, TAR and fluid restrictions sheets, the numbers did not add up correctly and stated, I don't know where they are getting those totals.Reference WAC 388-97- 1060 (3)(i)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure peripherally inserted central catheters (PICC, a long, flexible tube inserted into a vein in the arm, used for prolonged intravenous access to deliver medications, fluids, and nutrition) were assessed, maintained and monitored in accordance with professional standards of practice for 2 of 2 residents (Residents 73 & 84) reviewed for IV therapy. This failure placed residents at risk for unidentified complications, loss of vascular access, infection, and other potential negative health outcomes.Findings included . Review of the facility's Vascular Access Devices and Infusion Therapy Procedures policy, dated August 2021, showed upon admission or insertion staff would measure the PICC external length and the residents arm circumference 10 centimeter (cm) above the insertion site, to establish a baseline. The PICC external length would then be measured weekly with PICC dressing changes and compared with the baseline measurement to rule out line migration or dislodgement. A resident's arm circumference would be measured as indicated to rule out phlebitis (inflammation of a vein) or deep vein thrombosis (blood clot). Needleless injection caps would be changed at least every seven days and as needed. All valved vascular access devices would be flushed with 10 cubic centimeters (cc) of Normal Saline (NS) before and after infusion. After drawing blood from a PICC, staff would flush the line with 20 cc of NS to maintain patency. Resident 73 Resident 73 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 11/10/2025, showed the resident had moderate cognitive impairment, a diagnosis of sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), and received intravenous (IV) antibiotics via central catheter during the assessment period. The Avaadmission Nursing Database, dated 11/04/2025, showed Resident 73 had a PICC in their right upper arm. The assessment did not identify how many lumens (individual tubes or channels within a single PICC), the PICC had, what the external catheter length or resident's arm circumference was. Record review showed Resident 73's had the following IV medication, and PICC maintenance and monitoring orders, dated 11/04/2025.a) Cefepime IV infusion every 12 hours right lower extremity cellulitis (skin infection)b) Vancomycin IV infusion once a day for right lower extremity cellulitisc) Change IV administration set/ IV tubing every 72 hoursd) Change needleless injection caps with each dressing change and after blood draws and as needede) Change PICC dressing every seven days. Use a sterile dressing kit. Change injection caps and measure external catheter lengthf) Flush PICC with 10cc of NS before and after medication administrationg) Monitor PICC site every shift. Notify physician of any changesh) Flush PICC with 5cc NS. Draw 5 cc blood and discard, draw blood for labs, Flush with 10 cc NS as needed for blood draw The orders did not identify the location of Resident 73's PICC or the number of lumens that were present. Additionally, the facility's policy directed staff to flush with 20cc of NS after blood draws, not 10cc NS as ordered. The November 2025 Medication and Treatment Administration Records (MAR/TAR) showed Resident 73's weekly PICC dressing changes and external length measurements were scheduled to be done on 11/05/2025 and 11/12/2025. On 11/05/2025 staff documented 3 [resident out of facility]. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing change and external length measurement scheduled for 11/12/2025 was blank. Review of Resident 73's electronic health record showed there was no documentation facility staff measured the resident's PICC external length and arm circumference upon admission or any time thereafter. On 12/05/2025 at 11:16 AM, when asked if there was any documentation to show staff measured Resident 73's PICC external length or arm circumference upon admission or any time thereafter Staff B, Director of Nursing Services, stated, No. Staff B then confirmed that central lines should be flushed with 20 cc of NS after blood draws, not 10 cc NS as ordered, to ensure patency is maintained. Resident 84 Resident 84 was admitted to the facility on [DATE] with a diagnosis of sepsis. The admission MDS, dated [DATE], documented the resident was cognitively intact and had a special treatment of central IV (intravenous-referring to something given directly into a vein like fluids or medicine) access. Resident 84's orders, dated 11/25/2025, showed:- PICC dressing change with sterile dressing kit every evening shift on Wednesday and Measure external length of catheter with each dressing change. Resident 84's care plan IV Therapy provided through PICC Line dated 11/25/2025 said Document IV Line Measurements. Resident 84's TAR, where staff document dressing change and line measurement, showed on 11/26/2025 staff documented a 9 = other/see nurse notes. A review of Resident 84's nursing progress notes, dated 11/26/2025 at 3:12 PM, by Staff T, Registered Nurse, showed no documentation of external length of catheter measurements. On 12/05/2025 at 11:16 AM, Staff B, DNS said she did not see documentation of external catheter length for Resident 84 or arm circumference. Staff B said her expectation was that the nursing staff measure the external length on admission and weekly with dressing changes and show documentation of arm circumference on admission or insertion. Reference: WAC 388-97-1060(3)(j)(ii).

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen therapy was provided in accordance with physician's orders and accepted professional standards of practice for 1 of 1 resident (Resident 73) reviewed for respiratory care and services. The failure to document when oxygen was administered, to check and replace empty portable oxygen cylinders, and ensure humidifier bottles contained fluid and were functional, placed residents at risk for respiratory compromise and/or unmet respiratory needs. Findings included . Resident 73 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 11/10/2025, showed the resident had diagnoses of heart failure and pulmonary hypertension (high blood pressure in the arteries connecting your heart to your lungs) and received oxygen therapy during the assessment period.Review of Resident 73's electronic medical record showed the following 11/04/2025 oxygen orders:-Oxygen 1-2 liters via nasal canula as needed, for shortness of breath. Notify the physician when resident is placed on oxygen. -Change humidifier bottle every week when oxygen is in use, and as needed.-Change oxygen tubing when it becomes visibly soiled. On 12/02/2025 at 11:57AM, Resident 73 was sitting in a wheelchair in their room doing pursed lip breathing (a technique where air is inhaled slowly through the nose and then exhaled slowly through pursed lips to slow down breathing and improve air exchange). Resident 73 had a nasal canula in place that was attached to a portable oxygen cylinder secured to the back of their wheelchair. Observation of the regulator showed it was set to deliver two liters of oxygen per minute, but the oxygen cylinder gauge registered zero PSI (pounds per square inch) which showed the oxygen cylinder was empty.On 12/04/2025 at 8:34 AM, Resident 73 was in a wheelchair in their room with a nasal canula in place that was attached to a portable oxygen cylinder secured to the back of their wheelchair. The oxygen cylinder regulator was set to deliver two liters of oxygen per minute. Observation of the oxygen cylinder gauge showed it registered zero PSI (empty). Resident 73 reported they could not feel any air blowing through their nasal cannula.On 12/04/2025 at 9:00 AM, upon request Staff KK, Registered Nurse, checked Resident 73's portable oxygen cylinder and stated, It looks like it is empty and indicated they would replace it. When asked if they checked Resident 73's portable oxygen cylinder to ensure it was not empty prior to transferring Resident 73 to it from the oxygen concentrator Staff KK explained that the nurse aides transferred the resident from the concentrator to the portable oxygen cylinder when they got Resident 73 up. When asked if nurse aides were allowed to administer medications and/or set the liter flow for a resident's oxygen Staff KK stated, No. Review of the December 2025 Treatment Administration Record (TAR) on 12/04/2025 showed Resident 73 had not received any supplemental oxygen in the month of December. Facility nurses had not signed that they administered oxygen to Resident 73.On 12/04/2025 at 9:37 AM, Staff KK confirmed Resident 73 used oxygen daily. When asked if any nurse had documented on the December 2025 TAR that they administered Resident 73 oxygen, Staff KK stated, no.On 12/09/2025 at 9:30 AM, observation of the humidifier bottle attached to Resident 73's oxygen concentrator showed it was empty.On 12/09/2025 at 9:34 AM, Staff E, Registered Nurse, confirmed Resident 73's humidifier bottle was empty and needed to be replaced.Review of the December 2025 TAR showed Resident 73's humidifier bottle was not changed from 12/01/2025 - 12/09/2025 despite an order to change weekly when oxygen was in use.Reference WAC 388-97-1060 (3)(j)(vi)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reevaluate the necessity and safety of bed rails/mobility bars for 2 of 2 residents (Residents 12 & 8) reviewed for bed rails. This failure placed residents at risk of accidents and a diminished quality of life.Findings included.Review of the facility policy titled Assistive Devices and Equipment, revision date of 2/2021, showed the facility was to assess the appropriateness for resident condition, personal fit, device condition, and staff practices, to decrease the risk of avoidable accidents associated with the devices and equipment.Resident 12Resident 12 was admitted to the facility on [DATE], with a diagnosis of dementia (decline in mental ability severe enough to interfere with daily life, involving memory loss, thinking problems, reasoning issues, and personality changes). The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/2025, showed Resident 12 was severely cognitively impaired. Review of Resident 12's falls care plan, revised on 11/20/2025, showed they were a high risk for falls related to limited mobility, incontinence, cognitive problems, gait/balance problems, history of falls, lack of impulse control, poor communication and comprehension, poor insight and judgement, psychoactive drug use, were unaware of safety needs, and hearing problems. In this care plan, 14 total falls were listed: 05/24/2025, 05/25/2025, 06/09/2025, 06/13/2025, 06/17/2025, 06/18/2025, 07/01/2025, 08/05/2025, 08/27/2025, 08/29/2025, 08/30/2025, 10/18/2025, 11/05/2025, and 11/14/2025. Review of Resident 12's electronic health record (EHR), showed Resident 12 had an initial evaluation for mobility bars done on 08/06/2025, which did not document any falls (although there was a section asking about falls on the form). No reevaluation was found.During an observation on 12/01/2025 at 1:09 PM, Resident 12's bed was observed with bilateral mobility bars on the top of the bed. Resident 8Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact.Review of Resident 8's falls care plan, revised on 08/27/2025, showed they were a moderate risk for falls due to deconditioning, gait/balance problems. Recent falls were listed as 6/23-fall w/bruises and 6/26-NIF [no injury fall].Review of Resident 8's EHR, showed Resident 8 had an initial evaluation for the mobility bars done on 05/01/2025, which did not document any history of falls. No reevaluation was found. During an observation on 12/02/2025 at 8:29 AM, Resident 8's bed was observed with bilateral mobility bars on the top of the bed. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/ Registered Nurse, and Staff J, Resident Care Manager/Licensed Practical Nurse, were asked about mobility bars. When asked if Resident 12 had any mobility bar assessments done after the initial evaluation, Staff C said their quarterly assessment for the MDS was done in November, continued looking in the EHR, then said they could not find any documentation of a reevaluation for the bed mobility bars. Staff C said mobility bars were to be reassessed quarterly and also confirmed this had not happened for Resident 8. During an interview on 12/08/2025 at 1:53, Staff B, Director of Nursing Services, said their expectation for bedrails/mobility bars, was for them to be reassessed quarterly. Reference WAC 388-97-1060(3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure monthly pharmacist recommendations were carried out accurately and timely, for 1 of 5 residents (Resident 12) reviewed for unnecessary medications. This failure placed residents at increase for accidents, unnecessary medication, complications, and a diminished quality of life.Findings included.Review of the facility policy titled Medication Monitoring Medication Regimen Review and Reporting, dated 01/2024, documented the nursing care center would follow up on the recommendations to verify that appropriate action had been taken, with recommendations acted upon within thirty calendar days or per facility specific protocols. For issues that required physician intervention, the provider was to either accept the recommendation or to document their rational of why the recommendation was rejected in the medical record.Resident 12 was admitted to the facility on [DATE], with a diagnosis of dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/2025, showed Resident 12 was severely cognitively impaired, and had a history of falls.Review of Resident 12's pharmacy recommendation for July 2025, showed the pharmacist recommended directions for Resident 12's lidocaine patch order, for putting on in the morning and taking off at night, with a maximum amount of time on of twelve hours total. Review of Resident 12's November 2025 Medication Administration Record (MAR), showed the pharmacist recommendation was not followed, and Resident 12 was ordered to wear the lidocaine patch for twenty-four hours.During an interview on 12/03/2025 at 8:44 AM, Staff Q, Licensed Practical Nurse (LPN), confirmed Resident 12 was wearing their lidocaine patch for twenty-four hours a day. Review of Resident 12's pharmacist recommendation for November 2025, showed the pharmacist recommended a gradual dose reduction (GDR, decrease in dose) of Resident 12's antipsychotic medication. The pharmacist included a section to let the facility know the requirements of the GDR, CMS [Centers for Medicare and Medicaid Services] guidelines require that psychotropic medications undergo a gradual dose reduction (GDR) attempt in two separate quarters (with at least one month between the attempts) during the first year of initiation or admission; then annually thereafter, unless clinically contraindicated. Notes found on the GDR form showed the provider believed Resident 12 was a reasonable candidate for a cautious GDR attempt, as their behaviors had remained stable. There was no clinical rationale that documented why the GDR could not be attempted at the time. The form had a note that the Power of Attorney (POA, legal decision maker) rejected the GDR attempt. Review of Resident 12's additional pharmacist recommendation for November 2025, done in response to Resident 12's multiple falls (about 14 since admission), dizziness, and nose bleeds, showed the pharmacist gave multiple recommendations. The pharmacist documented that Resident 12 was receiving a dose of tamsulosin (a medication that relaxes muscles in the prostate and bladder neck to improve urine flow), that was double the general dosing and recommended the dose be decreased due to side effects of orthostatic hypotension (low blood pressure when standing after sitting or lying down), dizziness, headache, falls, and nose bleeds. The pharmacist also gave considerations for melatonin (sleep aide) and Resident 12's antipsychotic to be lowered. In the section that said it was to be completed by nursing staff/physician, no documentation was found on what the decision was or why no changes were made. The physician signed the form on 11/13/2025 and nursing signed on 11/14/2025. Review of Resident 12's MAR from 11/01/2025 to 12/08/2025, showed none of the recommendations for the above three medications had been implemented. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/ Registered Nurse, and Staff J, Resident Care Manager/LPN, were asked about Resident 12. Staff C reviewed Resident 12's July pharmacist recommendation and said the lidocaine order had been updated. Staff C reviewed Resident 12's EHR further and confirmed the lidocaine patch was being applied twice a day. Staff J said the order showed it was on for twenty-four hours. When asked (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if a POA declination was a clinical indication for not performing a GDR, Staff C said yes, because of resident rights. When asked about Resident 12's pharmacist recommendation review that was requested due to falls, Staff C acknowledged there was not a discussion on the recommendations and there should have been. Staff C said they had checked it off because they have pharmacy do a medication review when they run out of fall interventions, and there currently were unable to find why Resident 12 was on the higher doses of tamsulosin. During an interview on 12/08/2025 at 1:53 PM, Staff B, Director of Nursing Services, said their expectation for following medication regimen review recommendations was for them to go to the medical provider or mental health provider and behavior meetings, then the provider makes the decision on if they agree and they would then follow the instructions. When asked if the team was recommending a GDR and the POA declined, if that met a clinical indication for not following the recommendation, Staff B said they did not know and would need to look into that before answering.No follow-up information was provided.Reference F658Reference WAC 388-97-1300 (1)(c)(iii) -1300 (4)(c)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was properly stored and labeled in refrigerators, food temperatures were checked without preventing cross contamination, and the resident snack refrigerators were monitored in accordance with professional standards for safe food service. These failures placed the residents at potential risk for food borne illnesses, and a diminished quality of life.Findings included .Initial RoundsOn 12/01/2025 at 10:50 AM, an unidentified item in the dairy refrigerator without a date on it was observed. Staff BB, Registered Dietician, said it was a cake and she could not find a date on it and threw it away. Also observed was a stick of butter partially used with the excess paper crumbled around it. When asked if there was a date on it, Staff BB said no and it should have been placed in a container. Staff BB placed the butter in a container and dated it before she placed it back in the refrigerator.On 12/01/2025 at 10:51 AM, in the refrigerator, along the back wall with the clock and electrical panel, a cup of undated dressing was observed. Staff BB took the cup of dressing out of the refrigerator and threw it away.On 12/01/2025 at 10:58 AM, a greenish substance was observed on the surface of peppers in the produce refrigerator. Staff BB said the peppers were molded and threw them away. On 12/03/2025 at 2:23 PM, Staff CC, Dietary Services Manager, said her expectations for the molding peppers was to double check and make sure they were rotating the produce, and she said she had educated the staff on this. Staff CC said the butter with crumbled paper around it should been placed in a clean container and properly labeled.Meal PreparationOn 12/03/2025 at 10:49 AM, Staff DD, Cook, wiped off the thermometer used to check food temperatures with the rag from the disinfectant bucket also used to wipe the counters, before she checked the temperature of the noodles. Staff DD placed the rag back in the disinfectant bucket. At 10:50 AM, Staff DD cleaned sink and counters with rag from disinfectant bucket just used to wipe off the thermometer. At 10:53 AM, Staff DD checked the temperature of the hamburgers with the thermometer, cleaned with the rag in the bucket of cleaning solution just used to wipe off the counters. At 12:09 PM, Staff DD wiped the counters by the stove and sink and then wiped the thermometer with same rag from the disinfectant bucket.On 12/03/2025 at 2:23 PM, Staff CC, Dietary Services Manager, said it was not sanitary to use the rag from the disinfectant bucket to wipe the thermometer when it was also used to wipe the kitchen counters. Staff CC said she would prefer they used alcohol wipes but if they were not available then they could use a separate disinfectant rag and bucket to wipe the thermometer when they checked the food temperatures. Resident Snack RefrigeratorOn 12/03/2025 at 2:50 PM, Staff E, Resident Care Manager/Registered Nurse, observed the thermometer in the resident snack refrigerator, by the [NAME] dining room and near the administrator's office. Staff E said it was 50 degrees and he said it should be below 41 degrees. When asked how long it has been that way, Staff E stated, I don't know. Staff A, Administrator, said they did not want to take any chances and would talk to maintenance and have the food thrown. On 12/03/2025 at 2:56 PM, Staff Y, Scheduling Coordinator, was observed emptying the freezer and refrigerator located near the [NAME] dinning room for residents. Staff Y said he planned to put up a sign that it was out of order.On 12/03/2025 at 3:47 PM, a sign was observed that said out of order and the temperature gauge read 50 degrees by the [NAME] dinning room (resident refrigerator). There was no food in the refrigerator or freezer. Both Staff Y and Staff A, Administrator, confirmed the thermometer was at 50 degrees. Staff Y said they removed all the food. Staff A said the temperature should have decreased by now, it had been long enough. WAC Reference 388-97-1100(3),2980

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview and record review, the facility failed to ensure residents' records were accurate and complete for 10 of 24 sampled residents (Resident 9, 81, 6, 52, 10, 26, 31, 7, 1, & 37) reviewed for resident records. The failure to document resident information accurately and completely, and/or correctly identify residents' primary care physician, placed the resident at risk for incomplete and inaccurate medical records and unmet care needs.Findings included .Resident 9 Resident 9 was admitted to the facility on [DATE], with diagnoses of dementia with psychotic disturbance (involves symptoms of hallucinations (seeing things not there) and delusions (fixed false beliefs)). Review of the Modification of Quarterly Minimum Data Set (MDS, an assessment tool), dated 10/04/2025, documented Resident 9 was severely cognitively impaired. Record review of Resident 9's progress notes, from 07/04/2025 through 07/17/2025, showed the following behaviors were noted. A behavior progress note, dated 07/04/2025, documented Resident 9 was seeing children that were not there (hallucinating). A behavior progress note, dated 07/05/2025, documented Resident 9 was experiencing hallucinations and hollering out. A nursing progress note, dated 07/10/2025, documented Resident 9 was visually hallucinating, yelling out, and believed someone else was in the room. A behavior progress note, dated 07/17/2025, documented Resident 9 was experiencing visual hallucinations and delusions. Review of the July 2025 behavior monitors, showed Resident 9 had behavior monitors for potential behaviors for antipsychotic use, the behaviors to be documented on by staff included 1. verbal aggression, 2. physical aggression, 3. hallucinations, and 4. delusions. Staff were to document the number corresponding with the behavior noted on the behavior monitor. Review of the behavior monitor for 07/04/2025 (when it was documented Resident 9 was hallucinating), showed staff had documented a + (positive) sign for that date but did not indicate a number for which behavior Resident 9 was positive for. Review of the behavior monitor for 07/05/2025 (when it was documented Resident 9 was hallucinating), did not indicate Resident 9 was having any of the four behaviors included on the behavior monitor. Review of the behavior monitor for 07/10/2025 (when it was documented Resident 9 hallucinating), did not indicate Resident 9 was having any of the four behaviors included on the behavior monitor. Review of the behavior monitor for 07/17/2025 (when it was documented Resident 9 was hallucinating and having delusions), did not indicate Resident 9 was having any of the four behaviors included on the behavior monitor. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/08/2025 at 1:13 PM, Staff B, Director of Nursing Services (DNS), said she would expect listed behaviors to be charted on the behavior monitor if they were observed and documented in a progress note. Staff B reviewed Resident 9's behavior monitor and confirmed the documentation from progress notes for 07/04/2025, 07/05/2025, and 07/10/2025 was not there. Staff B said the staff had documented a positive sign on the 07/17/2025 behavior monitor, but they should have included the corresponding number to indicate which sign Resident 9 was positive for. When asked if the missing documentation on the behavior monitors met her expectations, Staff B said no, it should have been put there. Resident 81 Resident 81 was admitted to the facility on [DATE], with an admitting diagnosis of acute respiratory failure with hypoxia (a sudden, severe condition where the lungs fail to get enough oxygen into the blood). The 5 Day MDS, dated [DATE], indicated Resident 81 had some difficulty making decisions regarding tasks of daily life in new situations only. Resident 81 was transferred to the hospital on [DATE]. Review of a single nursing progress note, dated 09/06/2025 and entered at 1:14 pm, documented the day's events leading up to Resident 81's hospitalization. The note showed Resident 81 was smiling in the morning, and documented vital signs (measurements, such as temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation [O2, percentage of oxygen in the blood]) were stable. Without a documented time, Resident 81 later declined a shower and stated he did not feel well. Without a documented time, the nurse documented vital signs remained stable, without recording what the vital signs were. The nurse then documented Resident 81 reported mild shortness of breath when lying flat, the head of the bed was elevated, and Resident 81 was supplied with oxygen at 2 liters per minute. Documentation showed the certified nursing assistant notified the nurse Resident 81 had called 911 from his room. The nurse documented they entered the room for further evaluation and Resident 81's oxygen was then 86% on the 2 liters of oxygen. The note then said emergency medical services crew had arrived at Resident 81's room. Review of Resident 81's vitals showed only two oxygen readings from 09/06/2025 as follows: 09/06/2025 at 7:33 AM, O2 at 92% on room air (morning vital signs) 09/06/2025 at 12:57 PM, O2 at 85% on room air (not a stable vital) The second stable set of vitals, reported in the nursing progress note, was not found. On 12/08/2025 at 1:02 PM, Staff B, DNS, said if a resident reported being short of breath and oxygen was applied, an oxygen reading should be taken and then documented in the record. Regarding the missing documentation of vital signs for Resident 81, Staff B said the nurse should have documented the vital signs. Resident 6 Resident 6 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 6 was cognitively intact, relied on staff for most cares and had an indwelling catheter (a thin tube that remained in the bladder to remove urine). (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's electronic health record (EHR), showed they were sent to the hospital for chest pains and possible urinary tract infection (UTI), from 11/04/2025 to 11/05/2025. The EHR had no follow-up documentation or discharge summary from Resident 6's hospitalization. A Nursing care progress note, dated 11/06/2025 at 2:59 AM, documented Resident 6 returned from the hospital with a diagnosis of UTI (urinary tract infection), but they were unable to obtain antibiotic until provider completed visit with Resident 6. On 12/08/2025 at 10:46 AM, when asked about Resident 6's hospitalization, Staff B, DNS, said the reason for Resident 6's admit was UTI with possible sepsis and the follow-up recommendations included urology and nephrology (specialists in urinary system and kidneys) referrals, to repeat CBC (common blood test that counts your blood's key cells) and UA (urinalysis to look for infection) and antibiotics to be continued. Staff B reviewed the EHR and said none of the recommendations had been followed up with. Resident 52 Resident 52 was admitted to the facility on [DATE]. Review of the Quarterly MDS assessment, dated 10/02/2025, showed Resident 52 was severely cognitively impaired, impaired with decision making, and dependent on staff for cares. Review of Resident 52's EHR, showed they were taking a blood thinner and had a side effect monitor for it. Review of Resident 52's progress notes from 10/25/2025 to 12/04/2025, showed blood was noted by nursing in Resident 52's urine on 11/11/2025, 11/22/2025, 11/23/2025, 11/24/2025, 11/25/2025, and 12/04/2025. Review of Resident 52's Treatment Administration Record for their blood thinner side effect monitor, from 11/01/2025- 12/02/2025, showed blood-tinged or frank blood in the urine was a potential side effect and staff had documented no complications noted. During an interview on 12/08/2025 at 12:08 PM, Staff C, Assistant Director of Nursing (ADON)/RN, when asked if a resident on a blood thinner who was having blood in their urine, if that should be recorded on their side effect monitor, said yes it should. Resident 10 Resident 10 was admitted to the facility on [DATE] with a diagnosis of acute pancreatitis (inflammation of the pancreas). The admission MDS, dated [DATE], documented the resident was cognitively intact and had a urostomy (surgically made hole for urine removal through the abdomen). Appointment Documentation On 12/01/2025 at 2:58 PM, Resident 10 said they were supposed to get a scan (computed tomography [CT]- an advanced imaging test that uses X-rays and a computer to create detailed, cross-sectional pictures of the inside of the body). They said they went to the appointment and were sent back because they needed a prescription, and the facility was working on rescheduling the scan. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 10's orders, dated 11/13/2025, showed:- Please dress resident in comfortable clothes without metal, for CT appointment on 11/24/2025 at 1:30 PM.- Clear liquid diet three hours before CT appointment on 11/24/2025 at 1:30 PM. A review of Resident 10's Progress notes, dated 11/24/2025, did not show documentation of the resident going to and coming back from a CT appointment. On 12/04/2025 at 2:13 PM, Staff C, ADON/RN, said she did not see any documentation of a CT appointment in the progress notes and her expectation was that the staff document when a resident leaves the facility for an appointment and returns. On 12/05/2025 1:12 PM Staff B, DNS, when looking at the EHR, said she did not see documentation, and she would expect the nursing staff to put in a note that said Resident 10 went for a CT. Primary Care Physician Documentation Review of Resident 10's EHR showed, Staff LL was the primary care physician. On 12/05/2025 at 12:48 PM Staff LL, Medical Director, was asked if she was the physician for this resident and she said no. Staff LL said she had never seen this resident. When asked why she was listed as the primary care physician for Resident 10, Staff LL stated, Because I am the medical director. Review of Resident 26's EHR, showed Staff LL was the primary care physician. Review of Resident 31's EHR, showed Staff LL was the primary care physician. Review of Resident 7's EHR, showed Staff LL was the primary carer physician. Review of Resident 1's EHR, showed Staff LL was the primary care physician. Review of Resident 37's EHR, showed Staff LL was the primary care physician. During an interview on 12/05/2025 at 1:38 PM, Staff LL, Medical Director, reported they were not the primary care provider for any residents at the facility. Reference F690 Reference WAC 388-97-1720 (1)(a)(i-iv)(b)(2)(a-m)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed standard precautions (common sense practices to prevent the spread of infection in healthcare) and enhanced barrier precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug resistant organisms and precautions that are implemented when someone has chronic wounds or confirmed or suspected infections). Additionally, the facility failed to perform infection surveillance for 1 of 1 resident (Resident 52) reviewed for surveillance. This failure placed residents at risk of undetected infection, spread of infection, and a diminished quality of life. Findings included.STANDARD PRECAUTIONS During an observation on 12/02/2025 at 11:38 AM, Staff J, Resident Care Manager/Licensed Practical Nurse, gave Resident 74 insulin (medication injected via a needle, that regulates blood sugar) without wearing gloves. During an interview on 12/02/2025 at 11:51 AM, Staff J said they did not have to wear gloves while administering Resident 74's insulin, because it was administered with an insulin pen (a device with a needle, used to inject insulin with preloaded amounts of insulin). During an interview on 12/04/2025 at 1:31 PM, Staff R, Infection Preventionist/Registered Nurse (IP/RN), when asked if it met expectations that insulin was administered with an insulin pen and the nurse was not wearing gloves, said no, nurses were supposed to wear gloves. ENHANCED BARRIER PRECAUTIONS Review of the facility's policy titled Avamere Living-Enhanced Barrier Precautions, dated 03/21/2024, said in the purpose statement, The facility will implement Enhanced Barrier Precautions for residents with [.] wounds requiring dressing changes [.]. The guideline interpretation and implementation said, B. All residents with any of the following will be placed on EBP. 2) Wounds[.] (Wounds generally include chronic wounds e.g. pressure ulcer, [.]) Resident 24 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/19/2025, documented Resident 24 was cognitively impaired, was dependent on staff for all cares and admitted with an unstageable pressure ulcer (PU) on the right heel and moisture associated skin damage (MASD) on their coccyx (tailbone). During observation of wound care on 12/04/2025 at 10:53 AM, Staff T, RN, and Staff R, IP/RN, donned gloves, but no gowns, then uncovered and rolled Resident 24 onto their side. Staff T removed the old foam dressing and said the wound smelled like fish. Staff T cleansed with wound cleanser and then removed their gloves, sanitized their hands, and reapplied new gloves. Staff T patted the wound dry and applied foam dressing. Staff T confirmed two distinct open areas on buttock. On 12/04/2025 at 1:31 PM, when asked if Resident 24 should have been on EBP for wound care treatment, Staff R, IP, stated, It is not a massive pressure ulcer it is very superficial, it is a stage 2 pressure ulcer. It's so microscopic, tiny. Staff R confirmed Resident 24 admitted with a PU, but due to being open to air it doesn't need EBP. When asked if the wound was covered now and if Resident 24 required EBP at this time, Staff R stated, It is so insanely tiny, but probably. When asked if staff should wear personal protective equipment (PPE) during dressing changes, Staff R said for EBP yes. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/2025 at 11:15 AM, when asked when EBP was required, Staff K, Residential Care Manager (RCM), said when providing care to residents with open wounds, wounds that were draining and catheters. Observations were explained that Staff T, RN, and Staff R, IP/RN, only wore gloves during the wound care treatment. Staff K said that was not acceptable, both staff should have worn the appropriate PPEs. On 12/08/2025 at 10:46 AM, Staff B, Director of Nursing Services (DNS), was asked if they would expect Resident 24 to be on EBP due to required wound care treatments, Staff B said yes. Observations of no EBP signage or EBP cart outside Resident 24's room was reported and the observation of the wound care treatment was explained. Staff B said staff should have worn the appropriate PPE's, there should have been signage for the EBP with required PPE's available and that was not acceptable either. On 12/09/2025 at 12:02 PM, Staff A, Administrator, was told of the observation of Resident 24's wound care treatment. Staff A said both staff members should have been wearing appropriate PPEs for wound care treatment and there should have been EBP signage and PPEs available. INFECTION SURVEILLANCE Review of the facility policy titled, Infection Prevention and Control Program, revised 10/2018, showed it had multiple sections related to infection surveillance, including the following: surveillance, data analysis, outbreak management, and prevention of infection. The section on surveillance, showed surveillance tools would be used for recognizing the occurrence of infections, with a recording of their number and frequency, detecting outbreaks, and detecting unusual pathogens with infection control implications. The section on data analysis, showed the data obtained during surveillance would be used to oversee infections and spot trends. The infection preventionist would be responsible for collecting data from nursing units, categorizing each infection by body site, and recording the number of infections. The monthly rates could be plotted graphically or otherwise compared side-by-side to allow for trend comparison. The section on outbreak management, showed the facility would use specific criteria to differentiate sporadic cases from true outbreaks. The section on prevention of infection, showed staff were to identify possible infections or potential complications of existing infections, implement measures to avoid complications, educate staff and ensure proper infection prevention techniques, and have enhanced screening for possible significant pathogens. During a general infection control interview on 12/03/2025 at 11:23 AM, Staff R, IP/RN, was asked to explain their process for tracking and managing the spread of infections. Staff R said they tracked daily, that if someone was on an antibiotic or alert (facility had identified a potential safety or medical concern and was increasing observation and communication), such as for emesis (vomiting) or new cough, they would be placed on alert and Staff R would investigate to see if the doctor thinks it might be something (infectious). Staff R said their computer dashboard showed antibiotic and clinical alerts were listed, they looked at this every morning, tracked what was happening in current time, but also tracked the monthly look back. Resident 52 was admitted to the facility on [DATE] and had diagnoses of retention (bladder holds on to) of urine, obstructive and reflux uropathy (blockage in the urinary system that prevents normal urine flow), and dementia. Review of the Quarterly MDS assessment, dated 10/02/2025, showed Resident 52 was severely cognitively impaired, impaired with decision making, and dependent on staff for cares. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note, dated 11/06/2025, documented Resident 52 reported both pain and burning with urination, and they were placed on alert due to signs and symptoms of dysuria (painful or difficult urination). A second nursing progress note, dated 11/06/2025, documented Resident 52's urine was foul and slimy. Review of Resident 52's temperature log, showed they had a temperature taken on 10/18/2025 and not another until 11/15/2025. On 12/09/2025 at 11:13 AM, Staff R, IP/RN, said during an alert period, residents should have vitals taken once a day at a minimum, usually every shift. Regarding Resident 52's suspected infection and having their temperature taken on 10/18/2025 and not another until 11/15/2025, Staff R said she would have expected temperatures to be taken during that period. After reviewing the 11/06/2025 progress notes that indicated Resident 52 was having pain and burning with urination and was placed on alert for signs and symptoms of dysuria, Staff R was asked if Resident 52 was identified as a resident who had a suspected infection, Staff R said Resident 52 had many infections. Reference F686, F690Reference WAC 388-97-1320 (2)(a)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to ensure safety devices were consented for 1 of 2 residents (Resident 12) reviewed for safety devices/bed rails. This failure placed residents at risk of uninformed consent, increased chance of accidents, and a diminished quality of life. Findings included.Resident 12 was admitted to the facility on [DATE], with a diagnosis of dementia (decline in mental ability severe enough to interfere with daily life, involving memory loss, thinking problems, reasoning issues, and personality changes). The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/2025, showed Resident 12 was severely cognitively impaired. Review of Resident 12's safety device assessment and consent form for their wander guard device (device worn on person or mobility aid that alarms when exiting certain doors), dated 06/05/2025, showed the device was being used to remind the resident to not leave the facility without assistance. Under potential risks (a section on the risks of using the assistive device), other was selected and staff wrote, Leaving facility without assist and injuring self. Under consent, staff documented they had obtained Verbal Consent from Resident.Review of Resident 12's safety device assessment and consent form for their bilateral mobility bars/bed rails, dated 08/06/2025, showed staff documented they had obtained Verbal Consent from Resident.During an observation on 12/01/2025 at 1:09 PM, Resident 12 was seen with bilateral mobility bars on the top of their bed. During an observation on 12/03/2025 at 11:15 AM, Resident 12 was seen with a wander guard on their wheelchair. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/ Registered Nurse, and Staff J, Resident Care Manager/Licensed Practical Nurse, were interviewed about Resident 12. Staff C said if a resident showed signs of dementia, they would need to get consent from the Power of Attorney (legal decision maker) or primary emergency contact. Staff C said Resident 12 was not able to give informed consent, so their wife would need to be contacted. When asked if it was clear where they were consenting to have the wander guard placed, Staff C acknowledged the consent form did not say where. During an interview on 12/08/2025 at 1:53 PM, Staff B, Director of Nursing Services, said risk and benefits should be reviewed for informed consent, and residents unable to sign for themselves should not be signing consent. Reference WAC 388-97-0260,-1020(4)(a-b)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice and their comprehensive care plans for 4 of 22 sampled residents (Residents 1, 3, 8 & 81). The failure to initiate bowel care, identify and monitor non-pressure skin conditions, complete and document respiratory assessments, and evaluate daily weights and report significant variances to the physician, placed resident at risk for unidentified and/or avoidable decline, delay in treatment, pain/discomfort, unmet care needs and other potential negative health outcomes. Findings included . The facility's bowel care protocol dated 10/2020 documented, If a resident has not had a bowel movement for three consecutive days (must be medium or large), observe the following protocol after a physician order had been obtained.a. evening shift is to run a look back reportb. Evening shift to give milk of magnesia. If no results, thenc. Day shift to give the suppository. If no results, thend. Fleets enema will be given. If no results, complete a focused assessment of the abdomen and complete a digital exam and notify the Physician if needed.e. Suppositories and enemas are not to be given on night shift unless it is a resident's request. 1) Resident 1 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool) showed the resident was cognitively intact, had diagnoses of heart failure and kidney failure and received diuretic medication during the assessment period. Record review showed an order, dated 10/25/2025, order for daily weights. The order did not include weight variance parameters to indicate when physician notification was required. A nutritional problem care plan, revised 11/17/2025, directed staff to notify the physician and resident or representative of significant or severe weight loss or weight gain. Severe or significant weight loss or gain were not defined. Review of Resident 1's daily weight for November 2025 showed the following: a) 11/11/2025 weight- 265.1lbs; 11/12/2025 weight- 270.8 lbs. (+ 5.7 lbs. in 24 hours) b) 11/15/2025 weight -274 lbs.; 11/16/2025 weight- 278 lbs. (+ 4 lbs. in 24 hours, and + 13.1 lbs. in 6 days) c) 11/21/2025 weight- 279.6 lbs.; 11/22/2025 weight- 285 lbs. (+ 5.4 lbs. in 24 hours and + 19.9 lbs. in 11 days) Review of the electronic health record showed there was no documentation that the physician was notified of Resident 1's weight gain on the above referenced occasions. On 12/08/2025 at 2:36 PM, when asked if there was documentation the physician was notified of Resident 1's weight gain on 11/12/2025, 11/16/2025 or 11/22/2025 Staff B, Director of Nursing Services, said the physician should have been notified, but was unable to find documentation to show that it occurred. 2) Resident 81 was admitted to the facility on [DATE]. The 5 Day MDS, dated [DATE], indicated Resident 81 had some difficulty making decisions regarding tasks of daily life in new situations only. Resident 81 had an admitting diagnosis of Acute Respiratory Failure with Hypoxia (a sudden, severe (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition where the lungs fail to get enough oxygen into the blood.) Resident 81 was transferred to the hospital on [DATE]. Resident 81 had an order, dated 09/05/2025, for Oxygen to be applied at 2 liters per minute via nasal canula as needed for shortness of breath/cyanosis (bluish or grayish discoloration of the skin, lips, or nail beds due to a lack of oxygen in the blood or poor circulation, signaling that tissues are not getting enough oxygen). Staff were instructed in the order to notify the MD (provider) once resident was on oxygen. Review of a nursing progress note for Resident 81, dated 09/06/2025 entered at 1:14 PM, documented Resident 81 was smiling in the morning and vital signs (measurements of essential body functions, such as temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation [SpO2 or O2, percentage of oxygen in the blood]) were stable. At some point later (time was not documented in the note) Resident 81 declined a shower and stated he did not feel well. The note then documented vital signs remained stable (the note did not specify the time this set of vital signs were taken or what the vital sign readings were at this point.) The note then documented Resident 81 reported mild shortness of breath when lying flat and the head of the bed was elevated, and Resident 81 was supplied with oxygen at 2 liters per minute (the note did not document that vital signs were taken when oxygen was applied, that a respiratory assessment was done, or that the provider was notified when oxygen was applied). The note then documented that the certified nursing assistant notified the nurse that Resident 81 had called 911 from their room (time was not noted). The note then documented that the nurse entered Resident 81's room for further evaluation and Resident 81's oxygen was then 86% on the 2 liters of oxygen. The note then said Emergency Medical Services crew arrived to Resident 81's room, report was provided to the crew, and Emergency Medical Services transported Resident 81 to the hospital for evaluation. The note then documented O/C (on call) Resident Care Manager notified of event. Review of the note showed that vital signs were reportedly done three times, the first being in the morning, secondly when it was charted vital signs remained stable, and the third time when Resident 81 was reevaluated. Further review indicated a set of vital signs taken at 12:57 pm indicated that Resident 81 had an oxygen reading of 85% on room air at that time, however oxygen level of 85% on room air would not indicate vital signs were stable. Record review showed only two oxygen readings from 09/06/2025 as follows: On 09/06/2025 at 7:33 am O2 at 92% on room air (morning vital signs) On 09/06/2025 at 12:57 pm O2 at 85% on room air (a critical and dangerous reading) On 12/08/2025 at 9:39 AM, Staff F, Registered Nurse, when asked what steps she would take if a resident reported feeling short of breath, Staff F said she would have the resident sit down and would check their pulse ox (oxygen level) and do a respiratory assessment, listen to the lungs, and if oxygen reading was below 90% she would put 2 liters of oxygen via nasal cannula on the resident. On 12/08/2025 at 1:02 PM, Staff B, Director of Nursing Services, when asked her expectations of staff actions when a resident reports shortness of breath, Staff B said they should do an assessment, get vital signs, listen to the lungs, take pulse ox, look for edema and once assessment is done call the doctor. Staff B said if the pulse ox was low, staff should put oxygen on the resident and notify the doctor they did that. When asked where the respiratory assessment would be documented, Staff B said in a progress note. When asked if staff should get an oxygen reading if a resident required the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	application of oxygen due to shortness of breath, Staff B said yes. When asked if staff did get a set of vital signs should they be entered into the record, Staff B said yes. When asked if a resident had an as needed order for oxygen with instructions to notify the MD after oxygen was applied when she would expect the MD to be notified, Staff B said at the time. When Staff B reviewed the progress note from the nurse on 09/06/2025, and was asked about the missing vital sign documentation, Staff B said the nurse should have documented the vital signs that were reportedly stable. When asked if a respiratory assessment was done, Staff B said the progress note did not say the nurse had listened to Resident 81's lungs and they should have. When asked if the provider should have been notified, Staff B said the provider should have been notified of the oxygen application. When asked if this met her expectations, Staff B said no, adding that the nurse should have put in two progress notes. On 12/09/2025 at 1:06 PM, Staff C, Assistant Director of Nursing, reviewed the 09/06/2025 nursing progress note and said the nurse who provided care that day had written the vital signs were stable and should have listed the vital sign readings in the progress note. Staff C said it would have been good to know what Resident 81's oxygen level was at the time they were put on oxygen. 3) Resident 3 was admitted was admitted to the facility on [DATE] with a diagnosis of cellulitis (deep bacterial skin infection causing red, swollen, painful, and warm skin) of right and left lower limbs. The admission MDS, dated [DATE], documented the resident was cognitively intact. Review of Resident 3's bowel movement record documented the resident had no bowel movement on 11/26/2025, 11/27/2025, 11/28/2025, 11/29/2025, 11/30/2025, and 12/1/2025. Review of Resident 3's November and December Medication Administration Record (MAR) did not show any documentation of the resident receiving PRN (as needed) bowel medications. On 12/04/2025 at 10:48 AM, Staff C, Assistant Director of Nursing/Registered Nurse, said while looking at Resident 3's electronic medical record (EMR) she did not see any progress notes of resident refusing PRN medications or that they were offered. Staff C said her expectation is that the bowel protocol be initiated and or the staff document that they offered PRN medications if they were refused. On 12/08/2025 at 12:33 PM Staff B, Director of Nursing, said while looking at Resident 3's EMR that the staff did not give any PRN medications and her expectation is that they start the bowel protocol. 4) Resident 8 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE] showed Resident 8 was cognitively intact. During an observation and interview on 12/2/2025 at 8:28 AM, Resident 8 showed they had a bruise on their left forearm, said they had bumped something, and the bruises just happen. Review of Resident 8's electronic health record on 12/3/2025, showed there was no monitor in place for the bruise. During an interview on 12/5/2025 at 8:01 AM, Staff S, Registered Nurse, confirmed Resident 8 had a bruise on their forearm. When asked how long it had been there, Staff S said they did not know. When asked if they were doing any interventions for the bruise, Staff S said no they were not. During a joint interview on 12/8/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/ RN, and (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff J, Resident Care Manager/Licensed Practical Nurse, were asked about Resident 8. When asked about Resident 8's forearm bruise, both Staff C and Staff J were unable to find any documentation on it. Staff C confirmed there was no mention of it on the skin assessments for the month of November, it was not on the care plan, and there was not an accident and incident report on it. Staff J assessed Resident 8's forearm, returned, and said there was a bruise on the upper forearm, over the size of a dollar coin, and described it as red and circular. Staff J said they would have expected monitoring of the bruise, and for it to have been documented on a skin assessment. Refer to F628 and F842 Reference WAC 388-97-1060 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from accident hazards for 4 of 5 residents (Residents 12, 73, 59 & 17) reviewed for accident hazards. This failure placed residents at an increase for falls, injury, and a diminished quality of life. Findings included. Resident 12 Resident 12 was admitted to the facility on [DATE], with a diagnosis of dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/2025, showed Resident 12 was severely cognitively impaired. Review of Resident 12's falls care plan, revised 11/20/2025, showed they were a high risk for falls related to limited mobility, incontinence, cognitive problems gait/balance problems, history of falls, lack of impulse control, poor communication and comprehension, poor insight and judgement, psychoactive drug use, unaware of safety needs, and hearing problems. In this care plan, 14 total falls were listed: 05/24/2025, 05/25/2025, 06/09/2025, 06/13/2025, 06/17/2025, 06/18/2025, 07/01/2025, 08/05/2025, 08/27/2025, 08/29/2025, 08/30/2025, 10/18/2025, 11/05/2025, 11/14/2025. Under interventions for fall prevention, having the soft touch call light within reach was listed. During an interview on 12/01/2025 at 1:04 PM, Resident 12 reported their head hurt from a fall. During an observation on 12/03/2025 at 11:15 AM, Resident 12 was seen sleeping on the bed on their left side, with their hips on the bed and their legs on their wheelchair. Their call light was visualized on the left corner of their nightstand (the corner touching the wall) with bilateral mobility bars between the resident and their access to grab their call light (they would have to reach over the upper side of the mobility bar). At 11:55 AM, Staff M, Certified Nursing Assistant (CNA), came into the room and was heard talking to Resident 12 about lunch, then left the room. At 11:56 AM, Staff E, Resident Care Manager/Registered Nurse (RCM/RN), came into the room and was heard telling Resident 12 their position did not look comfortable, then left the room. At 11:58 AM, Resident 12's call light was seen in the same spot as before. During an observation on 12/04/2025 at 9:10 AM, Staff P, CNA, was seen assisting Resident 12's roommate with using the bathroom. At 9:20 AM, Resident 12 was seen rocking their wheelchair back and forth, with no lights on. At 9:26 AM, when asked what Resident 12 was looking at, Resident 12 said nothing really; lights continued to be off. At 9:32 AM, Staff N, Activities Director, came into the room to provide Resident 12's roommate a daily chronical sheet(activities). At 9:51 AM, Resident 12 continued to rock back and forth in their wheelchair with the lights off. At 10:26 AM, Staff H, MDS Coordinator/RN, entered Resident 12's room, told them they were there to check on them, heard asking the resident if they wanted something near them, then exited the room. At 10:39 AM, family arrived at bedside and turned the light on. During an observation on 12/05/2025 at 7:37 AM, Resident 12's call light was seen on the nightstand in the same spot as on 12/03/2025, the left corner near the wall. Resident 12 was seen in their wheelchair, they would have to have leaned over their lap, then over items including a landline phone (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before being able to grab the call light to use it. At 7:54 AM, when asked where their call light was, Resident 12 was able to point to the cord coming from the wall. When asked if it was within reach, Resident 12 said no. During a joint interview on 12/08/2025 at 9:47 AM, Staff C, Assistant Director of Nursing/ RN, and Staff J, RCM/Licensed Practical Nurse, were asked about Resident 12. When asked their expectation regarding fall prevention with the observation of Resident 12 sitting in dark without their light on, Staff C said staff should have offered to turn the light on and not made any assumptions. When provided descriptions of the call light observations, Staff C said they expected Resident 12's call light to have been in reach. Resident 73 Resident 73 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident had diagnoses of heart failure and pulmonary hypertension (high blood pressure in the arteries connecting your heart to your lungs) and received oxygen therapy during the assessment period. On 12/04/2025 at 7:00 AM, Resident 73 was lying in bed resting with eyes closed and receiving oxygen at two liters per minute via nasal canula. The nasal canula was attached to a 15-foot section of coiled oxygen tubing that trailed off the bed, crossed the floor in front of the entry/exit door to the room and into the bathroom where it was attached to an oxygen concentrator. Each coil was elevated off the floor the length of a sharpie (5.5 inches). Resident 73's roommate, Resident 91, who would have to traverse the oxygen tubing to get into the bathroom or to exit the room stated, I cannot believe that is allowed. It is not safe. Resident 91 reported they had not tripped on the tubing, but stated, My husband did. He didn't fall, but he stumbled. I can't believe they [facility staff] are allowed to do that. On 12/04/2025 at 7:00 AM, when informed other residents, staff, and visitors had to traverse over the five-inch coils of Resident 73's oxygen tubing when entering or exiting the room or bathroom, Staff B, Director of Nursing Services, said that it was a safety tripping hazard. Staff B explained that the oxygen concentrator was moved into the bathroom because it was loud, but indicated staff needed to find a different solution. Resident 59 Resident 59 admitted to the facility on [DATE], with diagnoses that included dementia and mild cognitive impairment. Review of the Quarterly MDS, dated [DATE], showed Resident 59 was moderately cognitively impaired. On 12/01/2025 at 1:09 PM, Resident 59 was noted to have a 32-ounce bottle of 91% isopropyl rubbing alcohol on the bedside table. When asked if they were using the rubbing alcohol, Resident 59 said they were using the alcohol for little things that could be taken care of without a doctor. On 12/03/2025 at 9:07 AM, Resident 59 said they used the rubbing alcohol on their athlete's foot, and it worked. On 12/04/2025 at 9:39 AM, Staff L, RN, when asked what was required for a resident to have a chemical product in their room, such as rubbing alcohol, Staff L said, a lock box. When asked if anything was required for self-administration, Staff L said they were pretty sure the RCM would do an assessment and watch the residents to assess if they were safe and knew what they were doing. Staff L said the RCM would put it in the care plan the resident was safe. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/2025 at 9:50 AM, Staff C, Assistant Director of Nursing (ADON)/RN, with Staff K, RCM/RN, present, when asked what was required for a resident to have a chemical in their room such as rubbing alcohol, Staff C said they should not have it at bedside. Staff C said staff would have to do a self-medication assessment to determine if the resident was capable mentally and physically of using it, make sure there was an order from the provider and an assessment was in place. When asked how the facility would make sure other residents were safe, Staff C said if the assessment was done, the rubbing alcohol would be kept in a locked box so no other residents with dementia could get to it. Staff C said there were residents in the facility that wandered. When asked if Resident 59 had a self-assessment done for the rubbing alcohol, Staff K said the only self-assessment she could find was for Herb Lax (a bowel medication) in 2023. On 12/04/2025 at 10:04 AM, Staff C confirmed there was a bottle of alcohol at Resident 59's bedside. Staff C confirmed no lock box or self-administration assessment had been done and said this did not meet her expectations. When informed Resident 59 reported using the rubbing alcohol to treat their athlete's foot, Staff C said Resident 59 had dementia. Resident 17 Resident 17 was admitted to the facility on [DATE]. According to the Quarterly MDS, dated [DATE], Resident 17 was mildly cognitively impaired. On 12/01/2025 at 1:20 PM, Resident 17 was observed with a 32-ounce bottle of 91% isopropyl rubbing alcohol on their bedside table. Resident 17 said they used the rubbing alcohol around their urinary catheter tubing and would put a little of the alcohol under the tubing on their skin. Resident 17 said the facility staff was all for it too. Resident 17 said the rubbing alcohol was good for little things so that they did not turn into infection. On 12/04/2025 at 9:50 AM, Staff C, ADON, was told of the observation of rubbing alcohol at the bedside of Resident 17 and their report that they self-administer the alcohol. When asked if Resident 17 had a self-administration assessment, Staff C looked in the electronic health record and said they did not see one. On 12/04/2025 at 10:04 AM, Staff C confirmed Resident 17 did not have a lock box for the rubbing alcohol. Reference WAC 388-97-1060(3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with urinary catheters (a flexible tube inserted into the bladder to drain urine) received appropriate care and monitoring for pre and post hospitalization, including following the hospital's discharge plan of care, to prevent or treat urinary tract infections (UTIs) for 2 of 4 residents (Resident 6 & 52) reviewed for urinary catheters and hospitalization. These failures placed residents at risk for hospitalization, urinary tract infections, urethral erosion and a decreased quality of life.Findings included.Resident 6 Resident 6 was admitted to the facility on [DATE], with a diagnosis of urinary retention (an inability to completely empty the bladder). The admission Minimum Data Set (MDS, an assessment tool), dated 10/16/2025, documented Resident 6 was cognitively intact, relied on staff for most cares, and had a urinary catheter. On 12/01/2025 at 12:44 PM, Resident 6 was observed seated in their wheelchair. Resident 6's urinary catheter bag (collection device for urine, at the end of the tubing) was seen dragging on the floor underneath their wheelchair. No dignity cover was seen over their catheter bag. On 12/03/2025 at 8:25 AM, Resident 6 was seated in their wheelchair, wheeling themself up and down the hallway. Resident 6's catheter bag and tubing were hanging underneath their wheelchair, dragging on floor. No dignity cover was seen over their catheter bag. On 12/03/2025 at 8:54 AM, Resident 6 was seated in their wheelchair and wheeled themself out to the front lobby. Residents 6's catheter bag and tubing were dragging on the floor, behind the front left wheelchair wheel. Resident 6 was able to touch the catheter bag with their left heel as they moved around the facility. On 12/03/2025 at 8:58 AM, Staff Y, Scheduling Coordinator, stopped Resident 6 at the reception desk, readjusted the catheter bag and tubing, to not touch the ground. As soon as Resident 6 started to wheel themselves down the hall, the catheter bag and tubing slid down the wheelchair and were dragging on the floor again, behind left front wheelchair wheel. On 12/03/2025 at 9:03 AM, Staff T, Registered Nurse (RN), was asked to walk past and observe Resident 6's catheter bag and tubing. Staff T confirmed Resident 6's catheter bag and tubing were dragging on the floor underneath the left front wheel. Staff T said they needed to find a way to secure the bag and tube because it kept falling. Staff T said the catheter bag and tubing should be off the ground and there should be a dignity cover bag over the catheter bag. On 12/04/2025 at 8:14 AM, Resident 6 was seated in their wheelchair, wheeling themself down the hallway. Resident 6's catheter bag was dragging underneath the wheelchair on the right side. Resident 6's right heel was touching the catheter bag. Resident 6's catheter care plan, revised 11/17/2025, documented the drainage bag was to remain covered, off the ground, below bladder level and ensure tubing was secured with a stabilizing device. Review of Resident 6's electronic health record (EHR) showed they had a urinalysis (UA, urine test for possible infection) obtained on 11/03/2025. Results written on the UA report stated, we don't treat (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her. It is most probably contamination. Resident 6's EHR showed they were sent to the hospital for chest pains and possible UTI from 11/04/2025 to 11/05/2025. The EHR had no follow-up documentation or discharge summary from Resident 6's hospitalization. On 12/03/2025 at 4:05 PM, an email requesting Resident 6's hospital records was sent to Staff A, Administrator and Staff B, Director of Nursing Services. Review of the provided hospitalization record for Resident 6, 11/05/2025, documented, HPI [history of present illness]/Reason for admission: Chronic urinary retentions with Foley catheter in place. By the time patient was evaluated by hospitalist she was feeling significantly better. However she had been noticing some sediment in her urine bag associated with lower abdominal discomfort and increased pain around catheter concerning for urinary trat infection. Hospital Discharge Dx [diagnosis]: Principle Problem: Urinary tract infection associated with indwelling urethral catheter. The Discharge summary, dated [DATE], showed the following recommended for Resident 6: -Follow up with Urology and Nephrology [bladder and urinary system specialist and kidney specialist] -Blood work: repeat a complete blood count (CBC, test to evaluate for infection and levels of blood components) and a comprehensive metabolic panel (test to measure substances in the body to provide a picture of overall health) -Urine test follow up. -Antibiotic Usage: 7days doxycycline (antibiotic), 100 mg tablet 2 times daily. A nursing care progress note, dated 11/06/2025 at 2:59 AM, documented Resident 6 returned from the hospital with a diagnosis of UTI, but they were unable to obtain the antibiotic until the provider completed a visit with Resident 6. A nursing care progress note, dated 11/06/2025 at 2:19 PM, documented the facility provider reviewed the culture and sensitivity report, Resident 6 was diagnosed with a UTI, and no new orders were prescribed. Resident 6's EHR showed no documentation that the antibiotic from the hospital was received/given and no new orders related to a UTI diagnosis. On 12/05/2025 at 9:45 AM, Staff T, RN, said when a resident was suspected of having a UTI, they would have to have a least three symptoms to meet criteria, staff would send notification to the provider, who would send back an order to complete a UA. When asked about retesting, Staff T, said they would retest if the UA was contaminated or had any discrepancies. Staff T was asked to review Resident 6's hospital discharge summary but was unbale to locate the discharge summary. Staff T was asked to review Resident 6's 11/03/2025 UA results. Staff T confirmed the handwritten note at bottom of page documented, We don't (something)., This (something) likely contamination. When asked if there should have been follow up to this UA, Staff T said most definitely and confirmed there (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no signature or date that the provider had reviewed the UA results. Staff T then found Resident 6's discharge summary, uploaded on 12/03/2025. Staff T reviewed the discharge summary. When asked what were the hospital's follow up recommendations, Staff T said a follow up with urology, nephrology, a CBC, UA, antibiotic sent with resident. Staff T reviewed the EHR and confirmed no antibiotics were received from the hospital, no new antibiotics were ordered from the provider, there was no documented follow up with urology or nephrology, and no new CBC and/or UA had been ordered. Staff T said there should have been follow-up on all of them. When asked what the risks were of starting and stopping antibiotics, Staff T stated, we create superbugs, antibiotic resistant organisms. On 12/05/2025 at 11:15 AM, Staff K, Residential Care Manager (RCM), said when a resident was suspected of having a UTI, they use the McGeer's criteria for diagnosing UTIs. If the resident had signs and symptoms of a UTI, they would notify the provider and ask for a UA. Staff K said symptoms of a UTI could include dysuria [painful urination], burning, frequency and pain. When asked about retesting, Staff K said they typically do not retest, unless it was contaminated or the symptoms returned. Staff K said they never saw discharge summary for Resident 6. Staff K was asked to review Resident 6's 11/03/2025 UA. Staff K confirmed the handwritten note stated, We don't treat her, this is most likely possible contained. Staff K said Staff C, Assistant Director of Nursing Services/Registered Nurse, was responsible for reviewing and following up on UA results. When asked if a retest should have been completed, based on the handwritten statement, Staff K stated, I would suspect a retest would have been completed. Staff K was asked to pull up Resident 6's discharge summary. Staff K reviewed the discharge summary saying, the hospital collected a UA, but Resident 6 went to the hospital for chest pains. Staff K confirmed the discharge summary recommendation included a follow-up with Urology and Nephrology, to complete a CBC and UA and complete antibiotic given at hospital. Staff confirmed there had been no CBC or UA completed and no orders for antibiotics. When asked what the risks were of starting and stopping antibiotics, Staff K said we develop antibiotic resistance. When asked about providing dignity to residents with catheter bag, Staff K said the catheter bag should be covered with a dignity bag, the catheter and tubing should not be dragging on the ground, and it should be secure. When observations of Resident 6's catheter bag and tubing were reported. Staff K said that was not acceptable. On 12/08/2025 at 10:46 AM, Staff B, Director of Nursing Services, said when a resident was suspected of having a UTI, staff would complete an assessment, using McGeer's criteria, notify the MD, obtain an order for a UA and then wait the MD to review the results for further orders, if needed. When asked about retesting, Staff B said a UA should be retested if it was contaminated. Staff B reviewed the 11/03/2025 UA results and said the results indicated possible contamination. When asked about Resident 6's hospitalization, Staff B said the reason for Resident 6's admit was UTI with possible sepsis and follow-up recommendation included urology and nephrology referrals, repeat CBC and UA and antibiotics to be continued. Staff B reviewed the EHR and said no antibiotics were received from the hospital or ordered by the MD and should have been. Staff B said the CBC and UA were not completed and should have been. When asked about the concerns with starting and stopping antibiotics, Staff B said with not having continued the antibiotics it could have led to sepsis. When asked how staff were expected to provide respect and dignity to residents with catheter bags, Staff B said by providing a cover bag, and the tubing and catheter bag not dragging on the ground. Observation of Resident 6's catheter bag and tubing dragging on the ground for multiple days were reported, Staff B said she had seen staff fixing the catheter bag. It was explained that one staff member attempted to fix the catheter bag and tubing, only once in two days, but there were multiple other incidents where the catheter bag and tubing were dragging on the floor. Staff B said the catheter bag and tubing should not have been dragged on the floor. (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 52 Resident 52 was admitted to the facility on [DATE], and had diagnoses of benign prostatic hyperplasia (prostate gland enlarges, which can cause difficulty urinating and a weak stream), retention (bladder holds on to) of urine, calculus of ureter (hard mineral deposits in the urinary tract, also known as kidney stones), obstructive and reflux uropathy (blockage in the urinary system that prevents normal urine flow), and dementia. Review of the Quarterly MDS assessment, dated 10/02/2025, showed Resident 52 was severely cognitively impaired, impaired with decision making, and dependent on staff for cares. Review of Resident 52's EHR, showed they last had a suprapubic catheter (an incision that was medically made through the abdomen which allowed a thin tube to drain the bladder) on 10/25/2025, and have had a penile indwelling catheter (also called a Foley, a thin tube that goes through the penis tip and into the bladder) since. Review of Resident 52's progress notes from 10/25/2025 to 12/04/2025, showed nursing had documented a potential introduction of organisms to the catheter, and following the episode had suspected potential infection multiple times without subsequent alert documentation or temperatures taken. On 11/03/2025, nursing documented the penile Foley catheter was found to be protruding through the suprapubic catheter site, and the action taken was to retract the catheter and reinflate the balloon. No documentation was found that the Foley catheter was changed/replaced at that time, or that resident was put on an alert for possible infection following the event. On 11/06/2025, nursing documented Resident 52's urine was smelling more foul than normal, and Resident 52 reported they were having pain and burning sensation with urination. Resident 52 was placed on an alert, and a UA sample was taken. Notes from 11/07/2025 to 11/08/2025, showed nursing had not completed alert documentation related to this. Further review of the nursing progress notes, showed on 11/11/2025, nursing noted blood in Resident 52's urine. On 11/16/2025, nursing documented Resident 52's urine was thick with mucous, was extremely foul smelling, and they requested a UA be done. Resident 52 was not placed on an alert. On 11/18/2025, after having a discussion with the provider, Resident 52 was placed on alert. No alert notes were found from 11/19/2025 to 11/21/2025 (4 days). Further review of the nursing progress notes, showed on 11/22/2025, Resident 52 was noted to have very bloody urine in the urine drainage bag. On 11/23/2025, blood and mucous were noted in Resident 52's urine. On 11/24/2025 blood was again noted in Resident 52's penile Foley catheter. On 11/25/2025, blood and mucous were noted in Resident 52's urine. On 12/04/2025, blood was noted in Resident 52's urine, and a note was placed they would obtain another UA. Review of Resident 52's temperatures, showed they only had one temperature taken in October, 10/18/2025, and one in November, 11/15/2025. In December, they had a temperature taken on 12/04/2025 and 12/05/2025. Review of Resident 52's laboratory results, showed one UA was completed in November, resulting on 11/10/2025. Resident 52 had 3+ leukocytes (indicated a significant presence of white blood cells, which may suggest an infection or inflammation in the urinary track) and positive nitrites (indicated a bacterial infection in the urinary tract), but only a few bacteria found. The provider had written, follow up with the culture and sensitivity. No documentation in the EHR was found of a culture and sensitivity having been completed, nor documentation in Resident 52's medical record of why it was (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not completed and provider notification/response. The next UA that was completed, resulted on 12/08/2025. It showed 3+ leukocytes, positive nitrites, and many bacteria. This time a culture and sensitivity was completed, with two organisms found: Providencia rettgeri (a gram negative bacteria commonly found in both water and land environments) and Morganella morganii ssp morganii (a gram negative bacteria commonly found in the intestinal tracts of humans). Review of Resident 52's Treatment Administration Record for their blood thinner side effect monitor, from 11/01/2025- 12/02/2025, showed blood-tinged or frank blood in the urine was a potential side effect and staff had documented no complications noted. During an observation on 12/01/2025 at 11:17 AM, Resident 52's penile Foley catheter was noted to have blood-tinged sediment in the tubing. During an observation and interview on 12/03/2025 at 11:59 AM, Resident 52's penile Foley tubing was noted to have dark red drainage in 75% of tubing that was visualized. At 12:02 AM, Staff F, Registered Nurse (RN), said since Resident 52 had switched to the penile Foley (no longer had the suprapubic), the output had been mucous like and bloody since. Staff F lifted the tubing in attempted to drain it, the drainage was slow moving from the tubing into the drainage bag. The drainage bag was visualized with similar thick dark blood drainage. During an interview on 12/03/2025 at 1:51 PM, Staff E, Resident Care Manager/RN, was asked about Resident 52 being assessed for UTI symptoms. Staff E said staff asked Resident 52 often about symptoms, they should ask every day. When asked how many times in the past two weeks this was documented on, Staff E said they were only able to find 3-4 times it was specifically stated. During a follow up interview at 3:42 PM, Staff E said the facility did not have a way to accurately monitor and record hematuria (blood in the urine). During an interview on 12/05/2025 at 12:41 PM, Staff D, Medical Doctor, when asked about the event on 11/03/2025 of Resident 52's penile Foley catheter protruding out of their previous suprapubic catheter site, said staff needed to have replaced the penile Foley catheter, and confirmed there was a concern with this being an infection control issue. Staff D said they did not place residents on antibiotics for this kind of situation, they waited to see if residents would have any symptoms. When asked about symptoms documented on 11/06/2025 (three days later) and the UA form saying waiting for culture, Staff D said they did not remember the situation entirely but did remember the culture was contaminated each time they tried to do a culture. When asked if they expected staff to take a temperature when Resident 52 reported dysuria (pain or discomfort with urinating), Staff D said yes of course. During an interview on 12/08/2025 at 12:08 PM, Staff C, Assistant Director of Nursing/RN, said their expectation for documentation when a resident was having blood in their urine was for everyone on each shift to document something about it. When asked if a resident on a blood thinner who was having blood in their urine, if that should be recorded on their side effect monitor, said yes it should. When asked how the facility was tracking blood in Resident 52's urine, Staff C said apparently, they were not tracking it as well as they should have been. When asked about alert documentation following the alert started on 11/18/2025, Staff C confirmed this was not done from 11/19/2025 to 11/21/2025, said they expected documentation should be occurring every shift, and from what they could see this was hit on miss on if it was done. Staff C was unable to find documentation of what happened to the November urine culture or what was discussed with the provider when the cultures were unsuccessfully completed, after the 11/10/2025 result. Staff C said their expectation for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505327	A. Building B. Wing	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse when they found Resident 52's penile Foley catheter protruding out of the suprapubic site, was for the whole system to have been changed out. Staff C confirmed there was only one temperature taken in November, and this did not meet expectations. Reference F628, F880, F842 Reference WAC 388-97-1060 (3)(c)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with professional standards, by not providing urostomy (urinary diversion, which is a surgical procedure to create an opening (stoma) on the abdomen to allow urine to exit the body when the bladder is not functioning or has been removed. The urine is then collected in a pouch attached to the stoma) supplies for 1 of 1 sample resident (Resident 10) reviewed for urostomy care. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Resident 10 was admitted to the facility on [DATE] with a diagnosis of acute pancreatitis (inflammation of the pancreas). The admission Minimum Data Set (an assessment tool), dated 10/07/2025, documented the resident was cognitively intact and had a urostomy.Resident 10's care plan, dated 10/01/2025, said The resident has Urostomy r/t [related to] Traumatic Injury. Interventions included Resident has Urostomy per MD order, Urinary drain bag changing and care, and Urostomy Care.Resident 10's orders, dated 10/01/2025, showed:- Urostomy: medical necessity for use history: traumatic injury.- Urostomy care every shift- Urostomy change bag as needed for leakage/drainage.- Change urostomy every week and as needed for malfunction.A nursing progress note, dated 12/02/2024 at 5:15 AM, created by Staff AA, Registered Nurse(RN), documented that she was unable to change the urostomy bag due to supplies being on order. Resident 10's family were bringing in supplies today. Staff AA documented they were using a brief and/or dressing to cover the stoma, with instructions to change frequently until we were able to obtain supplies for a new urostomy appliance.A nursing progress note, dated 12/02/2025 at 6:58 AM, created by Staff AA, documented a dressing was placed over stoma and Resident 10 was provided with additional dressings to have available and Resident 10 was instructed to turn on their call light when they noticed the current dressing was wet or soiled. A progress note, dated 12/02/2025 at 11:33 AM, created by Staff X, Social Services Director, documented Resident 10's family member was upset because the facility did not have supplies for Resident 10's ostomy. Staff X said the facility could provide the supplies if the family no longer wanted to bring in supplies from home.On 12/02/2025 at 11:42 AM, Resident 10 was observed with a dressing covering the stoma, and without the urostomy appliance (a pouching system worn over an abdominal opening (stoma) to collect urine). Resident 10 said the facility did not have any replacement bags. Resident 10's family member said the facility told them they, the family, were supposed to provide the urostomy appliance, and they said they could not get them from their insurance because Resident 10 was in the facility.On 12/04/2025 at 12:04 PM, Staff Z, Licensed Practical Nurse, said Resident 10 liked to use their own urostomy supplies and when family did not bring them in, she said they would use the house supplies. Staff Z said sometimes Resident 10 would refuse the house (facility) supplies and other times Resident 10 would allow use of house supplies. On 12/04/2025 at 2:13 PM, Staff C, Assistant Director of Nursing/ RN, said she called several area pharmacies that morning and tried to locate urostomy supplies for Resident 10, because they did not have any in central supply. Staff C said they had placed a dressing on the site because there was nothing else to put on it. Staff C said, Resident 10's family member were supposed to bring in supplies that morning. On 12/08/2025 at 12:43 PM, Staff B, Director of Nursing Services, said Resident 10 preferred using his own supplies from home and his family would bring them in. Staff B was asked what the process was when the family did not provide equipment for Resident 10's urostomy, and she said she could not say. Staff B said they were trying to find supplies and the staff were putting a dressing on it in the meantime. Reference WAC 388-97-1060 (3)(j)(iii)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete annual performance reviews as required for 5 of 5 Certified Nursing Assistants (CNA) (Staff EE, FF, GG, HH & II) who were reviewed. Failure to complete annual performance evaluations did not ensure staff were adequately trained, and placed residents at risk for unmet care needs.Findings included . 1) Staff GG, CNA, was hired on 01/30/1996. Review of Staff GG's employee records showed the most recent annual performance review was signed on 02/22/2024 for the period of 01/30/2023 - 01/30/2024. No annual performance review was completed in the previous 22 months. 2) Staff HH, CNA, was hired on 08/11/2015. Review of Staff HH's employee records showed the most recent annual performance review was for the period of 08/01/2023 - 08/01/2024. No performance review was completed in the previous 16 months. 3) Staff II, CNA, was hired on 11/22/2021. Review of Staff II's employee records showed the most recent annual performance review was signed on 01/06/2024. No annual performance review was completed in the previous 23 months. 4) Staff FF, CNA, was hired on 11/06/2023. Review of Staff FFs employee records showed no annual performance review had been completed. 5) Staff EE, CNA, was hired on 09/29/2022. Review of Staff EE's employee records showed the most recent annual performance review was signed on 07/11/2024 for the period of 09/2022 - 09/2023. No performance review was completed in the previous 27 months.On 12/08/2025 at 12:14 PM, Staff JJ, Pay Benefits Coordinator, said they could not find performance reviews for the five named employees that were conducted in the previous year. Reference WAC 388-97-1680 (1), (2) (a-c)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. .Based on observation and interview, the facility failed to maintain locked medication carts for 1 of 5 medication storage carts (Pine Ave Nurses station) when reviewed for medication storage. This failure placed the residents at risk for missing medications, medication discrepancies and impaired quality of life.Findings included.On 12/09/2025 at 10:57 AM, observation of unlocked medication cart parked at the Pine Ave Nurses station. No staff were present or around mediation cart. On 12/09/2025 at 11:11 AM, Staff R, Infection Preventionist, walked past the medication cart with a visitor. After escorting the visitor to the exit, Staff R was stopped and asked to open the medication cart. Staff R opened the medication cart without having to use keys. When asked what the expectation was when staff walked away from a medication cart, Staff R said the cart should have been locked. Staff R said the medication cart should have been locked. On 12/09/2025 at 11:24 AM, Staff C, Assistant Director of Nursing Services, was provided with details of unlocked mediation cart observation. When asked what the expectation was when staff walked away from a medication cart, Staff C said the cart should have been locked. Staff C said the medication should have been locked.Reference WAC 388-97 -1300 (2), 2340.

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an Antibiotic Stewardship Program with monitoring, documentation, reevaluation and/or education for three of three months (August 2025, September 2025, and October 2025) reviewed, and for 1 of 1 resident reviewed (Resident 8) for prophylactic (usage to prevent disease) antibiotic usage. This failure placed residents at risk for unnecessary antibiotics, an increased risk of infections and a decreased quality of life.Findings included.According to the facility's Antibiotic Stewardship Policy, revised December 2016, the purpose of the Antibiotic Stewardship Program was to monitor the use of antibiotics for the facility's residents. The policy documented that orientation, training, and education of staff would emphasize the importance of antibiotic stewardship and would include how inappropriate use of antibiotics affects individual residents and the overall community.Review of the facility provided document Minimum Criteria for Initiating Antibiotics for a Urinary Tract Infection [UTI], undated, showed the following: acute dysuria alone (painful or difficult urination) ORFever of 100 degrees or two repeated temperatures of 99 degrees AND at least one of the following: New or Worsening: Urgency, OR Frequency, OR Suprapubic pain (discomfort in the lower abdomen, above the pubic bone), OR Gross hematuria (blood in the urine), OR Costovertebral (pain in the flank area of the back) angle tenderness, OR Urinary incontinence OR 3. No fever, then two or more of the following: Urgency, OR frequency, OR suprapubic pain, OR Gross hematuria, OR Urinary incontinence.August 2025 Antibiotic Stewardship Program:Review of both the August 2025 Antibiotic Line Listing (tracking tool to monitor and review all antibiotic use) and the Infection by Unit report, showed 16 indicated infections in August. Of the 16 infections, seven did not have signs and symptoms listed on the antibiotic line list for the infection.Review of the Antibiotic Stewardship Meeting Minutes, dated 08/21/2025, showed 12 of the 16 indicated infections listed on the line list were not reviewed during the meeting.The August 2025 Antibiotic Line Listing, showed Resident 92 and Resident 32 were listed, each with a UTI (urinary tract infection), but both had no signs or symptoms listed. Resident 32 was not listed in the Antibiotic Stewardship Meeting Minutes.September 2025 Antibiotic Stewardship Program:Review of both the September 2025 Antibiotic Line Listing and the Infection by Unit report, showed 16 indicated infections in September. Of the 16 indicated infections, four did not list signs and symptoms associated with the infection. Review of the Antibiotic Stewardship Meeting Minutes, dated 09/11/2025, showed 11 of the 16 indicated infections listed on the line listing were not reviewed in the meeting.October 2025 Antibiotic Stewardship Program:Review of both the October 2025 Antibiotic Line Listing and the Infection by Unit report showed there were 32 indicated infections in October. Of the 32 indicated infections, 12 did not list signs and symptoms associated with the infection. The antibiotic line listing documented there were 13 UTIs that month in the facility, with no associated documentation of education provided to the staff.Review of the Antibiotic Stewardship Meeting Minutes, dated 10/23/2025, showed 21 of the 32 indicated infections listed on the line listing were not reviewed in the meeting.The October 2025 Antibiotic Line Listing, showed Resident 40 had two entries on the line listing for UTI. The first listed the infection onset date as 09/26/2025, with signs and symptoms listed as dysuria. The second entry listed the infection onset date as 10/06/2025, with no signs or symptoms listed.Further review of the list, showed Resident 93 was listed as having UTI, but was listed as asymptomatic (no symptoms.) Review of a provider note, dated 09/26/2025, showed Resident 93's nursing team reported Resident 93 had cloudy and malodorant (bad smelling) urine. Residents 40 and 93 were not listed in the Antibiotic Stewardship Meeting Minutes. On 12/04/2025 at 1:31 PM, Staff R, Infection Preventionist /Registered Nurse (IP/RN), when asked about Resident 92 having no signs or symptoms of infection listed on the August 2025 Antibiotic Line Listing, Staff R said there was a progress note in the electronic health record (EHR) from the doctor, documenting a urinalysis was sent due to increased confusion. When asked how Staff R was tracking (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs and symptoms to monitor that infections had resolved or how they were surveilling other residents for similar symptoms to monitor for possible spread of infection, Staff R said she had been on vacation that month (indicated August), and normally she would put symptoms on the Antibiotic Line Listing. Staff R said their process was to look for a progress note with symptoms and transfer the symptoms onto the Antibiotic Line Listing. During this same interview, Staff R said, regarding Resident 32 on the August Antibiotic Line Listing for UTI with no signs or symptoms listed, that she usually put a progress note or doctors note that had the symptoms listed. Staff R said if she closed the case and forgot to put something in, the computer system would not let her go back and enter the information. Staff R said that a doctor's note documented Resident 32 had been hallucinating, which the note indicated was likely the result of medication, and there was nothing regarding signs or symptoms of UTI. When asked if there should have been documentation about symptoms, Staff R said yes, and the doctor should have put a note in that they were treating empirically (starting medical treatment based on experience and an educated guess before a definitive diagnosis is confirmed). Staff R said this had happened in between antibiotic meetings.During this same interview, Staff R said, regarding Resident 40 not having signs and symptoms listed on the 10/06/2025 entry on the Antibiotic Line Listing, that there was a 09/26/2025 provider note that documented Resident 40 complained of burning with urination. When asked if residents report of burning with urination should be put on the line listing, Staff R said yes, but she could not go back in the system once the case was closed. Regarding Resident 93, being listed as asymptomatic (no symptoms) on the October 2025 line list, Staff R said she put asymptomatic because Resident 93's symptoms did not meet criteria for antibiotics, her computer system would not let her put symptoms that did not meet criteria on the line list. When asked if she had a conversation with the provider that Resident 93 did not meet criteria for antibiotics, Staff R said if the doctor put in their notes that the resident was asymptomatic but was choosing to treat anyway, then she would not write a note that criteria was reviewed.On 12/09/2025 at 11:13 AM, Staff R, when asked how she was keeping track of antibiotic criteria screenings, Staff R said she knew what was required to meet criteria (indicating there was no documentation of criteria screening). Regarding Resident 93, when asked if there was any documentation that they had discussed with the provider that they did not meet criteria for antibiotics, Staff R said no, she did not see any. Regarding Resident 32 when asked if there was any documentation that criteria for antibiotics had been discussed, Staff R said every note she reviewed showed no signs or symptoms for Resident 32 and someone should have put a note in, Staff R said she had been on vacation during that time. Staff R said Resident 32's urine test had come back positive whether there were signs or symptoms or not and the treatment had started after the urine culture came back. Staff R, when asked what steps were taken when 13 UTIs were identified in October, said she believed she had done education with the Certified Nursing Assistants in the first part of November on peri care (essential cleaning of the genital and anal areas to maintain hygiene and prevent infections). Staff R said she was unable to locate documentation of the education. Staff R said she would look for the documentation and provide it. No further documentation was received.Prophylactic Antibiotic Usage: Resident 8 was admitted to the facility on [DATE]. Record review showed that Resident 8 had an order, dated 10/21/2022, for azithromycin (antibiotic), one time a day every Monday, Wednesday, and Friday for prophylactic related to chronic obstructive pulmonary disease (COPD, a lung disease).On 12/04/2025 at 1:31 PM, Staff R, IP/RN, said she did antibiotic time-outs (a formal, structured reassessment of a patient's antibiotic therapy, aimed to optimize treatment, reduce unnecessary use, and combat resistance) for residents on long term antibiotics. Staff R said antibiotic time outs were put in the EHR under evaluations.Record review for Resident 8, showed no antibiotic time outs were present under evaluations.Review of August, September, and October 2025 Antibiotic Meeting Minutes and Antibiotic Line Listing, showed Resident 8 was not on the list and not reviewed. On 12/09/2025 at 9:05 AM, Staff R, when asked how many residents in the facility were on prophylactic antibiotics, Staff R said very few. Staff R listed several residents but did not list Resident 8. When asked where (continued on next page)

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she kept track of the residents on prophylactic antibiotics, Staff R said she knew all of them and they were reviewed for antibiotics once a year in a progress note, but the facility did not have anyone on prophylactic antibiotics for longer than a few months. Staff R said if residents were on antibiotics for longer than a year then they would need to relook at that with the provider. Staff R said any resident on antibiotics goes on the line listing. When asked if residents on prophylactic antibiotics go on the line listing, Staff R said no, it would be on the line listing when they first started on antibiotics, but once you checked off that they did not meet criteria, then it would not stay on the line listing. When asked what the indication was for Resident 8's prophylactic antibiotic use, Staff R said it was due to their COPD and a pulmonologist decided what would work for Resident 8. When asked how she knew to review a resident on prophylactic antibiotics, Staff R said she knew who they were. When it was pointed out that she had not previously mentioned Resident 8 being on prophylactic antibiotics, Staff R said, I need to write them down. When asked how Resident 8 was being reassessed for the continued need of antibiotics, Staff R said a review was not done because Resident 8 goes to pulmonology and they review it and then the facility provider would review the pulmonology notes. When asked if there were any pulmonology notes in Resident 8's record for the facility provider to review, Staff R looked and said she did not see anything. When asked if Resident 8 should have had an antibiotic time out, Staff R said yes, they should probably discuss it again. Reference F880No Associated WAC

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	12/09/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to develop, implement and maintain an in-service training program that ensured nursing assistants (NA) completed the required 12 hours of annual Inservice training for 1 of 5 NAs (Staff EE) reviewed for annual training hours. The failure to ensure NAs completed 12 hours of annual training as required, placed residents at risk of receiving inadequate care.Findings included . Review of Staff EE's, NA, employee file showed they were hired on 09/29/2022. Staff EE's in-service training records for the period of 09/29/2024 -09/29/2025 showed Staff EE completed 4.25 training hours, 7.75 hours short of the 12 hours required per year to ensure continuing competence. On 12/08/2025 at 12:37 PM, When asked if Staff EE met the requirement for 12 hours of training annually Staff R, Infection Preventionist, stated, No, he didn't complete the training. Reference WAC 388-97-1680(2)(a-c)