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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385053 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/01/2024 |
| NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Eugene | | STREET ADDRESS, CITY, STATE, ZIP CODE 2360 Chambers Street Eugene, OR 97405 | |

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) |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41455</p> <p>Based on interview and record review it was determined the facility failed to ensure interventions to prevent a resident's elopement were in place for 1 of 3 sampled residents (#315) reviewed for accidents. This placed residents at risk for lack of a safe environment. Findings include:</p> <p>Resident 315 admitted to the facility in 5/2024 with diagnoses including Parkinson's disease (disease of the nervous system) and repeat falls.</p> <p>A 9/15/24 revised care plan indicated Resident 315 was an elopement risk with impaired safety awareness, she/he was not to leave the facility unattended and staff were to determine the reason for her/him wanting to leave the facility with pleasant diversions offered.</p> <p>A 9/16/24 Nursing Care Note indicated Resident 315 was observed exiting the facility out the back door (close to her/his room) by Staff 10 (CNA) and two staff followed the resident. Resident 315 came back into the building with assistance by Staff 3 (Resident Care Manager-LPN). Resident 315 acknowledged she/he attempted to leave the building (unattended) and 15-minute checks were implemented.</p> <p>A 9/16/24 Elopement Risk Evaluation indicated Resident 315 was cognitively impaired with poor decision-making skills, verbally expressed the desire to leave the building, had a history of wandering, but no history of elopement.</p> <p>A 9/27/24 revised care plan indicated Resident 315 was able to self-propel with the use of a manual wheelchair and may need one staff to assist for mobility if weak and fatigued.</p> <p>A 9/28/24 at 2:26 PM Alert Note indicated Resident 315 was observed in her/his wheelchair in the hall at 2:00 PM. At 2:03 PM a staff member observed the resident from a facility window at the top of the hill on the road next to the stop sign which was next to the facility. Resident 315 hid her/his wheelchair in the courtyard and went out a different back door (not close to his room). Resident was placed on 15 minute checks.</p> <p>A 9/28/24 at 10:01 PM Situation, Background, Assessment and Recommendation Progress Note indicated Resident 315 did not seek to leave the building for the last 30 days until 9/28/24. Resident 315 was interviewed and was able to described how and why she/he left the building.</p> <p>(continued on next page)</p> |

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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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 9/30/24 at 11:59 AM Staff 11 (CNA) stated he was aware Resident 315 was exit-seeking over the last seven days.</p> <p>On 9/30/24 at 12:28 PM Staff 3 stated there was no investigation completed related to the 9/16/24 elopement incident because Resident 315 did not leave the facility grounds.</p> <p>On 9/30/24 at 1:08 PM and 1:30 PM Staff 10 stated on 9/16/24 she observed Resident 315 on the outside of the back door with no other staff around. Staff 10 stated she assumed the resident knew the code for the back door based on her observation of the 9/16/24 incident because no other staff were in the vicinity.</p> <p>On 9/30/24 at 8:50 PM Staff 7 (LPN) stated she began an investigation when Resident 315 eloped from the building at 2:00 PM on 9/28/24. Staff 7 acknowledged Resident 315 was not asked how she/he exited the building until she/he exited the building the second time in the evening on 9/28/24.</p> <p>On 10/1/24 at 3:52 PM Staff 1 (Administrator in Training) stated an investigation for Resident 315's exit seeking behavior was not started as required for the 9/16/24 incident. Staff 1 stated because she was unaware of the 9/16/24 incident, she believed 15 minute checks were sufficient to keep Resident 315 safe on 9/28/24 at 2:00 PM when she was informed. Staff 1 acknowledged interventions related to her/his ability to leave the building unattended and elope was not discovered and implemented due to the lack of investigations after the first two incidents.</p> | | |