

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 01/20/2026
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observations, interview, and record review it was determined the facility failed to report allegations of abuse and neglect to the State Survey Agency for 1 of 3 sampled residents (#60) reviewed for abuse and accidents. This placed residents at risk for further abuse and neglect. Findings include: Resident 60 was admitted to the facility in 7/2024 with diagnoses including heart failure and kidney disease. The 3/4/25 Annual MDS indicated Resident 60 was cognitively intact. A care plan dated 12/24/25 indicated if Resident 60 accusatory comments about family, and/or staff not treating her/him well and denying her/his medications, staff must alert the nurse so they may assess for signs and symptoms of urinary tract infection since this had been the case in the past. On 1/12/26 at 2:13 PM Resident 60 indicated a CNA/CMA abused her/him. Resident 60 stated the staff member spoke meanly and was rough with her/him and she/he felt abused. Resident 60 stated the staff member treated her/him like a bad dog. Resident 60 stated Staff 11 (LPN) was aware the staff member treated her/him badly but had not stopped the staff member. Resident 60 stated she/he was afraid of retaliation from the staff member and being discharged from the facility. On 1/12/26 at 2:16 PM Staff 11 stated the staff member she heard being rude to Resident 60 was Staff 26 (CNA/CMA). Staff 11 stated Staff 26's demeanor changed if she felt rushed or if she had a bad day. Staff 11 stated she heard Staff 26 be rude to other residents and other staff members observed this behavior as well, but she did not report the behavior to management. On 1/12/26 at 2:42 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified Resident 60 stated she/he felt abused by Staff 26. Staff 1 indicated this was the first he had heard of Resident 60 feeling abused by Staff 26. On 1/12/26 at 2:52 PM Staff 1 and Staff 2 stated their expectation when a resident felt abused by a staff member was for staff to notify both of them immediately. Staff 2 stated staff must notify the provider and family and ensure the safety of all residents.</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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure staff provided two-person assistance when transferring a resident and failed to ensure a environment remained free from accident hazards for 2 of 4 sampled resident (#s 31 and 42) reviewed for accidents. This placed residents at risk for accidents. Findings include:</p> <p>Resident 31 was admitted to the facility in 12/2025 with diagnoses including dementia.</p> <p>A 12/5/25 care plan indicated Resident 31 was at risk for falls and padded fall mats were to be placed at both sides of the bed when Resident 31 was in bed.</p> <p>On 1/13/26 at 9:27 AM, Resident 31 was observed in bed without a fall mat on the left side of her/his bed.</p> <p>On 1/14/26 at 9:01 AM, Resident 31 was observed in bed with the left side of the bed fall mat on the floor, but not next to Resident 31's bed.</p> <p>On 1/14/26 at 2:43 PM, Resident 31 was observed in bed without a fall mat on the left side of her/his bed.</p> <p>On 1/14/26 at 2:45 PM, Staff 4 (CNA) stated Resident 31 was at risk for falls and was to have fall mats on the floor next to her/his bed while Resident 31 was in bed. Staff 4 confirmed Resident 31 did not have a fall mat on the left side of her/his bed and Staff 4 placed the fall mat on the left side of Resident 31's bed.</p> <p>On 1/15/26 at 1:31 PM, Resident 31 was observed in bed, the fall mat for the left side of her/his bed was folded up and leaning against the foot of the bed.</p> <p>On 1/16/26 at 10:26 AM, Staff 5 (LPN Resident Care Manager) stated Resident 31 was at risk for falls and rolled out of bed when she/he first admitted . Staff 5 stated Resident 31 was care planned to have fall mats on the floor on both sides of the bed when she/he was in bed. Staff 5 stated staff were expected to follow the care plan.</p> <p>2. Resident 42 was admitted to the facility in 5/2025 with diagnoses including stroke and weakness.</p> <p>A 5/23/25 care plan revealed Resident 42 required two-person assistance with transfers using FWW (Front Wheeled Walker).</p> <p>A 7/21/25, fall investigation revealed at approximately 10:00 AM Staff 15 (Former CNA) indicated she took Resident 42 to her/his room after a shower. Staff 15 grabbed Resident 42's FWW and assisted her/him to stand. Resident 42 felt her/his legs weaken, lost balance, and fell to the floor. Staff 15 did not review the care plan.</p> <p>-On 7/22/25 Staff 16 (Former LPN) was notified and indicated no injuries were found on the resident.</p> <p>-The investigation indicated during training, CNAs were taught to read the care plan for the</p> <p>(continued on next page)</p>		

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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>residents' care needs. Staff 15 transferred Resident 42 without assistance when the care plan clearly stated she/he was a two-person transfer.</p> <p>-The Root Cause Analysis indicated the biggest contributing factor was Resident 42 was a two person assist with her/his FWW and Staff 15 did not check the care plan.</p> <p>On 1/14/26 4:24 PM Staff 15 stated she transferred Resident 42 to her/his wheelchair with the FWW, and the resident stood up and slid to the floor. Staff 15 stated she did not review the care plan which indicated Resident 42 was a two-person transfer with a FWW before she transferred her/him.</p> <p>On 1/14/26 4:25 PM Staff 16 stated Staff 15 notified her she gave resident 42 a shower and attempted to transfer her/him back to her/his wheelchair when the resident fell. Staff 16 stated Resident 42 was care planned as a two person assist with transfers and Staff 15 completed the transfer alone.</p> <p>On 1/15/26 at 3:02 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Regional Nurse Consultant) acknowledged Resident 42 was a two person transfer which was on her/his care plan. Staff 2 stated expectations were for staff to always look at the care plan before providing care for residents. Staff 3 stated the expectation was for an allegation of abuse or neglect to be reported to the State Survey Agency timely.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview it was determined the facility failed to ensure laundry was cleaned and sorted in a safe manner for 1 of 1 laundry rooms reviewed for infection control. This places residents at risk for exposure to mold and bacteria. Findings include: During the walk through of the facility laundry room on 1/15/26 at 12:11 PM, a hole in the wall was observed next to the wash machine. Behind the two wash machines and a clean linen cart was a large pool of standing water, the water appeared brown and dirty. Along the baseboard of the wall behind the two wash machines was a black substance which extended about an inch up the wall and an inch on the floor. Staff 13 (Housekeeping Director) stated the hole in the wall was present for some time but did not extend into the outside of the building. Staff 13 stated maintenance was notified of the standing water a few weeks ago, but it was not yet repaired. Staff 13 did not know what the black substance was. On 1/15/26 at 1:35 PM the standing water in the laundry room was observed, a cart of clean linen and laundry was near the water and a blanket from the cart was observed partially in the water. Staff 12 (Laundry Aide) confirmed the blanket touched the water and stated the blanket would be recleaned. On 1/15/25 at 3:15 PM Staff 1 (Administrator) walked through the laundry room; there was less standing water and some of the black substance appeared removed. Staff 1 confirmed the standing water and black substance on the wall and floor and acknowledged the laundry area needed to be repaired. Staff 1 asked Staff 12 if the water on the floor happened often, Staff 12 stated it occurred for the last three weeks when the wash machines were in use. Staff 12 stated the water and some of the black substance on the wall were just cleaned up.</p>