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	08/22/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review it was determined the facility failed to provide dental care to 1 of 2 sampled residents (#1) reviewed for ADLs. This placed residents at risk for unmet care needs. Findings include:Resident 1 was admitted to the facility in 7/2025 with diagnoses including COPD (chronic obstructive pulmonary disease) and dementia. A 7/25/25 Dental/Oral Evaluation revealed Resident 1 had oral thrush (fungal infection of the mouth) and wore full upper and partial lower dentures. A 7/27/25 admission MDS indicated Resident 1 was assessed with a BIMS score of 2 (severe cognitive impairment) and required set-up assistance for oral hygiene. An 8/5/25 care plan revealed oral care was to include cleaning her/his full upper and partial lower dentures. On 8/18/25 at 9:23 PM, Witness 3 (Family) stated she was in the facility for 72 hours with Resident 1 and family cleaned and inserted the resident's dentures because staff did not assist the resident. On 8/20/25 at 8:58 AM, Resident 1 was observed with mouth odor and the resident stated she/he wore her/his dentures overnight. On 8/20/25 at 4:44 PM, Staff 25 (CNA) stated a note was in Resident 1's room to ensure denture care was provided. Staff 25 stated dentures were to be removed and cleaned nightly and confirmed Resident 1's dentures were found in her/his mouth in the mornings on the last two days. Staff 25 stated nurses were not informed in order to address Resident 1's lack of oral care. On 8/20/25 at 6:51 PM, Staff 26 (CNA) stated she was not aware Resident 1 wore dentures and confirmed she assisted Resident 1 in the evenings with oral care. On 8/21/25 at 1:03 PM, Staff 15 (LPN-Resident Care Manager) confirmed Resident 1's dentures were to be cleaned in the morning and evenings and removed at night. Staff 15 expected staff to communicate resident care concerns to ensure adjustments were made for Resident 1's oral care hygiene.

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