STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 34703 Based on interview and record review it was determined the facility failed to treat residents with respect for 1 of 1 sampled resident (#63) reviewed for abuse and call lights. This placed residents at risk for lack of dignified treatment. Findings include: Resident 63 admitted to the facility in 2023 with diagnoses including kidney failure and difficulty walking. A 11/19/23 Admission MDS indicated Resident 63 was cognitively intact. A 12/15/23 FRI indicated staff yelled at Resident 63, and refused to assist her/him with cares. The FRI included the resident had significant care needs and depended on staff for assistance. On 4/18/24 at 11:23 AM Witness 5 (Complainant) indicated Resident 63 stated staff yelled at her/him all the time. An Incident report dated 12/15/23 included the following: -Staff 7 (CNA) and Staff 48 (CNA) were bathing Resident 63's roommate. Resident 63 asked Staff 7 if she/he could have a shower later in the day. Staff 7 stated he would try to do a shower for her/him in the afternoon. Resident 63 stated later she/he asked Staff 48 for a shower and Staff 48 stated you're going to have to wait, I'm here to take care of your roommate. You are not even elderly, you need to get your fat ass up, I don't even know why you are here. Resident 63 stated Staff 49 called her/him a bitch and she/he spoke with a nurse about it, but the nurse stated suck it up. On 12/15/23 Resident 63 left the facility for a dialysis appointment. When the resident returned from her/his appointment she/he stated to Staff 26 (LPN) she/he was going home and wanted her/his medications. Staff 26 explained if the resident left she/he would leave AMA (against medical advice) because there was not a physician order for discharge. Resident 63 stated Staff 26 told her/him I'm not giving you shit. Resident 63 responded she/he was concerned about dying if she/he did not have her/his medications and Staff 26 stated Go home and die. Resident 63 stated she/he left the facility. Staff 26 stated she returned with AMA paperwork but the resident left the facility. (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
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Final Investigation dated 12/19/23 indicated management was notified of the 12/15/23 incident and staff involved were placed on suspension. Staff 10 (LPN Unit Manager) indicated the resident left AMA due to being yelled at by staff. On 4/18/24 at 8:09 AM Staff 26 stated she remembered the resident but did not remember her/him being yelled at by staff. On 4/18/24 at 8:05 AM Staff 49 (CNA) stated she did not yell at Resident 63.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43690 Based on interview and record review it was determined the facility failed to ensure grievances were resolved or resolutions sustained for 2 of 3 sampled residents (#s 7 and 29) reviewed for grievances and care planning. This placed residents at risk for unresolved concerns. Findings include: The facility's Grievance Policy dated 5/2000 stated: It is the policy of this facility to ensure that all residents and their family members are afforded the opportunity to express their concerns and suggest changes in facility policy formally, in writing if they desire without the fear of restraint, interference, coercion, discrimination or reprisal. Additionally, the nursing facility will listen to and act promplty upon grievances and recommendations received from resident, family and advocacy groups. 1. Resident 7 admitted to the facility in 10/2017 with diagnoses including type 2 diabetes and major depressive disorder. On 10/12/23 a public complaint was received which indicated Resident 7 expressed concerns about nursing staff throwing her/his food away and the facility administration refusing to follow up on a grievance that was submitted. On 4/16/24 at 12:11 PM Staff 14 (Social Services Director) stated if a resident reported a concern a grievance was initiatied within five days. Staff 14 stated she did not have a paper grievance for Resident 7 regarding staff throwing food away without the resident's permission, and Resident 7 submitted grievances often via emails to Staff 1 (Administrator). On 4/17/24 at 11:00 AM Staff 1 confirmed an email was sent to him from Resident 7 regarding her/his food being thrown away and a grievance was not started or completed related to Resident 7's concerns. 26991 2. Resident 29 admitted to the facility in 2024 with a diagnosis of dementia. A 1/25/24 Complaints/Grievances form revealed Witness 9 (Family Member) did not want Staff 43 (Night shift LPN) to work with Resident 29. The form indicated it would be difficult for the other nurse on the night shift to provide Resident 29 care if Staff 43 worked on the hall where Resident 29 resided. The form indicated a plan would be coordinated with Staff 2 (DNS) to ensure Resident 29 felt safe. A 1/27/24 Progress Note revealed Witness 9 requested Staff 43 not work with Resident 29. The note indicated the .nurse passed this message along. Resident 29's Progress Notes revealed Staff 43 documented the following: -1/27/24 Resident 29 walked in the hall with her/his walker without assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/8/24 Staff 43 was called to Resident 29's room due to the resident's fall. -2/23/24 Resident 29 was on alert for a non-injury fall -3/8/24 Resident 29 was on alert for a non-injury fall and she/he did not report pain. -3/23/24 Resident 29 did not have a bowel movement and denied abdominal pain. -3/29/24 Resident 29 did not have a bowel movement and denied abdominal pain -4/5/24 Resident 29 was administered milk of magnesia (laxative) On 4/15/24 at 4:55 PM Witness 9 stated she filled out a Grievance form and spoke to staff and informed them she did not want Staff 43 to work with Resident 29 but Staff 43 continued to care for the resident. On 4/17/24 at 7:37 AM Staff 43 stated Resident 29 had dementia and was more confused when she/he first admitted to the facility. At the end of 1/2024 Resident 29 alleged she pushed the resident which caused her/him to fall. Staff 43 stated she tried to communicate with Resident 29, it agitated the resident, and then the resident reported to Witness 9 she/he was upset with Staff 43. Staff 43 stated she was told not to provide care to Resident 29 and the other night nurse would provide care to Resident 29. Staff 43 stated at times she still provided care and administered medications to Resident 29. On 4/17/24 at 11:47 AM Staff 10 (LPN Unit Manager) stated Staff 43 was to only work with Resident 29 on an emergency basis, but acknowledged Staff 43 continued to administer medications and provide routine care which was documented in Resident 29's clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47001 Based on observation, interview, and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 1 sampled resident (#19) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 19 was admitted to the facility in 8/2020 with diagnoses including post laminectomy syndrome (a condition in which a person continues to feel pain after back surgery). An 8/22/23 MDS indicated Resident 19 was cognitively intact. A 9/9/23 Progress Note stated Resident 19 was subjected to physical aggression when she/he ignored Resident 1. Resident 1 yanked on Resident 19's hair. Both residents were separated, and Resident 19 was placed on alert charting. A review of a 9/9/23 care plan revealed Resident 1 had a resolved care plan for physical aggression toward another resident. A 9/13/23 Brief Interview for Mental Status (BIMS) Evaluation indicated Resident 1 was cognitively intact. On 4/18/24 at 8:05 AM Resident 1 stated, when asked about the 9/2023 incident with another resident, I do not remember the incident, but it sounds like something I would do. I'm sorry, but I have a temper. Random observations from 4/15/24 through 4/18/24 revealed Resident 19 was either outside or sat in the hall in front of her/his room. Resident 19 and Resident 1 were not observed interacting. On 4/18/24 at 7:56 AM Resident 19 stated in 9/2023 she/he was sitting in Resident 1's spot in the hallway and Resident 1 went up to her/him and said she/he was in her/his spot. Resident 19 ignored Resident 1. Resident 19 stated Resident 1 scooted forward and yelled I know you can hear me, and then Resident 1 pulled Resident 19's hair. Resident 19 stated staff separated them. Per Resident 19 she/he had no pain or injuries related to the incident. On 4/19/24 at 8:41 AM Staff 1 (Administrator) and Staff 2 (DNS) agreed Resident 1 pulled Resident 19's hair. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35855 Based on interview and record review it was determined the facility failed to ensure residents received medications as prescribed, were monitored for medication side effects and provide wound care as ordered for 4 of 14 sampled residents (#s 8, 52, 58 and 59) reviewed for dignity, medications, and pressure ulcers. This placed residents at risk for an ineffective medication regimen and worsening wounds. Findings include: 1. Resident 8 admitted to the facility in 2018 with diagnoses including depression and irregular heartbeat. A 2/22/24 revised care plan indicated the following: -Resident 8 was on anticoagulant therapy and was at risk for bleeding. Interventions included monitoring, documenting, and reporting to the physician any anticoagulant complications. -Resident 8 was on antidepressant medications to reduce sexual behaviors toward staff. Interventions included monitoring the side effects of antidepressant medication and its effectiveness. An 4/2024 MAR instructed staff to administer Zoloft (for treating depression) every morning for depressive disorder and apixaban (an anticoagulant) for an irregular heartbeat. No documentation was found in clinical records Resident 8's anticoagulant and antidepressant medication side effects were monitored and documented daily. On 4/19/24 at 8:01 AM Staff 1 (Administrator) and Staff 2 (DNS) stated Resident 8's monitoring for anticoagulant and antidepressant medication should be in the physician's orders and monitored daily. 26991 2. Resident 52 was admitted to the facility in 2024 with a diagnosis of pernicious anemia (inability of the body to absorb vitamin B12; left untreated it can cause irreversible damage to the nervous system). An 4/2024 MAR revealed Resident 52 was to be administered Folic Acid 400 micrograms QD for vitamin B12 deficiency. The MAR indicated the Folic Acid was not administered from 4/13/24 through 4/16/24. Progress Notes revealed the following: -4/13/24 Folic Acid-dose on order -4/14/24 Folic Acid-waiting on pharmacy to deliver -4/15/24 Folic Acid-waiting on pharmacy to dispense -4/16/24 Folic Acid-waiting on pharmacy to dispense (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 - Some	On 4/17/24 at 3:50 PM Staff 10 (LPN Unit Manager) stated Folic Acid 400 micrograms was an over-the-counter medication which was available in the central supply closet and should have been administered. 47001 3. Resident 58 admitted to the facility in 4/2023 with diagnoses including an infection in a right foot wound. On 9/11/23 a public complaint was received alleging Staff 15 (LPN) failed to complete wound care and falsified records by signing the wound care as complete. A review of Resident 58's 8/2023 TAR indicated her/his dressing change to the right great toe was not completed on 8/24/23 and 8/25/23. A review of Resident 58's 8/2023 Progress Notes revealed the dressing change to the right great toes was passed to the next shift on 8/24/23 and 8/25/23. No evidence was located which indicated Resident 58's dressing was changed on 8/24/23 and 8/25/23. A review of Resident 58's 8/2023 Progress notes revealed on 8/26/23 it was discovered Resident 58's right great toe dressing was not changed for two days, 8/24/23 and 8/25/23, and it was noted there were maggots found in the wound and the wound had increased redness around it. A review of Resident 58's 8/28/23 Wound Evaluation indicated there was increased redness around the wound. A review of Resident 58's 8/2023 MAR revealed on 8/30/23 Resident 58 began Keflex (an antibiotic) for her/his wound. An 8/30/24 Order Note stated new orders for an antibiotic were received due to redness around the wound. On 4/15/24 at 6:34 PM Witness 4 (Complainant) stated she was unable to complete Resident 58's wound care on 8/24/23 and 8/25/23 and she notified the next shift. Witness 4 stated Staff 15 did not complete Resident 58's wound care the days before 8/24/23 but signed it as completed. On 4/16/24 at 6:15 PM Witness 3 (Complainant) stated they were informed Resident 58's wound care was not completed for two days which resulted in maggots being in the wound and a wound infection. On 4/17/24 at 9:04 AM Staff 15 stated she changed Resident 58's dressing to her/his right great toe on 8/23/24 and there were no maggots present. Staff 15 denied signing wound care was completed when it was not. On 4/19/24 at 8:41 AM Staff 2 (DNS) stated she was aware maggots were found in Resident 58's right great toe wound on 8/26/24. Staff 2 acknowledged Resident 58's wound care was not completed on 8/24/23 and 8/25/23 and Resident 58 was started on antibiotics on 8/30/24 related to her/his right great toe wound. Staff 2 denied any increased redness around the wound and stated the wound did not worsen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 - Some	4. Resident 59 admitted to the facility in 7/2018 with diagnoses including a pressure injury (wound caused by pressure) to the sacrum region (the large, triangle-shaped bone in the lower spine that forms part of the pelvis). On 9/11/23 a public complaint was received alleging Staff 15 (LPN) failed to complete wound care and falsified records by signing the wound care was completed in 5/2023. A review of Resident 59's 5/2023 TAR revealed blank entries related to Resident 59's sacral wound care on 5/19/23 and 5/20/23. A review of Resident 59's 5/2023 Progress Notes revealed no evidence her/his sacral wound dressing was changed on 5/19/23 and 5/20/23. On 4/15/24 at 6:34 PM Witness 4 (Complainant) stated Staff 15 did not complete Resident 59's wound care in 5/2023, but Staff 15 signed on the TAR the wound care was completed. On 4/17/24 at 9:04 AM Staff 15 stated if she was unable to complete wound care she passed the wound care task to the next shift and informed management. Staff 15 denied signing wound care as completed when it was not. On 4/19/24 at 8:41 AM Staff 2 (DNS) stated she expected wound care to completed as ordered. Staff 2 acknowledged missed documentation on 5/19/23 and 5/20/23 for Resident 59's sacral wound care. Staff 2 and Staff 35 (Regional Nurse Consultant) acknowledged there was no indication wound care was completed for Resident 59's sacrum wound on 5/19/23 and 5/20/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35855 Based on observation, interview, and record review the facility failed to maintain healthy parameters of nutritional status for 3 of 6 residents (#s 32, 60 and 358) reviewed for nutrition. This placed residents at risk for weight loss. Findings include: 1. Resident 32 admitted to the facility in 2023 with diagnoses including stroke and dementia. An 10/3/23 MDS indicated Resident 32 had moderate cognitive impairment. No dietary issues were noted, and she/he was working with ST and currently weighed 142 pounds. An 10/2023 MAR instructed staff to administer a nutritional supplement three times a day with a discontinuation date of 10/30/23. An 10/28/23 Order Note indicated the supplement appeared to cause gastrointestinal upset. A Weight Summary Review revealed Resident 32 weighed 148 pounds on 9/29/23 and 135 pounds on 10/30/23. (Eight percent weight loss) No documentation was found in Resident 32's clinical record for a Nutritional Assessment after an eight percent weight loss. On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated there was usually a report which was created to review weight loss and Resident 32 should have been discussed by the Nutrition At Risk committee. 2. Resident 60 admitted to the facility in 2023 with diagnoses including severe protein-calorie malnutrition. A 11/13/23 hospital Clinical Nutrition Follow-up indicated Resident 60 had a weight loss greater than 7.5 percent in the last three months with severe body fat and muscle mass depletion. Recommendations and interventions included changing the food supplement to a strawberry bene-protein shake three times a day with meals. Weight on 1/13/23 was 123 pounds. The MAR from 11/18/23 through 11/30/23 instructed staff to obtain weight daily on the day shift before breakfast and notify the physician of any weight gain. On 11/18/23 Resident 60's weight was documented at 135 pounds, on 11/20/23 her/his weight was documented at 114. On 11/24/23, 11/25/23, and 11/29/23 it was documented as NA. From 11/26/23 through 11/28/23 and 11/30/23 there was no documentation weights were obtained. The 12/2023 MAR instructed staff to obtain weight daily on the day shift before breakfast and notify the physician of any weight gain. On 12/1/23 and 12/30/23 there was no documentation of Resident 60's weight was obtained. On 12/10/23, 12/14/23, and 12/15/23 the MAR referred the reader to order notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders signed on 12/30/23 instructed staff to provide a nutritonal supplement three times a day with a start date of 11/27/23 and to obtain weight daily on the day shift before breakfast with a start date of 11/18/23. Order Notes reviewed for 12/10/23, 12/14/23, and 12/15/23 did not have documentation of why Resident 60's weight was not obtained. On 4/19/24 at 7:51 AM Staff 1 (Administrator) and Staff 2 (DNS) stated when there was a large discrepancy in weight staff may be weighing in a wheelchair and not taking off the weight of the wheelchair. Staff 2 stated education may be needed for staff. 47001 3. Resident 358 admitted to the facility in 3/2024 with diagnoses including adult failure to thrive. A 3/26/24 Nutrition Assessment from the hospital stated Resident 358's eating was inadequate with an average intake of 33% of meals, and Resident 358's most recent weight on 2/29/24 was 220 lbs. An 4/4/24 Nutrition at Risk Assessment indicated Resident 358 was at risk for nutritional deficits due to malnutrition, inadequate intake and wounds. An 4/12/24 Nutrition at Risk Assessment indicated Resident 358's intake declined but she/he accepted 100% of the nutritional interventions. A review of Resident 358's 4/2024 MAR revealed 4/4/24 orders for a nutritional supplement, Med Pass 2.0, twice a day, and an 4/12/24 order to increase Med Pass 2.0 to three times a day. On 4/15/24 at 1:40 PM Resident 358 was observed sitting in bed with lunch on the tray table over her/his bed. Resident 358's food was untouched. The food tray was observed in front of Resident 358 until 2:58 PM. Resident 358's CNA Task charting indicated on 4/15/24 at 1:33 PM, Resident 358 consumed 0-25% of lunch. On 4/16/24 at 8:15 AM Resident 358 was observed sleeping in bed, her/his covered breakfast tray was located on the bedside table to the right side of the bed. Resident 358's CNA Task charting indicated she/he consumed 0-25% of breakfast. On 4/16/24 at 3:01 PM Staff 17 (LPN) stated Resident 358 often refused meals and alternate meals. An 4/16/24 review of Resident 358's weights revealed a weight of 142.8 lbs. on 3/29/24 and a weight of 191 lbs on 4/2/24. The 3/29/24 weight was struck out due to a technical error on 4/2/24. On 4/17/24 at 12:00 PM Resident 358's covered lunch tray was observed on the bedside table, Resident 358 was not observed in the room until 1:16 PM. At 1:16 PM staff set up Resident 358's lunch and left the room. Resident 358's CNA Task charting indicated at 1:00 PM Resident 358 consumed 0-25% of her/his lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 7:53 AM Resident 358 was observed sitting in a wheelchair eating breakfast. At 8:00 AM Staff 18 (CNA) asked Resident 358 if she/he was done eating. Resident 358 replied she/he could not eat now. CNA Task charting indicated Resident 358 consumed 0-25% of breakfast. On 4/18/24 at 12:06 PM Staff 19 (LPN Unit Manager) stated Resident 358 had a lot of missed weights due to refusals and Staff 19 confirmed the refusals were not documented. Staff 19 stated Resident 358's average meal intake was 33% and she/he should have been offered a replacement meal when she/he ate less than 50% of her/his meal. Staff 19 confirmed there was no documentation for meal replacements and Resident 358 lost weight since the last weight at the hospital prior to admission. On 4/18/24 at 12:38 PM Staff 20 (LPN) stated Resident 358 did not eat well during meals at times, but stated Resident 358 was offered snacks throughout the day. Staff 20 stated bedtime snacks were offered and charted in the CNA Tasks, but there was no documentation of the snacks offered throughout the day. Staff 20 confirmed bedtime snacks were charted once since Resident 358 admitted to the facility. An 4/19/24 review of CNA Task charting from 3/29/24 through 4/18/24 revealed Resident 358 consumed 76-100% of the meal eight times, consumed 51-75% of the meal 10 times, consumed 26-50% of the meal 20 times and consumed 0-25% of the meal 23 times. An 4/19/24 review of CNA Meal Replacement task charting revealed, from 3/29/24 through 4/18/24, Resident 358 consumed a meal replacement once on 4/16/24 at 1:00 PM and she/he consumed 50% of the meal replacement. An 4/19/24 review of Resident 358's weights revealed on 4/19/24 Resident 358 weighted 192 lbs. On 4/19/24 at 8:41 AM Staff 2 (DNS) confirmed Resident 358 had two weights since admission. Staff 35 (Regional Nurse Consultant) stated, per policy, weights should be obtained upon admission, then weekly for four weeks, and then monthly. Staff 2 stated if a resident consumed less than 50% of their meal she expected the alternate meal to be offered. Staff 2 confirmed Resident 358 ate on average less than 50% of meals with an alternate meal being offered once, and Resident 358 lost weight since admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure ongoing communication with the dialysis center for 1 of 2 sampled residents (#63) reviewed for rehab. This placed residents at risk for dialysis complications. Findings include: Resident 63 admitted to the facility in 2023 with diagnoses including chronic kidney disease and was dependent on dialysis (a procedure to remove waste products from the blood when the kidneys stop working). Resident 63's care plan for renal failure dialysis, revised on 11/15/23, indicated the resident's scheduled dialysis days were Monday, Wednesday, and Friday. A review of the resident's clinical record revealed a 11/21/23 document related to dialysis communication. There were no forms from 11/22/23 through 12/15/23 between the facility and the dialysis provider. On 4/19/23 at 8:39 AM Staff 10 (LPN Unit Manager) indicated there was one dialysis communication form in Resident 63's clinical record. Staff 10 stated the form was an important document and used for communication between the dialysis center and the facility. On 4/19/23 at 9:34 AM Staff 2 (DNS) stated she would look for the missing dialysis communication documentation. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35855 Based on observation, interview, and record review it was determined the facility failed to have adequate staff available to timely meet the needs of residents for 3 of 18 sampled residents (#s 32, 60 and 160) and for 2 of 3 wings (Wings 1 and 2). This placed residents at risk for unmet needs. Findings include: 1. A 2/7/24 Quality Assurance Resident Council note indicated call light wait times were too long. The 2/12/24 Response Form indicated the facility followed the state minimum CNA staffing requirements. A 3/6/24 Resident Council Department Response Form indicated the residents felt they needed more nurses and there were not enough which affected their care. The facility's response was they staffed to meet the state minimum staffing requirements. An 4/10/24 Bi-Monthly Resident Counsel Questions form revealed the questions if residents felt staff answered call lights within a 10-minute time frame, and if the resident counsel felt the facility was staffed well enough to meet the needs of the residents, to which the answer to both was documented as no. An 4/10/24 Resident Council Department Response Form indicated the facility needed more CNAs on the evening shift because staff was working with residents who were sundowning (a neurological phenomenon associated with increased confusion and restlessness in people with delirium or dementia). The facility response was the facility staffed to meet or exceed the state minimum staffing requirements on all three shifts. On 4/15/24 interviews were conducted revealing the following: -11:28 AM Resident 1 stated she/he had to activate the call light long before she/he had to urinate as after 2:00 PM call light wait times were 10 minutes to an hour. Resident 1 stated she/he fell because she/he took herself/himself self to the bathroom. One night no CNAs ever came after activating the call light. -11:51 AM Resident 44 stated she/he was a dissatisfied consumer as she/he had chronic bowel issues, and she/he would be on the bedpan after activating the call light for up to 30 to 45 minutes. At times staff gathered and just gossiped and did not answer call lights. -1:21 PM Resident 31 stated she/he had to wait up to 30 minutes for her/his call light to be answered and stated the facility needed more staff. -1:26 PM Resident 52 stated the call light wait time was approximately one to one and a half hours for a response on all shifts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1:35 PM Resident 37 stated it took an hour and a half to get assistance and on 4/15/24 she/he had to wait 40 minutes. At times staff came in to the room, turned off the call light, and then did not come back. Resident 37 stated at times she/he was in pain, and she/he had to wait an hour. Resident 37 stated it depended on who was working and not the time of day. -1:36 PM Resident 36 stated the facility was always short of staff. In the middle of the night she/he heard hear her/his roommate in pain and activated her/his call light, but waited an hour for a response. -1:42 PM Resident 6 stated it took forever for staff to respond to call lights. Resident 6 stated she/he would go down the hall to try and find someone to help but could not find anyone. Resident 6 stated it happened a lot on the evening shift around 7:00 PM and ,at times, she/he saw staff talking at the nurses' station and not answering call lights. -1:51 PM Resident 50 stated during the night she/he had to wait for care, she/he was a two-person assist and there were not always two staff members available to help. Resident 50 stated she/he, at times, had incontinent episodes because she/he could not wait any longer for assistance. -2:13 PM Resident 29 stated at night and on the weekends when she/he activated her/his call light it took a long time for staff to respond. Resident 29 stated at times she/he had incontinent episodes because she/he had to wait too long. -2:24 PM Resident 34 stated there was not enough staff on day and evening shifts, and residents had to wait a long time for their call lights to be answered. -2:25 PM Resident 308 stated she/he had to call out for help one night because her/his call light was not answered. Resident 308 stated she/he did not feel the facility had enough nurses. -5:24 PM Resident 26 stated call light wait times were over 15 minutes. Resident 26 stated the facility needed more CNAs and nurses during the day. On 4/16/24 at 7:35 AM Resident 8 stated her/his call light wait times were mostly over half an hour. On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 10/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes. On 4/18/24 at 9:30 AM Staff 8 (CNA) stated that call light wait times went over 20 minutes. On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she took lunch break, and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents activated their call light when on a bedpan and did not have timely follow up. Residents who were continent had incontinent episodes and their dignity was affected because of a long call light wait times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/24 at 1:00 PM Staff 11 (CNA) stated residents complained of long call light wait times very much and she observed residents who were left on a bedside commode for long periods of time, and a couple of residents had incontinent episodes when they were continent because staff did not attend to timely. On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours. 2. Resident 32 was admitted to the facility in 2023 with diagnoses including stroke and dementia. A 9/29/23 care plan indicated Resident 32 was incontinent of bowel and bladder with interventions including an incontinent program to toilet upon rising, before meals, after meals, at bedtime, and PRN. An 10/23/23 MDS indicated Resident 32 had moderate cognitive impairment and was occasionally incontinent of bowel and bladder. Resident 32 was normally aware of her/his need to go to the bathroom and staff assisted her/him with toileting and incontinent care needs. A review of the Direct Care Staff Daily Reports from 10/22/23 through 11/22/23 revealed the facility did not have sufficient CNA staff to meet the state minimum CNA staffing requirements on the following days: 10/28/23 day shift, 10/29/23 day shift,11/12/23 day shift, and 11/24/23 night shift. On 11/22/23 a public complaint was received which indicated Resident 32 was left in a soiled brief for an extended period. A family member visited daily and observed Resident 32 sitting in wet brief because not enough staff were available to assist, and stated call light wait times were longer than 20 minutes. On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 10/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes. On 4/18/24 at 9:16 AM Witness 1 (Family Member) confirmed Resident 32 was left in a soiled brief for an extended period of time. On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she went on lunch break and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents activated their call light when on a bedpan and there was no timely response. Staff 4 stated she found Resident 32 in a soaked brief, and she/he complained to her about having to wait a long time for assistance. On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours. 3. Resident 60 was admitted to the facility in 2023 with diagnoses including anxiety, a pressure ulcer to the right buttock, and muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Direct Care Staff Daily Reports from 11/15/23 through 11/14/23 revealed the facility did not have sufficient CNA staff to meet the state minimum CNA staffing requirements on the following days: 11/24/23 night shift, 11/26/23 evening shift, 12/1/23 night shift, 12/3/23 evening shift, and 12/7/23 night shift. A 11/15/23 care plan indicated Resident 60 was incontinent of bowel and bladder and was at risk for skin impairment. Interventions included an incontinent program to toilet upon rising, before meals, after meals, at bedtime, and PRN. Resident 60 used briefs for dignity. A 11/18/23 Nursing Care Note indicated Resident 60 called the police for help. The note indicated Resident 60 wanted staff to always stay in her room. The note indicated Resident 60 used her/his call light multiple times and each time it was answered timely. The note indicated the facility would do frequent checks on the night of 11/18/23. A 11/19/23 MDS indicated Resident 60 had moderate cognitive impairment and was frequently incontinent of bladder and always incontinent of bowel. Resident 60 was at risk for skin impairment and was dependent on staff for assistance with toileting. A Documentation Survey Report for 11/2023 indicated no documentation of assistance with toileting hygiene for the day shift on 11/22/23 and the night shift on 11/23/23. A public complaint was received on 12/14/23 which indicated Resident 60 was lying in urine and she/he attempted to reach staff by phone, but no one answered. Resident 60 called Witness 2 (Family Member) and Witness 2 stayed on the phone with Resident 60 until staff came and assisted Resident 60. This occurred two nights in a row and Resident 60 ended up calling 911. Police came to the facility for a welfare check. On 4/16/24 at 12:03 PM Witness 2 confirmed call light wait times of up to an hour and staff standing around and talking with multiple lights on at the nurses' station. On 4/17/24 at 5:45 AM Staff 3 (CNA) stated from 11/2023 through 12/2023 the facility was short-staffed approximately six out of seven days a week and she worked a lot of double shifts. Residents complained of long call light wait times up to 20 to 30 minutes. On 4/17/24 at 10:28 AM Staff 6 stated in 11/2023 the facility was short-staffed and she had to work very fast. Staff 6 stated it was overwhelming and stressful and residents thought staff were ignoring them. On 4/18/24 at 10:56 AM Staff 4 (CNA) stated at times she would go on lunch and when she came back her assigned residents' call lights were on for over 20 minutes. Staff 4 stated residents would activate their call light when on a bedpan and not have it answered timely. Staff 4 stated she had found Resident 60 in a soaked brief and if she/he would push her/his call light a lot it was because her/his needs were not met. On 4/19/24 at 7:46 AM Staff 1 (Administrator) and Staff 2 (DNS) stated the expectation for call light response was five to 10 minutes and to check on the residents every couple of hours. 34703 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 160 was admitted to the facility in 2023 with diagnosis including shoulder replacement. A 8/12/23 Admission MDS indicated Resident 160 was cognitively intact and required supervision or touching assistance from staff for toileting. A 9/7/23 FRI indicated on 8/27/23 Resident 160 had her/his call light on for 45 minutes and needed to use the restroom. Resident 160 indicated she/he heard Staff 36 (Former CNA) talking in the hallway. Resident 160 stated Staff 36 came into her/his room, turned around and left without attending to the resident's needs. Resident 160 stated Staff 36 did not return to assist her/him. On 4/18/24 at 8:09 AM Staff 27 (CNA) stated she remembered Staff 39; she did not answer her resident's call lights or other resident's call lights. On 4/18/24 at 9:14 AM Staff 1 (Administrator) and Staff 2 (DNS) stated Staff 39 (Former CNA) worked in the facility for years and had multiple warnings and write ups related to resident care and not answering call lights. Staff 36 was terminated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35855 Based on interview, and record review, it was determined the facility failed to post accurate and complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include: A review of the Direct Care Staff Daily Reports (DCSDR) from 11/23/23 through 12/15/23 revealed no staff hours were documented on eight days, census was documented only one day, and the number of staff was not documented two days out of 23 days reviewed. On 4/19/24 at 7:39 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they were not aware of the issues with the DCSDR reports. Staff 2 stated the Staffing Coordinator was newer to the facility during the above reviewed time period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview, and record review it was determined the facility failed to ensure residents were assessed prior to prescription and use of psychotropic medications for 1 of 6 sampled residents (#29) reviewed for unnecessary medications. This placed residents at risk for over-sedation. Findings include: Resident 29 admitted to the facility on [DATE] with a diagnosis of mild dementia without behaviors. Progress Notes revealed the following: -1/19/24 Resident 29 admitted to the facility and was noted to have some short-term memory loss. -1/20/24 Resident 29 was alert, oriented, followed commands, had some forgetfulness, no unwanted behaviors, and slept through the night. The resident was noted to be adjusting well. -1/20/24 at 11:50 PM Resident 29 was found on the floor. The resident was at her/his baseline mental status. -1/21/24 and 1/22/24 Resident 29 was assessed to have no injury from her/his fall. -1/22/24, 1/23/24, and 1/25/24 Resident 29's mood was pleasant with no unwanted behaviors. -1/25/24 Resident 29's daughter was notified Seroquel (antipsychotic medication used to treat bipolar disorder [mood swings from depressive lows to manic highs] and schizophrenia [disorder affecting a person's ability to behave clearly]) was added at HS. Review of Resident 29's 1/2024 MAR revealed Seroquel was administered once on 1/25/24 and was then discontinued. Resident 29's record did not have an assessment or rationale for starting the medication on 1/25/24 or for stopping the medication after 1/25/24. Progress notes from 1/25/24 to 3/6/24 revealed the following: -1/26/24 Resident 26 was assessed after a fall and cursed at the nurse, denied the fall and later apologized to the nurse for cursing. -1/27/24 Resident 29 walked in the hall on the evening/night shift without assistance and was easily redirected back to her/his room. -2/2/24 Resident 29 participated with therapy, did not have unwanted behaviors and slept at night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/8/24 Resident 29 had an unwitnessed fall in her/his room. The resident walked in halls without assistance and staff were able to redirect the resident back to her/his room. -2/11/24 on night shift, Resident 29 stood without assistance and staff redirected the resident. -2/17/24 evening shift Resident 29 walked without assistance. Staff provided education, provided the resident blocks and a snack which distracted the resident from self-ambulating. -2/27/24 Resident 29 was found kneeling on the floor and the resident stated she/he was cleaning the floor. -3/6/24 Resident 29 participated in her/his RA program. A 2/2/24 psychologist Progress Note revealed Resident 29 was assessed and the resident reported difficulty sleeping due to the environment. The resident stated she/he had some depression, had good family support, wanted to go home but realized she/he required more support, and moving to a higher level of care would be appropriate. A recommendation was made for an increase in melatonin (sleep aid) for sleep. The progress note did not indicate the resident was assessed for behaviors the facility was not able to be manage. A 3/2024 MAR revealed on 3/6/24 Resident 29 was started on Seroquel, was administered the medication every night, and on 3/20/24 was started on Nuplazid (treats Parkinson's related psychosis [mental disorder with a disconnection from reality]) and was administered the medication every morning. The MAR also indicated Resident 29 was started on an antibiotic on 3/28/24. Resident 29's clinical record did not have an assessment for the initiation of the Seroquel or Nuplazid. On 4/15/24 at 1:57 PM Witness 9 (Family) stated in 1/2024 the facility started the resident on Seroquel for no reason. Witness 9 stated the facility staff called in 1/2024 and stated they reported Resident 29 got up at night and fell and then they started the Seroquel. Witness 9 stated she was upset, came into the facility, and wanted the medication to be stopped. Witness 9 stated she wanted Resident 29's neurologist to monitor the resident's medications due to the resident's Parkinson's disease. On 4/16/24 at 2:42 PM Resident 29 was observed in her/his room playing dominos with her/his roommate. Resident 29 explained the rules of dominos to the surveyor. On 4/16/24 at 2:50 PM Staff 47 (CNA) stated at times Resident 29 was confused but was easily redirected. Resident 29 at times needed safety reminders to not walk without assistance and at times stated to staff to get away from me but otherwise the resident did not have behaviors. Resident 29 liked to color and colored for hours, liked to put art on the wall, and showed staff what she/he created. Resident 29 also liked to talk to her/his roommate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385024	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Health Services of Rogue Valley	625 Stevens Street Medford, OR 97504

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 1:47 PM Staff 10 (LPN Unit Manager) stated after the Seroquel was initially started in 1/2024 Witness 9 was very upset. Witness 9 came in to the facility and Staff 10 spoke to Witness 9 about Resident 29's dementia diagnosis. Staff 10 stated Witness 9 was not aware the resident had a diagnosis of dementia. Witness 9 wanted the resident's neurologist to assist with any psychotropic medication management due to the resident's diagnosis of Parkinson's disease. On 3/5/24 Resident 29 went to her/his neurologist and was started on Seroquel and Nuplazid. The resident's clinical record did not contain the neurologist's assessment or rationale for the psychotropic medications. Staff 10 acknowledged the resident's record did not contain information to indicate Resident 10 had delusions, hallucinations or behaviors which staff were not able to redirect with non-pharmacological interventions prior to 1/25/24 or prior to the restart of the Seroquel and Nuplazid in 3/2024. A request was made for an assessment or rationale for the initiation of Seroquel and Nuplazid. No additional information was provided. On 4/17/24 at 4:02 PM Staff 20 (IP/LPN) stated Resident 29 was more confused when she/he was first admitted to the facility in 1/2024 but seemed to improve. Staff 20 stated Resident 29 had quite a few falls. After one of the falls at the end of 3/2024 Resident 29 reported knee pain and was sent to the hospital for evaluation. At the hospital the resident denied knee pain and the resident was tested and diagnosed to have a UTI. Resident 29 was started on antibiotics. Staff 20 was not able to identify Resident 29's behaviors which would warrant initiating psychotropic medications. Staff 20 also stated it was unclear if the resident's condition improved because she/he was treated for the UTI or was started on the psychotropic medications.