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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to provide a safe and comfortable environment for 1 of 7 sampled residents (# 84) and 2 of 3 halls reviewed for environment. This placed residents at risk for discomfort and burns. Findings include:1. On 8/19/25 at 8:03 AM, Resident 84 stated her/his room was very cold and at night she/he wore two pairs of socks on her/his feet, sweatpants, a sweatshirt, and socks on her/his hands to stay warm. Resident 84 was observed in the wheelchair, had a blanket around her/his shoulders. At this time a staff entered the room and asked Resident 84 if she/he was still cold. On 8/19/25 at 3:29 PM, Staff 17 (Maintenance Director) stated he checked temperatures in the resident rooms weekly and would expect resident rooms to be between 72 and 78 degrees. Staff 17 was asked to check the room temperature in Resident 84's room. Temperatures obtained were 64 degrees, 65 degrees, and the area around the air conditioner vent in Resident 84's room was 54 degrees. On 5/19/25 at 3:44 PM, Staff 1 (Administrator) acknowledged the temperature in Resident 84's room. 2. On 8/18/25 at 2:48 PM, room [ROOM NUMBER]'s hot water in the restroom was turned on and became very hot within 10 seconds. The resident in room [ROOM NUMBER] confirmed she/he did not go into the restroom.On 8/19/25 at 3:29 PM, Staff 17 (Maintenance Director) stated the water temperature in the resident rooms were not to exceed 120 degrees. Staff 17 stated he checked five resident rooms per week. The temperature of the hot water in room [ROOM NUMBER] was checked and revealed to be 132 degrees. On 8/19/25 at 3:44 PM, Staff 1 (Administrator) stated the water temperature should not exceed 120 degrees. On 8/20/25 at 2:35 PM, Staff 17 was asked to check the water temperature for multiple rooms and the public restroom in the 300 hall. It was found to be 142 degrees.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation it was determined the facility failed to store medications in a safe manner for 2 of 3 halls. This placed residents at risk for misuse of medications. Findings include:On 8/18/25 at 12:13 PM, an observation was made with Staff 18 (LPN) of a bottle of antifungal powder in an unlocked precaution cart outside room [ROOM NUMBER]. Staff 18 stated the antifungal powder should be locked in the treatment cart.On 8/19/25 at 11:05 AM, an observation was made with Staff 18 of a bottle of antifungal powder located in room [ROOM NUMBER] on a small table near the bed. Staff 18 stated the antifungal powder should be locked in the treatment cart.On 8/21/25 at 8:28 AM, an observation was made with Staff 16 (RN) of a bottle of antifungal powder located in room [ROOM NUMBER] on the overbed table. Staff 16 stated the antifungal powder should be locked in the treatment cart.On 8/21/25 at 8:45 AM, Staff 2 (DNS) stated antifungal powder should be locked in the treatment cart.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 it was determined the facility failed to ensure staff followed transmission-based precautions and provided wound care in a sanitary manner for 2 of 3 halls reviewed for infection control and 1 of 1 sampled resident (#47) reviewed for pressure ulcers. This placed residents at risk for spread of infections. Findings include: 1. On 8/18/25 at 12:35 PM, signage was posted outside room [ROOM NUMBER] and instructed all staff who assisted the resident in Bed A to wear gowns and gloves during high-contact (frequent physical interaction) activities, including resident transfers. On 8/18/25 at 12:36 PM, Staff 29 (PT) was observed transferring the resident in Bed A from the bed to a wheelchair without wearing a gown or gloves. Staff 29 stated she did not wear personal protective equipment (PPE) because she did not handle the resident's catheter. On 8/20/25 at 8:40 AM, Staff 19 (IP) stated therapy staff were provided with a list of residents on transmission-based precautions. Staff 19 reported therapy staff were expected to reference the list and follow signage posted outside resident rooms to ensure appropriate PPE use. 2. On 8/18/25 at 11:56 AM, Staff 32 (CNA) was observed walking into room [ROOM NUMBER], a room on contact precautions, without a gown or gloves. Staff 32 acknowledged she did not wear a gown or gloves when delivering the tray to room [ROOM NUMBER], she stated she did not touch the resident. The contact precaution sign indicated staff were to where a gown and gloves upon entering room. Staff 32 acknowledged the sign said to wear a gown and gloves before entering the room, and stated, well ok and walked away. On 8/20/25 at 8:40 AM, Staff 19 (IP) stated staff were expected to follow the signage posted outside resident rooms. 3. Resident 47 was admitted to the facility in 8/2023 with diagnoses including depression. The 7/24/25 Annual MDS indicated Resident 47 had a stage 4 pressure wound (a wound caused by pressure that has gone through all layers of skin and fat to reach down to muscle, bone, or tendon) on her/his coccyx which was present upon admission. On 8/18/25 at 2:08 PM, Resident 47 stated she/he had a pressure wound. On 8/21/25 at 10:42 AM, Resident 47's pressure wound dressing change was observed with Staff 31 (LPN). The pressure wound was located on Resident 47's coccyx and the wound appeared to meet the criteria of a stage 4 pressure wound. Staff 31 gathered the wound care supplies, completed hand hygiene, donned a gown and gloves, and entered Resident 47's room. Staff 31 set up the dressing supplies on Resident 47's bed. While wearing the same gloves, Staff 31 cleaned Resident 47's wound, applied the clean dressing, reached into her pocket, retrieved a pen, dated and signed Resident 47's dressing, and put the pen back into her pocket. Staff 31 then removed her gloves, gown, and washed her hands. On 8/21/25 at 10:51 AM, Staff 31 stated she completed hand hygiene before starting Resident 47's wound care and after completing the wound care. Staff 31 stated she did not change her gloves during Resident 47's wound care. Staff 31 stated this was how she always completed wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/25 at 10:55 AM, Staff 19 (IP) stated she expected hand hygiene to be completed, new gloves applied after and in between dirty and clean steps during wound care. Staff 19 stated Staff 31 should have completed hand hygiene, donned gown and gloves, entered Resident 47's room, set up wound care supplies, removed soiled gloves, completed hand hygiene, applied new gloves, cleaned the wound, removed soiled gloves, completed hand hygiene, applied new gloves, applied clean dressing, removed soiled gloves, completed hand hygiene, applied new gloves, retrieved pen out of her pocket, dated wound, returned pen to pocket, removed soiled gloves and gown, and completed hand hygiene.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review it was determined that the facility failed to report to the State Survey Agency allegations of verbal abuse for 1 of 1 sampled resident (#14) reviewed for dignity. This placed residents at risk for verbal abuse. Findings include:Resident 14 was admitted to the facility in 6/2025 with diagnoses including alcohol abuse and seizures.On 8/18/25 at 2:41 PM, Resident 14 stated she/he received a NOMNC (Notice of Medicare Non-Coverage) from the Social Service Director and a nurse. Resident 14 stated the nurse told her/him the facility was not a homeless shelter. Resident 14 stated she/he felt belittled by the comment, and she/he notified the administrator via email but did not hear back from the administrator. Resident 14 provided a copy of a NOMNC signed on 8/6/25 by Staff 4 (Social Service Director) and Staff 19 (LPN Infection Preventionist).On 8/20/25 at 2:20 PM, Staff 1 provided an email between Resident 14 and himself sent from Resident 14 on 8/7/25 with a subject line Formal Complaint Regarding Improper Notice, Coercion, and Staff Conduct. Item 3 of the email stated while Resident 14 was receiving a NOMNC the nurse, stated, 'This isn't a homeless shelter'. I asked, ?Do you think I'm homeless?' To which she smirked but did not respond. This type of comment is not only demeaning but reflects an unprofessional and prejudiced tone that should have no place in a care setting. Regardless of intent, the remark was belittling and left a lasting emotional impact. Staff 1 replied to Resident 14 on 8/12/25, Regarding items 3 and 4: I will address this concern with the staff member involved. We do not have a nurse by that name working here, could you clarify her name?On 8/20/25 at 2:45 PM, Staff 1 (Administrator) stated he received an email from Resident 14 regarding a staff complaint. Staff 1 stated Resident 14 never got back to him with the staff's name, so an investigation was not completed.On 8/22/25 at 10:01 AM, Staff 1 acknowledged he should have asked Resident 14 when he did not receive a reply to the email. Staff 1 also acknowledged Resident 14's email was an allegation of verbal abuse, and it should have been reported to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to investigate allegations of verbal abuse for 1 of 1 sampled resident (#14) reviewed for dignity. This placed residents at risk for verbal abuse.Resident 14 was admitted to the facility in 6/2025 with diagnoses including alcohol abuse and seizures.On 8/18/25 at 2:41 PM, Resident 14 stated she/he received a NOMNC (Notice of Medicare Non-Coverage) from the Social Service Director and a nurse. Resident 14 stated the nurse told her/him the facility was not a homeless shelter. Resident 14 stated she/he felt belittled by the comment, and she/he notified the administrator via email but did not hear back from the administrator. Resident 14 provided a copy of a NOMNC signed on 8/6/25 by Staff 4 (Social Service Director) and Staff 19 (LPN Infection Preventionist).On 8/20/25 at 2:20 PM, Staff 1 provided an email between Resident 14 and himself sent from Resident 14 on 8/7/25 with a subject line Formal Complaint Regarding Improper Notice, Coercion, and Staff Conduct. Item 3 of the email stated while Resident 14 was receiving a NOMNC the nurse stated, 'This isn't a homeless shelter'. I asked, ?Do you think I'm homeless?' To which she smirked but did not respond. This type of comment is not only demeaning but reflects an unprofessional and prejudiced tone that should have no place in a care setting. Regardless of intent, the remark was belittling and left a lasting emotional impact. Staff 1 replied to Resident 14 on 8/12/25, Regarding items 3 and 4: I will address this concern with the staff member involved. We do not have a nurse by that name working here, could you clarify her name?On 8/20/25 at 2:45 PM, Staff 1 (Administrator) stated he received an email from Resident 14 regarding a staff complaint. Staff 1 stated Resident 14 never got back to him with the staff's name, so an investigation was not completed.On 8/22/25 at 10:01 AM, Staff 1 acknowledged he should have asked Resident 14 when he did not receive a reply to the email. Staff 1 also acknowledged Resident 14's email was an allegation of verbal abuse, and the allegation should have been investigated to rule out abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review it was determined the facility failed to ensure care plans were revised to reflect resident-centered care for 1 of 1 sampled resident (#6) reviewed for behavior. This placed residents at risk for unmet needs. Findings include: Resident 6 admitted to the facility in 3/2025 with diagnoses including dementia. A comprehensive care plan dated 5/21/25 revealed Resident 6 had a behavior monitor in place, with behaviors of agitation, fabricating stories, and anxiety. The behavior monitor identified the following triggers: history of growing up in an alcoholic environment, dealing with physical/mental changes, and roommate issues. There was no additional behavior care plan.A 5/28/25 progress note revealed Resident 6 had hallucinations. A 6/18/25 progress note revealed Resident 6 was very confused and argumentative with CNA staff. A 6/26/25 Quarterly MDS revealed Resident 6 had verbal behaviors towards others. A 7/16/25 progress note revealed Resident 6 often called out, had difficulty sleeping, displayed agitation with staff and other residents, and displayed agitation surrounding meals. The progress note also indicated television noise and commercials caused Resident 6's behaviors. The progress note also revealed Resident 6 made comments about hitting and raping staff. A 7/30/25 progress note revealed Resident 6 accused the staff of attempting to kill her/him. A 7/31/25 progress note revealed Resident 6 stated the facility staff tried to kill her/him with food and made death threats towards staff. An 8/15/25 progress note revealed Resident 6 yelled at a CNA and was triggered after seeing the color yellow. In an interview on 8/19/25 at 7:51 AM Resident 6 became fixated on food preferences and stated she/he should kill the facility cook but was afraid of God. Resident 6 made multiple statements of how she/he could kill others.On 8/20/25 at 8:40 AM, Staff 12 (CMA) stated Resident 6 threatened staff, yelled for care, and became upset if the staff were not in the room immediately. On 8/21/25 at 8:12 AM, Staff 9 (CNA) stated Resident 6 was very religious, made statements about going to hell, made derogatory statements towards women, and what Resident 6 watched on television affected how she/he acted. On 8/21/25 at 8:15 AM, Staff 13 (LPN) stated Resident 6 made sexual comments, stated she/he would rape the CNA staff, and her/his behaviors were affected by which television show she/he watched.On 8/21/25 at 10:41 AM, Staff 10 (CNA) stated Resident 6 became easily frustrated, could be verbally abusive, and made statements of killing others but would also say she/he was Godly. Staff 10 also stated she recently picked up on Resident 6's mood being affected by what was on the television, but that was not in the care plan.On 8/21/25 at 3:24 PM Staff 4 (Social Services Director) stated Resident 6 became agitated with certain things, including roommates. Staff 4 stated Resident 6 fabricated stories and what she/he watched on television affected how she/he acted, such as a military movie resulting in Resident 6 talking about killing. Staff 4 reviewed Resident 6's care plan and stated the care plan did not address all of her/his behaviors.On 8/21/25 at 4:09 PM Staff 2 (DNS) reviewed Resident 6's care plan and confirmed it would be appropriate for the care plan to address her/his current behaviors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interviews, and record review it was determined the facility failed to provide meaningful activities for 2 of 3 sampled residents (#s 2 and 3) reviewed for activities. This placed residents at risk for lack of social interaction and isolation. Findings include:1. Resident 2 was admitted to the facility in 8/2025 with diagnoses including Alzheimer's (major decline in cognitive abilities) disease and stroke. An 8/10/25 admission MDS indicated Resident 2 was assessed with a BIMS score of 2 (severe cognitive impairment), it was important to the resident to have things to read, to do her/his favorite activities, and get outside when the weather was good. Activities were encouraged for Resident 2 related to her/his cognitive impairment and staff were to anticipate her/his needs. An 8/18/25 care plan indicated Resident 2 required assistance to attend activities and in-room materials as indicated. Resident 2's interests included: engineering shows, technology reading materials, table games, gardening, and music. Review of the 8/5/25 through 8/18/25 CNA Tasks: Activities for Groups and One on One revealed no activities were provided for Resident 2. On 8/19/25 at 8:27 AM and 8/20/25 at 8:24 AM, Resident 2 was observed sitting in the hall in her/his wheelchair with no activity or staff interaction. On 8/19/25 at 9:18 AM, Staff 16 (RN) indicated Resident 2 had behaviors and confirmed no activities were offered to the resident. On 8/19/25 at 10:14 AM, Staff 30 (Activities Director) acknowledged she lacked understanding of appropriate activities for residents with dementia and lacked time to provide residents with one-on-one interactions without the assistance of CNAs. On 8/20/25 at 6:50 PM, Staff 26 (CNA) stated she assisted Resident 2 and was not aware of her/his care plan related to activities. On 8/21/25 at 1:03 PM, Staff 15 (LPN-Resident Care Manager) expected residents with dementia to be busy with meaningful activities which would include CNA involvement. 2. Resident 67 was admitted to the facility in 8/2025 with diagnoses including Parkinson's (degenerative nerve) disease and sepsis (life-threatening and overreactive immune response). An 8/10/25 admission MDS indicated Resident 67 was assessed with a BIMS score of 15 (cognitively intact) and activities which included books, music, news and getting outside when the weather was good were very important to the resident. An 8/18/25 care plan indicated Resident 67 was interested in joining group activities and her/his interests included: gardening, reading, exercise classes, music, and videos. An 8/6/25 Activity Profile revealed likes and dislikes for group activities, individual activities, and the resident's preference for exercise were all left blank. Review of the 8/6/25 through 8/18/25 CNA Tasks: Activities for Groups and One on One revealed no activities were provided for Resident 67. On 8/18/2025 at 12:26 PM Resident 67 was observed sitting in her/his room in her/his wheelchair with no television on and stated she/he was bored. Resident 67 was shown the daily activity calendar in her/his room with no locations listed. Resident 67 stated she/he was open to attend activities if she/he was invited. She/he did not know where activities were located. On 8/19/25 at 8:17 AM, Resident 67 was observed sitting in her/his room in her/his wheelchair just waiting to go home.On 8/19/25 at 9:47 AM, Resident 67 was sitting in her/his room with no television on. Staff 30 (Activities Director) entered Resident 67's room and provided the resident an activity calendar with no further discussion. On 8/19/25 at 10:14 AM, Staff 30 acknowledged she was behind on activity assessments which resulted in an incomplete assessment for Resident 67.On 8/21/25 at 1:03 PM Staff 15 (LPN-Resident Care Manager) acknowledged the lack of staff education related to activities and confirmed Resident 67 required additional staff engagement to meet her/his need for socialization and activities.On 8/22/25 at 10:37 AM, Staff 27 (CNA) stated, at times, Resident 67 declined reading materials and they were unsure where to chart activities for residents. On 8/21/25 at 4:49 PM, Staff 1 (Administrator) expected residents to have meaningful activities supported by all staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations, interviews, and record review it was determined the facility failed to implement fall precautions for 2 of 4 sampled residents (#s 5 and 13) reviewed for accidents. This placed residents at risk for injuries related to falls. Findings include:1. Resident 5 was admitted to the facility in 7/2025 with diagnoses including stroke, hip fracture, and dementia.An 8/13/25 revised care plan indicated Resident 5 was at high risk for falls and instructed staff to place fall mats on each side of her/his bed. On 8/19/25 at 2:20 PM, Resident 5 was observed in bed with no fall mats at her/his bedside. On 8/20/25 at 2:05 PM, Witness 2 (Family) stated she visited Resident 5 routinely and no fall mats were used for Resident 5. On 8/20/25 at 6:48 PM, Staff 26 (CNA) stated she provided care for Resident 5 and was unaware fall mats were indicated in her/his care plan. On 8/21/25 at 11:45 AM, Staff 24 (LPN) stated she was not aware Resident 5 was to have fall mats in place because it was not on the TAR. On 8/21/25 at 1:03 PM, Staff 15 (LPN-Resident Care Manager) expected staff to utilize fall mats as indicated in the care plan.On 8/22/25 at 11:22 AM, no fall mats were in place while Resident 5 was in bed. On 8/22/25 at 11:36 AM, Staff 2 (DNS) confirmed staff were to use fall mats for Resident 5.2. Resident 13 was admitted to the facility in 7/2025 with diagnoses including sepsis (severe reaction to infection in the body) and respiratory failure.A 7/5/25 care plan for falls indicated to place Resident 13's bed in the lowest position, except during care. The 7/9/25 admission MDS indicated Resident 13 was admitted with generalized weakness, some disorganized thinking, was assessed to have a BIMS score of 14 (cognitively intact) and was dependent on staff for toileting. On 8/19/25 at 8:32 AM, Resident 13 was observed lying crosswise on her/his bed with the bed in an elevated position.On 8/22/25 at 10:07 AM, Resident 13's bed was in an elevated position, the resident was positioned lying across the bed with her/his feet within one foot of the floor. Resident 13 indicated she/he required staff assistance. On 8/22/25 at 10:24 AM, Staff 28 (CNA) stated Resident 13 always positioned herself/himself in the bed in unsafe positions and refused to keep her/his bed in the low position. Staff 28 stated nursing staff were not informed.On 8/22/25 at 10:37 AM, Staff 27 (CNA) stated he told nurses four to five times about his concern related to Resident 13's positioning in bed. Staff 27 confirmed Staff 15 (LPN-Resident Care Manager) was not informed.On 8/22/25 at 11:27 AM, Staff 2 (DNS) expected information about Resident 13's positioning and bed position to be communicated to Staff 15. Staff 2 acknowledged Resident 13's care plan was not updated to address her/his bed placement and she/he needed a care plan revision to address appropriate fall risk interventions.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews it was determined the facility failed to maintain a healthy nutritional status for 1 of 2 sampled residents (#55) reviewed for nutrition. This placed residents at risk for malnutrition and weight loss. Findings include: Resident 55 was admitted to the facility on [DATE] with diagnoses including falls and Multiple Sclerosis (an autoimmune disease of the brain and spinal cord where the body's immune system attacks the protective area around nerve cells causing damage that disrupts communication between the brain and body).A 7/31/25 Physician Order revealed Resident 55 had orders for a regular diet.A review of Resident 55's weights revealed the following: 7/31/25 146.8 lbs. (weight was struck out for being inaccurate) 8/4/25 131.8 lbs. 8/5/25 128 lbs. 8/11/25 123.6 lbs. 8/12/25 124.2 lbs.An 8/13/25 Progress Note revealed Resident 55 had a 5.8% weight loss.On 8/18/25 at 12:39 PM, Resident 55 stated she/he did not eat much due to the food being, terrible. Resident 55 stated she/he was not sure if she/he lost weight.A review of Resident 55's medical record revealed no evidence of supplements or other interventions for weight loss.On 8/21/25 at 12:49 PM, Staff 25 (CNA) stated Resident 55 did not have much of an appetite, but at times requested a snack.Resident 55's weight was documented on 8/21/24 as 123.2 lbs.On 8/21/25 at 1:07 PM, Staff 31 (LPN) stated she was not sure if Resident 55 lost weight.On 8/21/25 at 1:27 PM, Staff 5 (RD) stated Resident 55's weight was on 8/12/25 showed significant weight loss. Staff 5 stated Resident 55 was to be seen in the Nutrition at Risk meeting on 8/21/25. Staff 5 acknowledged Resident 55 had no interventions or supplements in place for weight loss.On 8/21/25 at 4:54 PM, Staff 15 (LPN Resident Care Manager) stated between Resident 55's weight on 8/4/25 and 8/12/25, she/he showed significant weight loss. Staff 15 stated an assessment of Resident 55's significant weight loss was completed on 8/21/25 and Staff 5 ordered a nutritional supplement for Resident 55 to be started on 8/22/25. Staff 15 stated her expectation for residents with significant weight loss was for them to be assessed, reviewed by the IDT in the Nutritional at Risk meeting, and weight loss prevention interventions put in place within the same week the significant weight loss occurred.On 8/22/25 at 10:40 AM, Staff 2 (DNS) acknowledged there were 12 days between Resident 55's significant weight loss and assessment, and having interventions put in place. Staff 2 stated she expected interventions to prevent any further weight loss to be put in place quicker than 12 days.

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	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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to treat resident's pain in accordance with resident preference for 1 of 2 sampled residents (#10) reviewed for pain. This placed residents at risk for unmanaged pain. Findings include: Resident 10 was admitted to the facility in 2017 with diagnoses including chronic pain. A 7/9/25 Progress Note revealed the resident requested she/he be prescribed lidocaine patches to manage her/his pain. The request was also documented in the Provider Communications Notebook by Staff 22 (former LPN-Resident Care Manager). A review of the 8/2025 Pain Level Summary revealed Resident 10 reported pain levels of 3 to 6 (moderate to severe) on 9 of 21 days reviewed. On 8/19/25 at 8:44 AM, Resident 10 stated she/he regularly experienced severe pain.On 8/21/25 at 12:22 PM, Staff 23 (Medical Director) stated she was not aware Resident 10 requested lidocaine patches. Staff 23 stated she and the nurse practitioner reviewed the Provider Communications Notebook during each visit to the facility. On 8/22/25 at 11:30 AM, Staff 2 (DNS) stated she was unable to locate any documentation from the Provider Communications Notebook of Resident 10's request for lidocaine patches. On 8/22/25 at 12:05 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed nursing staff should document residents' medication needs in the Provider Communications Notebook and follow up if they do not receive a response from the provider.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review it was determined the facility failed to obtain routine dental services for 1 of 2 sampled residents (#27) reviewed for dental care. This placed residents at risk for unmet dental needs. Findings include: Resident 27 was admitted to the facility in 1/2025 with diagnoses including dementia.A 2/6/25 progress note revealed Resident 27's diet was downgraded due to loose dentures.A 2/13/25 progress note revealed Resident 27 did not want to get up for meals as she/he was having trouble with her/his dentures.A 3/21/25 progress note revealed Resident 27 did not want other people to see her/his top dentures because they always fell down while eating.A Care Plan revised 4/21/25 revealed Resident 27 wore upper dentures.A 5/27/25 social service progress note revealed an attempt to make a dental appointment for Resident 27. A 6/20/25 Care Conference Information evaluation revealed Resident 27 was concerned about her/his dentures not fitting and had a dental appointment coming up. On 8/19/2025 at 7:49 AM, Resident 27 was observed eating in her/his room. Resident 27's dentures appeared to not fit well and moved while she/he talked and ate.On 8/21/25 at 8:09 AM, Staff 9 (CNA) stated Resident 27 liked to seclude her/himself due to of being self-conscious about her/his dentures. On 8/21/25 at 10:46 AM, Staff 10 (CNA) stated Resident 27's dentures have been loose since she/he admitted to the facility and the dentist appointment was still being worked on. On 8/21/25 at 3:35 PM, Staff 4 (Social Services Director) stated she was made aware of Resident 27's need for a dental appointment and first reached out to a dentist on 5/27/25. She also confirmed Resident 27's dentures still did not fit and she/he was self-conscious. On 8/21/25 at 4:11 PM, Staff 2 (DNS) reviewed Resident 27's records and confirmed there was delay in arranging the dental appointment.