STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385053	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to timely report an allegation of potential neglect to the State Agency for 1 of 1 sampled resident (#3) reviewed for CPR. This placed residents at risk of neglect. Findings included:Resident 3 was admitted to the facility in 2/2026 with diagnoses including respiratory failure and pneumonia. The facility's [DATE] investigation documented that staff found Resident 3 and suspected the resident was deceased during routine rounds. The nurse was notified, and the resident was confirmed as deceased . Resident 3 was not on hospice, had a Full Code status, and CPR was not initiated. Included in the investigation on [DATE], six days after the resident's death, that upon the nurse assessment Resident 3 did not have rigor mortis and the nurse did not initiate code blue or resuscitation interventions. A Nursing Facility Reported Incident Form, dated [DATE], indicated the incident from [DATE] was reported to the State Agency on [DATE]. On [DATE] at 12:48 PM, Staff 26 (Regional Director of Quality Assurance) confirmed the facility did not report the incident to the State Agency within the required two-hour timeline.

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
	385053	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, it was determined the facility failed to ensure a safe and orderly discharge was provided for 1 of 3 sampled residents (#8) reviewed for discharge. This placed residents at risk for an unsafe discharge. Findings include:Resident 8 was admitted to the facility in 3/2026 with diagnoses including chronic pain, absence of left leg below the knee, and after care following a surgical amputation. A 3/10/26 admission MDS indicated Resident 8 was cognitively intact and required supervision or touching assistance with toileting, transfers, and bathing. No referrals were documented for medical equipment ordered, or home health referral submitted. A 3/11/26 Discharge Instructions documented Resident 8 was being discharged home and noted her/his current physical status required assistance and assistive devices. A 3/13/26 Nursing Note indicated at 12:23 AM, Resident 8 returned after an outing. The facility notified the police because her/his location was unknown. Resident 8 had been out with friends and was unaware of any concern. A 3/13/26 Social Services Note documented because Resident 8 was out past midnight, she/he was discharging from the facility. NOMNC was not issued due to leaving prior to scheduled discharge and leaving on own initiative. A 3/13/26 Discharge Summary note documented the discharge instructions were reviewed with Resident 8 and she/he refused to sign leaving the facility voluntarily. The facility's Voluntary Consent form included a handwritten statement that Resident 8 refused to sign. On 3/26/25 at 10:58 AM, Resident 8 stated he was kicked out of the facility for coming back late. Resident 8 stated she/he was currently sleeping on a friend's couch, and it was difficult to get around. On 3/30/26 at 10:36 AM, Staff 21 (Business Office Manager) stated Resident 8 did not have any financial notes for lack of payment and she did not have any information about why she/he discharged from the facility. On 3/30/26 at 12:06 PM, Staff 19 (Social Services Coordinator) stated Resident 8 stayed out late and the facility called the police. Resident 8 returned to the facility after midnight and because she/he was a Medicare resident, insurance would not cover her/him if out of the facility past midnight. Staff 19 stated Resident 8 was scheduled for discharge from the facility on 3/17/26. On 3/30/26 at 12:57 PM, Staff 27 (Regional Director of Operations) stated he thought it was a clerical error and confirmed the facility should have completed a normal discharge for Resident 8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385053	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	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)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide CPR according to code status for 1 of 1 sampled resident (#3) reviewed for CPR. This placed all residents with full code status at risk for untimely CPR and constituted substandard quality of care.A determination was made that the facility's noncompliance placed Resident 3 in immediate jeopardy (IJ) and cited as Past Noncompliance. On [DATE] at 10:47 AM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the IJ situation and provided a copy of the template related to the facility's failure to initiate CPR. Findings include:The facility's Emergency Procedure CPR policy initiated in 2001 required a staff member trained in CPR to initiate CPR on unresponsive residents not breathing unless a valid DNR (do not resuscitate) order existed or signs of irreversible death, such as rigor mortis, were present. If the resident's DNR status was unclear, CPR will be initiated until it is determined there was a DNR. Resident 3 was admitted to the facility in 2/2026 with diagnoses including acute respiratory failure, and heart failure. The [DATE] Care Plan included Resident 3 was Full Code (CPR) and the resident's POLST (Portable Orders for Life-Sustaining Treatment) was on file with the facility. The [DATE] POLST indicated Resident 3's code status was Attempt Resuscitation/CPR (meaning the resident desired intervention such as CPR should her/his heart stop beating or she/he stops breathing) and Full Treatment (use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated). The facility's [DATE] investigation documented Staff 5 (CNA) found Resident 3 with no vital signs at about 4:00 AM. Staff 4 (LPN) was notified for further assessment. Staff 4 assessed Resident 3 and determined no pulse, respirations, or heart rate, body cold to the touch and absence of rigor mortis. Staff 4 did not initiate code blue or CPR despite full code status. Resident 3 was full code. The investigation included the following written staff statements:-Staff 5 recorded last vitals around 10:45 PM, 92 percent on one liter of oxygen. At 2:00 AM the resident was sleeping and breathing and brief was dry. At 4:00 AM Staff 5 and Staff 8 (CNA) entered Resident 3's room, and both determined Resident 3 was deceased and informed Staff 4.-Staff 4 reported Resident 3 was found in her/his room by Staff 5 at approximately 3:45 AM and suspected she/he was deceased . Staff 4 entered the room and checked for signs of life. No pulse, blood pressure or respirations. Resident 3's body was cold and suspected to have passed one to two hours. No signs of rigor mortis and some mottled skin on the lower legs. Resident was pale whitish and yellowish in color. Sternal rub serval times with no response. Staff 2 (DNS) and the physician were called. No CPR was attempted or any lifesaving attempts.-No witness statement from Staff 8 (CNA) was included in the investigation. On [DATE] at 1:13 PM, Staff 5 stated he had received recent CPR training before the incident. On [DATE] around 4:00 AM, Staff 5 and Staff 8 entered Resident 3's room and observed her/his skin was yellow. Staff checked the resident's pulse and stated there was no pulse, and the resident's skin was cool to the touch. Staff 5 stated he nor Staff 8 started CPR and went to get Staff 4 (LPN). Staff stated Staff 4 entered the room and felt Staff 4 was haywire and frantic. Staff 5 stated if he had to do it over, he would start CPR until the crash cart came and yell loudly for Code Blue. On [DATE] at 2:10 PM, Staff 8 stated in the summer of 2025 she completed CPR training. On [DATE] around 4:00 AM, she and Staff 5 entered Resident 3's room to complete resident check. Staff 8 stated she noticed right away the resident was not breathing and placed her hand on Resident 3's arm, which was cold, but no rigor mortis and the resident's skin color was yellow. Staff stated that she and Staff 8 went get Staff 4 and when Staff 8 entered the resident's room and suggested starting CPR and to call the paramedics. Staff 8 stated CPR was not administered and if she had to do it over, she would have started CPR and ask Staff 5 to go get Staff 4. On [DATE] at 9:10 AM, Staff 4 (LPN) stated Staff 8 and Staff 5 came and reported to her that Resident 3 was deceased . Staff 4 entered Resident 3's room and stated the resident's hands and feet (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385053	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	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)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were cold. Staff 4 checked for pulse and breathing and found none. Resident 3's skin was yellow in color. Staff 8 stated she did not believe CPR was needed and called Staff 2 and the physician. Staff 8 then called 911 to obtain the coroner's phone number. Staff 8 stated it is facility policy to complete CPR on anyone no matter how long they have been deceased . On [DATE] at 8:44 AM, Staff 2 (DNS) stated she was called by Staff 4 at 4:10 AM informing her of Resident 3's death. Staff 2 stated she expected staff to call a code blue right away, start CPR, call 911 and get the resident's code status. The immediate jeopardy was identified as Past Noncompliance based on the following:On [DATE], the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a delay in initiating CPR. The Plan of Correction included:1. Administrator, DNS and Nursing staff would be re-educated prior to next scheduled shift, on the process for code blue, how to locate a resident's code status in PCC and POLST on file and importance of following individual resident care plans and orders.2. Resident's code status would be crossed referenced with PCC order, POLST scanned in binder, care plan and resident dashboard.3. DNS or Designee to monitor Resident code status preferences for new admissions/returning admissions from hospitalizations for the next seven days.4. Monitoring: DNS or designee would audit code status for all new admissions and readmissions from hospitalization or ED visits weekly for eight weeks. Audit results would be shared with QAPI committee to ensure substantial compliance was maintained.5. DNS or designee would complete mock code on [DATE]. DNS or designee would complete mock cod monthly for three months then quarterly going forward.