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	08/05/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34703 Based on interview and record review it was determined the facility failed to inform residents of the risks and benefits of psychotropic medication use for 1 of 5 sampled resident (#12) reviewed for medications. This placed residents at risk for being uniformed. Findings include: Resident 12 admitted to the facility in 2024 with diagnoses including anxiety disorder and depression. A review a 7/18/24 physician order revealed Resident 12 received Lexapro (antidepressant) daily. A review of the medical record revealed no risk and benefit information for Lexapro. On 8/5/24 at 10:26 AM Staff 2 (DNS) verified the risk and benefit information was not reviewed with Resident 12.

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	08/05/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34703 Based on observation, interview, and record review it was determined the facility failed to assess a resident's ability to self-administer medications for 1 of 1 sampled resident (#11) reviewed for respiratory care. This placed residents at risk for improper medication administration. Findings include: Resident 11 was admitted to the facility in 8/2014 with diagnoses including COPD (lung disease). On 7/31/24 at 10:57 AM Resident 11 was sitting up in bed with two inhaler medications for COPD on the bedside table. Resident 11 explained these medications were used to help her/his breathing. No assessment was found in the medical record for self-administration of medications for Resident 11. On 7/31/24 at 11:23 AM Staff 26 (LPN) confirmed Resident 11 was not assessed to self-administer her/his medications and should have been assessed prior to self-administration of her/his medications.

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	08/05/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47001 Based on interview and record review it was determined the facility failed to ensure residents were treated in a dignified manner for 1 of 3 sampled residents (#265) reviewed for dignity. This placed residents at risk for psychosocial harm. Findings include: Resident 265 was admitted to the facility in 12/2023 with diagnoses including depression. A 12/10/23 MDS indicated Resident 265 was cognitively intact. A review of a 2/9/24 Nursing Facility Reported Incident Form revealed Resident 265 had complained about a HIPPA violation committed by Staff 34 (former SSD). A review of a 2/12/24 witness statement from Staff 35 (Activities Director) revealed on 2/7/24 Staff 35 was driving the bus to the bank and heard Staff 34 talking with Resident 265 about the name Resident 265 preferred to go by and Staff 34 asked Resident 265 about her/his finances. When they returned to the facility, Staff 35 brought Resident 265 to her/his room and Resident 265 expressed to Staff 35 how the interaction with Staff 34 had upset her/him. A review of a 2/12/24 witness statement from Resident 265 stated on 2/7/24 Staff 3 asked her/him all kinds of probing questions about her/his preferred name her/his finances and Staff 34 stated Resident 265's house was in foreclosure. Resident 265 stated she/he told Staff 34 she was wrong and Staff 34 replied and said she had read Resident 265's chart and knew everything about her/him. Resident 265 stated she/he felt her/his HIPPA rights were violated. Resident 265 stated on 2/9/24 Staff 34 came into her/his room. Staff 34 asked how Resident 265 liked her/his new room, Resident 265's hands were shaking and she/he replied the room was ok. Staff 34 stated, it could be worse, you could be homeless. A review of a 2/12/24 witness statement from Staff 34 revealed on 2/7/24 while on the bus she was talking to Resident 265 to try to make a connection with her/him. Staff 34 stated she asked about Resident 265's preferred name and asked about Resident 265's finances. Staff 34 stated there was another resident in the back of the bus but this resident was unable to hear the discussion. Staff 34 stated on 2/9/24 she checked in with Resident 265 and Staff 34 denied any issues from that visit. A review of a 2/12/24 investigation had indicated Staff 34 had violated Resident 265's HIPPA rights and had caused Resident 265 to have increased anxiety and distress. On 8/2/24 at 9:14 AM Staff 36 (CNA) stated Resident 265 had informed her of the incident on the bus on 2/7/24 with Staff 34. Staff 36 stated Resident 265 was a private person and was upset by the incident. (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	08/05/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24 at 10:00 AM Staff 35 stated she was driving Staff 34, Resident 265 and another resident to the bank. The other resident was sitting in the back of the bus and Resident 265 was sitting in the middle of the bus. Staff 35 stated she heard Staff 34 talking to Resident 265 about the name she/he preferred to go by and about Resident 265's house getting foreclosed on. Staff 35 stated she could hear Resident 265 getting upset but Staff 34 kept talking and did not appear to understand Resident 265 was getting upset. When they returned to the facility, Staff 35 took Resident 265 to her/his room. Resident 265 asked Staff 35 why Staff 34 would say those things in front of another resident and Resident 265 stated she felt like her/his privacy was violated. Staff 35 assisted Resident 265 with completing a grievance form. On 8/5/24 at 10:35 AM the investigation was reviewed with Staff 1 (Administrator in Training), no further information was provided.

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	08/05/2024

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. 41455 Based on interview and record review it was determined the facility failed to provide rules and regulations governing resident conduct and responsibilities for 1 of 3 sampled residents (#214) reviewed for food. This placed residents at risk for being unformed about rules for resident conduct. Finding include: Resident 214 was admitted to the facility in 6/2024 with diagnoses including stroke and anxiety. A 1/2024 facility Resident Handbook indicated compact refrigerators may be approved for patient use. A 7/16/24 Quarterly MDS indicated Resident 214 was cognitively intact. On 8/2/24 at 11:38 AM Resident 214 stated Staff 14 (Maintenance Director) at one time indicated small refrigerators were allowed in resident rooms and she/he was confused why a request for her/his own refrigerator was recently denied. Resident 214 stated she/he did not receive a copy of a Resident Handbook upon admission to the facility and had no knowledge related to any official rules related to compact refrigerators in resident rooms. On 8/2/24 at 3:49 PM Staff 1 (Administrator in Training) acknowledged at least since 3/2024 residents were not provided a copy of the Resident Handbook as expected.

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	08/05/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34703 Based on interview and record review it was determined the facility failed to obtain information related to advance directives and health care decisions for 2 of 3 sampled residents (#s 12 and 18) reviewed for advance directives. This placed residents at risk for not having their health care decisions honored. Findings include: 1. Resident 12 was admitted to the facility in 3/2024 with a diagnosis of a hip fracture. A 3/28/24 Admission 72-hour huddle note indicated Resident 12 had an advance directive and a copy was to be retained for the resident's electronic record. Resident 12's clinical record did not contain her/his advance directive. On 8/1/24 at 1:50 PM Staff 24 (Social Services Director) acknowledged Resident 12's electronic record did not contain an advance directive. 47001 2. Resident 18 was admitted to the facility in 5/2016 with diagnoses including congested heart failure (a disease in which the heart cannot pump enough blood). A 5/30/24 care conference indicated Resident 18 would like assistance formulating an Advanced Directive. A 7/30/24 review of Resident 18's medical record revealed no evidence of an Advanced Directive. On 7/31/24 at 10:43 AM Resident 18 stated she/he would like to complete an Advanced Directive. On 8/2/24 at 8:26 AM Staff 24 (Social Service Director) confirmed Resident 18 did not have an Advanced Directive on file.

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	08/05/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 26991 Based on interview and record review it was determined the facility failed to notify family for 2 of 4 sampled residents (#s 4 and 266) reviewed for notification. This placed resident representatives at risk for lack of being informed. Findings include: 1. Resident 4 was admitted to the facility in 1/2024 with a diagnosis of MS (multiple sclerosis: lack of electrical impulses from the brain to the body creating impaired body functions). Resident 4's undated Admission Record revealed Witness 6 (Family) was her/his first emergency contact. A 5/21/24 Progress Note revealed Resident 4 had a change in mentation, loose stools and, dark orange urine. The note indicated a RN sent the resident to the hospital for evaluation based on her/his history of decreased kidney function and diagnosis of MS. The note did not indicate Resident 4's emergency contact was notified. On 8/5/24 at 12:51 PM Witness 6 stated she was not notified of Resident 4's 5/2024 hospitalization . On 8/5/24 at 2:11 PM Staff 1 (Administrator) stated Resident 4's emergency contact was not notified of the resident's change of condition and hospitalization . 41455 2. Resident 266 was admitted to the facility in 7/2024 with diagnoses including dementia and history of UTIs. A 7/26/24 census for Resident 266 revealed she/he moved to a different room on 7/26/24. On 7/29/24 at 8:02 PM Witness 3 (Family) stated she was not informed prior to Resident 266's room move even when Witness 3 arrived for a family visit. Review of Resident 266's clinical record revealed no communication to family related to Resident 266's room move. On 8/2/24 at 3:53 PM Staff 9 (Admission Coordinator) stated she did not consider the impact of a room move on Resident 266 with her/his dementia. Staff 9 acknowledged the move occurred without family involvement and there was no written communication related to Resident 266's room move.

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	08/05/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41455 Based on interview and record review it was determined the facility failed to maintain resident rights to privacy for 2 of 5 sampled residents (#s 263 and 265) reviewed for dignity and privacy. This placed residents at risk for psychosocial harm. Findings include: 1. Resident 263 was admitted to the facility in 6/2023 with diagnoses including dementia and malnutrition. A 1/16/24 Quarterly MDS indicated Resident 263 was cognitively impaired. A 2/9/24 Discharge Plan of Care indicated Resident 263 was discharged to a memory care facility. On 7/30/24 at 10:15 AM Witness 4 stated unwanted family members entered Resident 263's new memory care facility and she was unaware how they obtained the information regarding Resident 263's discharge location. A 7/31/24 Contacts list for Resident 263 indicated only Witness 4 (Family) and Witness 5 (Family) had access to Resident 263's medical information. On 7/31/24 at 4:18 PM Staff 1 (Administrator in Training) acknowledged she was aware Staff 27 (former Social Service Director) informed family members who were not on Resident 263's contact list about Resident 263's discharge location. 47001 2. Resident 265 was admitted to the facility in 12/2023 with diagnoses including depression. A 12/10/23 Admission MDS indicated Resident 265 was cognitively intact. A review of a 2/9/24 Nursing Facility Reported Incident Form revealed Resident 265 had complained about a HIPPA violation committed by Staff 34 (former SSD). A review of a 2/12/24 witness statement from Staff 35 (Activities Director) revealed on 2/7/24 Staff 35 was driving the bus to the bank and heard Staff 34 talking with Resident 265 about the name Resident 265 preferred to go by and Staff 34 asked Resident 265 about her/his finances. When they returned to the facility, Staff 35 brought Resident 265 to her/his room and Resident 265 expressed to Staff 35 how the interaction with Staff 34 had upset her/him. (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	08/05/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a 2/12/24 witness statement from Resident 265 stated on 2/7/24 Staff 34 asked her/him all kinds of probing questions about her/his preferred name her/his finances and Staff 34 stated Resident 265's house was in foreclosure. Resident 265 stated she/he told Staff 34 she was wrong and Staff 34 replied and said she read Resident 265's chart and knew everything about her/him. Resident 265 stated she/he felt her/his HIPPA rights were violated. Resident 265 stated on 2/9/24 Staff 34 came into her/his room. Staff 34 asked how Resident 265 liked her/his new room, Resident 265's hands were shaking and she/he replied the room was ok. Staff 34 stated, it could be worse, you could be homeless. A review of a 2/12/24 witness statement from Staff 34 stated on 2/7/24 while on the bus she was talking to Resident 265 to try to make a connection with her/him. Staff 34 stated she asked about Resident 265's preferred name and asked about Resident 265's finances. Staff 34 stated there was another resident in the back of the bus but this resident was unable to hear the discussion. Staff 34 stated on 2/9/24 she checked in with Resident 265 and Staff 34 denied any issues from that visit. A review of a 2/12/24 investigation had indicated Staff 34 violated Resident 265's HIPPA rights and caused Resident 265 to have increased anxiety and distress. On 8/2/24 at 9:14 AM Staff 36 (CNA) stated Resident 265 informed her of the incident on the bus on 2/7/24 with Staff 34. Staff 36 stated Resident 265 was a private person and was upset by the incident. On 8/2/24 at 10:00 AM Staff 35 stated she was driving Staff 34, Resident 265 and another resident to the bank. The other resident was sitting in the back of the bus and Resident 265 was sitting in the middle of the bus. Staff 35 stated she heard Staff 34 talking to Resident 265 about the name she/he preferred to go by and about Resident 265's house getting foreclosed on. Staff 35 stated she could hear Resident 265 getting upset but Staff 34 kept talking and did not appear to understand Resident 265 was getting upset. When they returned to the facility, Staff 35 took Resident 265 to her/his room. Resident 265 asked Staff 35 why Staff 34 would say those things in front of another resident and Resident 265 stated she felt like her/his privacy was violated. Staff 35 assisted Resident 265 complete a grievance form. On 8/5/24 at 10:35 AM the investigation was reviewed with Staff 1 (Administrator in Training), no further information was provided.

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	08/05/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34703 Based on observation, interview, and record review it was determined the facility failed to provide a comfortable and homelike environment for 1 of 4 sampled residents (#48) reviewed for ADLS. This placed residents at risk for an unhomelike living environment. Findings include: Resident 48 admitted to the facility in 3/2024 with diagnoses including palliative care and schizophrenia (mental illness). Observations made from 7/29/24 through 8/1/24 on day and evening shifts revealed the following: -7/29/24 at 2:13 PM, fall mats with dried white and yellow debris, brown dirt and a blanket were on top of the fall mats. Washcloths in the resident's sink with a dark brown substance on them. -7/30/24 at 9:10 AM, fall mats still with dried white and yellow debris and what appeared to be pink ice cream or juice. -8/1/24 at 10:55 AM, large towels remained on the floor mat and dirty wash clothes in sink. Staff 19 (CNA) was observed going in and out of the resident's room without grabbing the dirty towels or washcloths. -8/1/24 at 11:02 AM, large towels with yellow and brown debris on the fall mats, and wash clothes in the sink with brown debris on them. -On 8/1/24 at 11:10 AM, Staff 29 (Regional Nurse Consultant) observed Resident 48's room and acknowledged the room was not a homelike environment.

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	08/05/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34703 Based on interview and record review it was determined the facility failed to ensure residents were free from neglect for 1 of 1 sampled resident (#264) reviewed for accidents. This place residents at risk for neglect. Findings include: Resident 264 admitted to the facility in 4/2024 with diagnoses including leg surgery and chronic pain. An 4/23/24 Admission MDS indicated Resident 264 was cognitively intact. A FRI (facility reported incident) indicated on 4/28/24 at 8:00 PM Resident 264 requested tea from Staff 28 (Former CNA). The tea was brought in a hydration mug with a straw, Resident 264 took a drink through the straw and the hot water burnt her/his tongue and roof of her/his mouth. The FRI indicated the administrator was notified on 4/29/24 at 11:00 AM A facility investigation, finalized on 4/29/24, concluded neglect was substantiated as Resident 264 was injured from the hot tea. On 7/31/24 at 11:25 AM Staff 19 (CNA) stated staff training involved not serving the resident really hot beverages, and to make sure the beverages are tempted before serving them to the residents. On 7/31/24 11:45 AM Resident 264 stated she/he was getting ready for bed and Staff 28 offered the resident some hot tea. Resident 264 stated Staff 28 returned with her/his hydration mug which had a large plastic straw, and took a large drink of the tea and burnt her/his mouth. Resident 264 stated Staff 28 filled the mug with extremely hot water and neglected to warn her/him that the tea was very hot. Resident 264 stated she/he was screaming from the pain, and burnt her/his throat and tongue. Resident 264 stated skin came off the roof or her/his mouth, and the pain lasted for approximately two days. On 7/31/24 at 12:14 PM Staff 8 (CNA) stated staff completed training related to hot beverages and to make sure they are not too hot for the residents. On 8/1/24 at 2:40 PM Staff 6 (LPN-Resident Care Manager) acknowledged the tea was hot enough to burn Resident 264's mouth and tongue and caused discomfort. Staff 6 stated staff completed training related to serving hot beverages to residents. Staff 6 acknowledged the staff member should have tempted the beverage before serving it to Resident 264.

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	08/05/2024

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. 34703 Based on interview and record review it was determined the facility failed to report an allegation of neglect to the appropriate State Agency within two hours for 1 of 1 sampled resident (#264) reviewed for accidents. This placed residents at risk for abuse and neglect. Findings include: Resident 264 admitted to the facility in 4/2024 with diagnoses including leg surgery and chronic pain. An 4/23/24 Admission MDS indicated the Resident 264 was cognitively intact. A FRI (facility reported incident) indicated on 4/28/24 at 8:00 PM Resident 264 requested tea from Staff 28 (Former CNA). The tea was brought in a hydration mug with a straw, Resident 264 took a drink through the straw and the hot water burnt her/his tongue and roof of her/his mouth. The FRI indicated the administrator was notified on 4/29/24 at 11:00 AM A facility investigation, finalized on 4/29/24, concluded neglect was substantiated as Resident 264 was injured from the hot tea. On 8/1/24 at 2:40 PM Staff 6 (LPN-Resident Care Manager) acknowledged he was aware of the incident on 4/28/24 at 8:00 PM but did not send the FRI to the State Agency until 4/29/24 at 12:00 PM. Staff 6 acknowledged the facility did not report the neglect within the two hour timeframe.

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	08/05/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41455 Based on observation, interview and record review it was determined the facility failed to implement a comprehensive care plan for 3 of 9 sampled residents (#s 2, 165, and 266) reviewed for medications, accidents, and hospice. This placed residents at risk for unmet care needs. Finding include: 1. Resident 2 was admitted to the facility in 2/2024 with diagnoses including diabetes and dementia. The 6/5/24 revised care plan indicated there was no initial care plan for Resident 2's diabetic goals and interventions. The 6/30/24 through 7/30/24 Order Review History Report indicated Resident 2 had multiple orders for diabetic care which started on 2/26/24 including nail care by nursing. The 7/2024 Diabetic Administration Record indicated Resident 2 received insulin each morning. On 8/1/24 at approximately 1:00 PM Staff 23 (LPN-Resident Care Manager) acknowledged Resident 2 lacked a diabetic care plan. 2. Resident 266 was admitted to the facility in 7/2024 with diagnoses including dementia and history of UTIs. A 7/16/24 Elopement Risk Evaluation identified Resident 266 as high risk for wandering. A 7/16/24 care plan had no goal or interventions related to Resident 266's high risk for wandering. On 7/29/24 at 12:41 PM and 3:05 PM Resident 266 was observed in the hall while wandering in her/his wheelchair and asked to get out of the building to find her/his car and family. On 8/1/24 at 12:46 PM Staff 6 (LPN-Resident Care Manager) acknowledged Resident 266's care plan was not complete related to her/his risk of elopement. 34703 3. Resident 165 was admitted to the facility in 7/2024 with diagnoses including hospice care. A review of Resident 165's clinical record revealed no comprehensive care plan was completed related to the resident's hospice care and or scheduled hospice visits. On 8/5/24 at 9:56 AM Staff 2 (DNS) acknowledged Resident 165's comprehensive care plan did not include any information regarding hospice care and services or scheduled hospice visits.

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	08/05/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 26991 Based on interview and record review it was determined the facility failed to update care plans for 4 of 11 sampled residents (#s 4, 15, 18, and 48) reviewed for UTIs, medications, ADLs, and accidents. This placed residents at risk for unmet care needs. Findings include: 1. Resident 4 was admitted to the facility in 1/2024 with a diagnosis of MS (multiple sclerosis: lack of electrical impulses from the brain to the body creating impaired body functions). Resident 4's care plan initiated on 5/7/24 revealed her/his urinary catheter was to be flushed (instilling a sterile solution into the catheter to ensure the tubing does not clog) three times per week. A 7/20/24 Progress Note revealed Resident 4's urology (specialized in urinary systems i.e. bladder, kidneys etc.) clinic sent physician orders to flush her/his urinary catheter (medical tubing inserted in the bladder to drain urine) one to two times each day. On 8/2/24 at 10:59 AM Staff 23 (LPN Resident Care Manager) stated when new orders were received for residents, the floor nurses were to update care plans. Staff 23 stated Resident 4's care plan was not updated to reflect a change in urinary catheter flushes. 2. Resident 15 was admitted to the facility in 11/2016 with a diagnosis of heart disease. A Care Plan revised on 5/16/24 revealed Resident 15 was at risk for falls and non-slip material was to be placed on her/his walker handles to prevent her/his hands from slipping. A 5/22/24 quarterly MDS indicated Resident 15 was cognitively intact. On 7/31/24 at 10:58 AM Resident 15's walker handles were observed without non-slip material. Resident 15 stated the non-slip material always came off and she/he did not use it because her/his hands did not slip. On 8/2/24 at 8:39 AM Staff 23 (LPN Resident Care Manager) stated she was not aware the resident no longer used the non-slip material on her/his walker and acknowledged the care plan was not updated. 47001 3. Resident 18 was admitted to the facility in 5/2016 with diagnoses including atrial fibrillation (an irregular heartbeat). A review of Resident 18's physician orders revealed a 7/11/22 order for apixaban, an anticoagulant medication (a blood thinner). A 7/31/24 review of Resident 18's care plan revealed no evidence of a care plan for anticoagulant medication. (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	08/05/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/24 at 1:52 PM Staff 23 (LPN Resident Care Manager) Stated Resident 18 took an anticoagulant medication, apixaban, and confirmed Resident 18 was not care planned for anticoagulant medications. 34703 4. Resident 48 was admitted to the facility in 4/2024 with diagnoses including paranoid schizophrenia (mental disorder), chronic bed confinement, and hospice care. Resident 48's 3/14/24 care plan indicated the resident was moderate risk for falls related to a history of falls. The resident is bedbound with impaired mobility. Observations from 7/29/24 through 8/1/24 on day and evening shifts revealed Resident 48 had bilateral fall mats. On 7/31/23 at 11:06 AM Witness 9 (Caregiver) stated Resident 48 had fall mats for a while related to falls. On 8/2/24 at 9:35 AM Staff 23 (LPN-Resident Care Manager) acknowledged Resident 48 had bilateral fall mats related to falls but the care plan was not revised for the fall mats.

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	08/05/2024

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 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. 34703 Based on observation, interview, and record review it was determined the facility failed to provide care and services to maintain good grooming and hygiene for 2 of 4 sampled residents (#s 48 and 164) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include: 1. Resident 48 was admitted to the facility in 3/2024 with diagnoses including hospice services and chronic bed confinement. The 3/11/24 care plan indicated Resident 48 was totally dependent on staff for personal hygiene care and dressing. On 7/29/24 at 2:32 PM Resident 48 was observed to have greasy, uncombed hair, long jagged fingernails with brown debris underneath, food on her/his face and in her/his mouth, facial hair, and a shirt with dried dark brown debris. On 7/31/24 at 11:06 AM Witness 9 (Caregiver) stated Resident 48 did not receive the ADLS care she/he needed. Witness 9 stated Resident 48 needed staff to wash her/his hair, trim and clean her/his nails, shave her/him daily, lotion her/his dry feet, and put a clean shirt on the resident daily. Witness 9 stated she completed the ADL care while visiting but staff should provide the care. On 8/2/24 at 9:35 AM Staff 23 (LPN-Resident Care Manager) acknowledged Resident 48 should be cleaned up daily which included being shaved per her/his request. Staff 23 stated all ADLS should be completed by staff daily as the standard of care and not Witness 9. 2. Resident 164 was admitted to the facility in 7/2024 with diagnoses including hospice services and chronic dementia. The 7/12/24 care plan directed staff to provide constant/intermittent supervision with physical assist combing hair, brushing teeth, shaving, washing and drying face and hands. On 7/30/24 at 2:32 PM Resident 164 was observed with long fingernails with brown debris underneath. On 8/2/24 at 9:47 AM Staff 23 (LPN-Resident Care Manager) acknowledged Resident 164's nails were long with brown debris underneath and needed to be cleaned.

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	08/05/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 26991 Based on observation, interview, and record review it was determined the facility failed to follow-up with pain medication, perform neuro checks, follow physician orders and perform wound assessments for 5 of 10 sampled residents (#s 4, 15, 42, 163, and 165) reviewed for pain, accidents, UTI, and hospice. This placed residents at risk for unmet care needs. Findings include: 1. Resident 4 was admitted to the facility in 1/2024 with a diagnosis of MS ((multiple sclerosis: lack of electrical impulses from the brain to the body creating impaired body functions). A 7/2024 TAR revealed when Resident 4's urinary catheter (medical tubing inserted in the bladder to drain urine) was replaced, staff were to obtain a UA and culture (identified orginisms which caused a UTI). A 7/18/24 Progress Note revealed Resident 4 reported abdominal pain and there was no urine in the resident's catheter tubing or catheter urine collection bag. Staff replaced the existing catheter with a new sterile catheter and obtained a urine sample. A 7/18/24 Lab Results Report revealed the UA was not completed because the temperature of the sample was not correct and the urine was sent in the incorrect specimen collection tube. Resident 4's clinical record revealed no information to indicate a new sample was obtained. On 8/2/24 at 10:59 AM Staff 23 (LPN Resident Care Manager) stated if the sample was not able to be processed in the lab, staff should communicate with the physian and obtain orders if the UA was to be recollected. Staff 23 stated this was not done for Resident 4's 7/18/24 urine sample. 2. Resident 15 was admitted to the facility in 11/2016 with a diagnosis of heart disease. A 5/15/24 fall investigation revealed Resident 15 fell and hit her/his head. The fall was not observed by staff. A 5/15/24 Neurological Flow Sheet (a tool to identify a head injury) revealed staff were to obtain vital signs, check pupil size, assess if a resident could follow commands, and the assess the strength of her/his legs and arms. 12 of 22 opportunies a complete assessment was not performed. Eight of the incomplete assessments indicated Resident 4 refused the assessment or was sleeping. A 5/22/24 quarterly MDS revealed Resident 15 was cognitively intact. On 7/31/24 at 12:11 PM Resident 15 stated she/he did not refuse the neurological assessments and stated the assessments were important for the staff to monitor her/him after a fall when her/his head hit the floor hard. On 7/31/24 at 1:16 PM Staff 2 (DNS) stated the assessments should have been done to ensure the resident did not have a head injury. If the resident was asleep, staff should wake the resident and complete the assessment. (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	08/05/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 163 was admitted to the facility in 5/2024 with a diagnosis of cervical (neck) spine surgery. A 5/29/24 Admission Nursing Database assessment revealed Resident 163 had a neck incision and it was covered with a neck brace. There was no assessment of the incision. Resident 163's clinical record from 5/29/24 through 6/3/24 did not include any assessment of her/his incision. A 6/3/24 Discharge Skin Summary revealed the resident had a surgical incision that was covered. There was no assessment to describe the status of the incision. On 7/29/24 at 12:30 PM Witness 7 (Complainant) stated the dressing to the incision was not removed until 6/3/24 when Resident 163 was discharged from the facility and admitted to a new nursing facility. Witness 7 stated when the new facility staff removed the dressing the incision did not have signs of infection and was healing. On 8/1/24 at10:35 AM Staff 2 (DNS) stated she was not able to find an assessment of Resident 163's incision. 47001 4. Resident 42 was admitted to the facility in 7/2023 with diagnoses including spinal stenosis (a narrowing of the spinal canal in the lower part of the back). A review of a 12/7/23 neurology appointment form revealed orders for a MRI (magnetic resonance imaging test that uses magnets and radio waves to make detailed pictures of the inside of the body) of Resident 42's spine. A 2/15/24 Progress Note stated Resident 42 was unable to get an MRI completed due to a pacemaker with no information available on the type of pacemaker. The Progress Note stated the neurologist's office was to fax an order for a CT scan (computed tomography is a diagnostic test that uses a series of computerized views take from different angles to create internal pictures of the body). A review of Resident 42's medical record revealed no evidence of an order for a CT scan and no evidence it was completed. On 8/5/24 at 9:39 AM Staff 2 (DNS) stated Resident 42 was unable to get a MRI completed because there was no information about her/his pacemaker that was placed in China. Staff 2 stated the neurology office was notified in 2/2024 and was to send orders for a CT scan. Staff 2 confirmed there was no other documentation related to the CT scan and the it had not been completed. 34703 5. Resident 165 was admitted to the facility in 7/2024 with diagnoses including hospice. (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	08/05/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/19/24 care plan for Resident 165 provide instructions for pain management including: assessment, monitoring for pain as well as prompt treatment with ordered pain medication. The goal was for Resident 165 to verbalize satisfaction with pain management by decreased reports of pain. The 7/23/24 Admission MDS indicated Resident 165 had pain related to lower left extremity infection. A progress note dated 7/21/24 at 5:20 PM indicated Resident 165 stated her/his pain was not well controlled with current medications. The on-call hospice nurse was to inform the hospice office on the morning of 7/22/24. A progress note dated 8/2/24 at 11:28 PM indicated hospice had an order for Resident 165 to receive morphine IR (immediate release). The note further indicated the resident was made aware due to her/him requesting the medication for a while. A progress note dated 8/2/24 at 1:31 PM indicated Resident 165 was not getting pain relief from the current regimen. Staff 17 (LPN) stated she told hospice again of the resident's concerns, but no new orders were provided. On 7/29/24 at 1:06 PM Resident 165 stated she/he had been asking hospice for morphine IR because the regimen she/he was on did not control her/his pain. On 7/30/24 at 1:44 PM Resident 165 was observed in her/his room and stated she/he was painful and her/his pain medications were not working. On 8/1/24 at 1:46 PM Resident 165 was observed in her/his room and stated she/he was in a lot of pain. Resident 165 stated she/he thought hospice was supposed to keep her/him comfortable but they were not. On 8/5/24 at 10:00 AM Staff 2 (DNS) stated she could not find physician notes indicating why the resident was not started on morphine IR when hospice was notified on 7/21/24.

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	08/05/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47001 Based on interview, and record review it was determined the facility failed to investigate a new facility acquired pressure ulcer for 1 of 2 sampled residents (#20) reviewed for pressure ulcers. This placed residents at risk for worsening pressure ulcers. Findings include: Resident 20 was admitted to the facility in 2/2020 with diagnoses including hemiplegia (paralysis of one side of the body) of the left nondominant side. A 7/29/24 review of Resident 20's medical record revealed a 2/9/24 facility acquired stage 3 pressure ulcer (a full thickness tissue loss wound cause by pressure) to her/his sacrococcygel (tailbone). A review of a 7/29/24 Wound Evaluation revealed a stage 3 wound on Resident 20's sacrococcygel which measured 0.76 cm by 0.5 cm. On 8/1/24 at 12:28 PM Staff 37 (Regional Nurse Consultant) stated there was no investigation completed for Resident 20's 2/9/24 facility acquired pressure ulcer to her/his sacrococcygel. On 8/2/24 at 10:53 AM Resident 20 was observed to have an open stage 3 wound on her/his right upper buttock near the sacrococcygel area. Resident 20's wound and entire buttock area was surrounded by red moisture associated damaged skin.

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	08/05/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview, and record review it was determined the facility failed to ensure windows on the first floor locked for 1 of 1 sampled resident (#163) reviewed for accidents. This placed residents at risk for an unsecured environment. Findings include: 1. Resident 163 was admitted to the facility in 5/2024 with a diagnosis of spinal (neck) surgery. A Census report from 5/29/24 through 6/3/24 revealed Resident 163 resided in room [ROOM NUMBER] and 205. While in both rooms, Resident 163 was in a bed located by a window. On 7/29/24 at 12:30 PM Witness 7 (Complainant) stated Resident 163's windows were able to be opened even when the locking device was utilized. On 7/31/24 at 7:50 AM Staff 14 (Maintenance) verified the windows in both 201 and 205 had broken locking devices and were easily opened. Staff 14 stated he was not aware of the issue.

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	08/05/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 26991 Based on interview and record review it was determined the facility failed to provide adequate care for 2 of 3 sampled residents (#s 4 and 266) reviewed for UTIs. This placed residents at risk for UTIs. 1. Resident 4 was admitted to the facility in 1/2024 with a diagnosis of MS (multiple sclerosis: lack of electrical impulses from the brain to the body creating impaired body functions). A 1/26/24 admission MDS revealed Resident 4 had a urinary catheter (medical tubing inserted in the bladder to drain urine) and staff were to ensure the urine flowed to prevent UTIs. A 7/2024 TAR and associated Progress Notes revealed staff were to flush (instill sterile fluid to prevent the tubing from clogging) Resident 4's urinary catheter on Monday, Wednesday, and Fridays. From 7/1/24 through 7/19/24 staff had eight opportunities to flush the catheter. On five occasions the flush was not completed due to lack of sterile solution or did not occur. On 8/5/24 at 12:51 PM Witness 6 (Family) stated Resident 4 was susceptible to UTIs and staff were to flush the catheter to ensure good urine flow. One Friday, staff did not flush the catheter and the staff reported it would get done on the next scheduled Monday. On 8/5/24 at 2:11 PM Staff 29 (Regional RN Consultant) stated there was a nationwide recall of sterile water. If a resident's catheter was not able to be flushed due to lack of supply, the physician was to be notified to determine if an alternate solution was to be used. A request was made to Staff 29 to provide documentation the flushes were completed as ordered. No additional information was provided. 41455 2. Resident 266 was admitted to the facility in 7/2024 with diagnoses including dementia and history of UTIs. A 6/19/24 hospital History and Physical indicated Resident 266 was seen at the emergency department and admitted to the hospital with increased confusion, dark urine and a fever. A 7/9/24 hospital Progress Note indicated Resident 266's repeat UTIs were most likely due to poor perineum (area around genitals) hygiene based on her/his unique anatomical features. A 7/16/24 care plan indicated Resident 266 required intermittent to constant supervision for personal hygiene including hands and perineum and had acute pain related to UTIs. A 7/22/24 Admission MDS indicated Resident 266 was frequently incontinent of bladder and never incontinent of bowel. (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	08/05/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 12:06 PM Staff 11 (CNA) stated she understood general perineum care but did not recall any communication or training related to Resident 266's unique needs. On 8/1/24 at 12:46 PM Staff 6 (LPN-Resident Care Manager) stated Witness 3 (Family) revealed Resident 266 had distinct behaviors which increased with her/his UTIs and Witness 3 was informed by the hospital that lack of Resident 266's perineum care was likely the cause of her/his repeat UTIs. Staff 6 stated he did not review Resident 266's hospital notes and acknowledged Resident 266's care plan lacked personalized details related to her/his UTI symptoms. Staff 6 acknowledged he did not inform all CNAs verbally or update the resident's care plan regarding the need for improved perineum care for Resident 266.

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	08/05/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34703 Based on observation, interview, and record review it was determined the facility failed to ensure residents' respiratory equipment was maintained for 3 of 6 sampled residents (#s 11, 164 and 267) reviewed for respiratory, ADLs and dialysis. This placed residents at risk for respiratory issues. Findings include: 1. Resident 11 was admitted to the facility in 8/2014 with diagnoses including COPD (lung disease). The facility's revised Policy and Procedure dated 11/2011 indicated the following: - after a nebulizer (a compressor which turns liquid medications into a fine mist which is inhaled through a mouthpiece) treatment the nebulizer container should be removed, rinsed with fresh tap water, and dried on a clean paper towel or gauze sponge -reconnect to the administration set-up when air dried -Take care not to contaminate the internal nebulizer tubes -Wipe the mouthpiece with a damp paper towel or gauze sponge -Store the circuit in a plastic bag -Discard the administration set-up every seven days Observations from 7/29/24 through 8/5/24 on day and evening shifts revealed Resident 11 had nebulizer equipment including the mouthpiece in her/his recliner, laying on an emesis bag, urinal, and incontinent wipes. An incontinent pad, dirty shirt and dirty pillowcases were also on top of the equipment. A review of the resident's medical record revealed no documentation for the care and services of the nebulizer. On 8/2/24 at 9:21 AM Staff 23 (LPN-Resident Care Manager) confirmed Resident 11's nebulizer was not cleaned or stored in a sanitary manner and there was nothing in the resident's medical record for the care and services of the nebulizer. 2. Resident 164 was admitted to the facility in 7/2024 with diagnoses including pneumonia and hypoxia (oxygen deficiency). The facility's revised Policy and Procedure dated 11/2011 indicated the following: - after a nebulizer (a compressor which turns liquid medications into a fine mist which is inhaled through a mouthpiece) treatment the nebulizer container should be removed, rinsed with fresh tap water, and dried on a clean paper towel or gauze sponge (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	08/05/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-reconnect to the administration set-up when air dried -Take care not to contaminate the internal nebulizer tubes -Wipe the mouthpiece with a damp paper towel or gauze sponge -Store the circuit in a plastic bag -Discard the administration set-up every seven days Observations from 7/29/24 through 8/5/24 on day and evening shifts revealed Resident 164 had nebulizer equipment including the mouthpiece on her/his night stand with a bag of incontinent briefs, and bedding laying on top of the equipment. A review of the resident's medical record revealed no documentation for care and service of the nebulizer. On 8/2/24 at 9:47 AM Staff 23 (LPN-Resident Care Manager) confirmed Resident 164's nebulizer was not cleaned or stored in a sanitary manner and there was nothing in the resident's medical record regarding the care and services of the nebulizer equipment. 41455 3. Resident 267 admitted to the facility in 7/2024 with diagnoses including kidney failure and sleep apnea (interruption in breathing). A 7/24/24 Nursing Admission Assessment for respiratory indicated Resident 267 had a CPAP (Continuous Positive Airway Pressure) machine. Review of the clinical record for Resident 267 did not indicate any care plan interventions or treatments related to her/his CPAP machine. On 8/1/24 at 10:29 AM Resident 267 was observed in bed with a CPAP machine and exposed mask on her/his bedside table with a package of bowel movement wipes placed on top of the mask. [NAME] flecks were observed inside the tubing connected to the CPAP machine. On 8/1/24 at 11:04 AM Staff 11(CNA) confirmed Resident 267's CPAP mask was exposed during the day on her/his bedside table whenever she worked. On 8/1/24 at 11:06 AM Staff 6 (LPN-Resident Care Manager) acknowledged there was no follow-up to obtain orders or care plan for Resident 267's CPAP machine, the tubing was dirty, and the CPAP mask was improperly stored.

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	08/05/2024

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 41455 Based on interview and record review it was determined the facility failed to evaluate and provide person centered interventions for 1 of 1 sampled resident (#51) reviewed for mood and behavior. This place residents at risk for re-traumatization. Finding include: Resident 51 was admitted to the facility in 5/2024 with diagnoses including PTSD (Post Traumatic Stress Disorder) and anxiety. A 5/25/24 care plan for trauma indicated Resident 51 had PTSD and to ask permission to approach the resident during activities such as personal care, delivering medication and combing/brushing of hair (which were not mentioned as triggers by Resident 51). An activity intervention included not to touch Resident 51 when she/he was sleeping. On 7/29/24 at 12:14 PM Resident 51 stated she/he had disturbing nightmares related to combat and staff were not aware of how to assist with her/his PTSD. Staff 51 stated she/he had requested counseling but there was no followup to the request. On 8/2/24 at 9:22 AM Staff 15 (CNA) confirmed Resident 51 had one to three disruptive nightmares weekly and believed other CNAs documented the nightmares. On 8/2/24 at 9:38 AM Staff 6 (LPN-Resident Care Manager) stated no nightmares were documented for Resident 51 so this issue was not addressed. On 8/2/24 at 10:08 AM Staff 24 (Social Services Director) stated no assessment form for PTSD was available or completed when Resident 51 was admitted so details about Resident 51's PTSD were unknown. Staff 24 stated he was unaware of Resident 51's request for counseling. On 8/2/24 at 10:18 AM Staff 2 (DNS) stated there was no formal training for PTSD when a new PTSD form was introduced six months prior. Staff 2 acknowledged the facility should have evaluated Resident 51 on admission for her/his PTSD, the care plan for trauma for the resident should be personalized and charting for Resident 51's nightmares needed to improve.

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	08/05/2024

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 26991 Based on interview and record review it was determined the facility failed to complete nurse aide performance reviews every twelve months for 3 of 5 sampled CNAs (#s 3, 4, and 7) reviewed for staffing. Findings include: Review of 5/23/24 through 7/2024 training documents revealed the following: -Staff 3's last performance review was in 2022. -Staff 4's last performance review was in not in her record and her hire date was 7/18/22. -Staff 7's last performance review was in 2022. On 8/1/24 at 8:30 AM Staff 2 (DNS) verified Staff #s 3, 4, and 7 did not have their annual performance reviews.

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	08/05/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 47001 Based on interview and record review it was determined the facility failed to provide monitoring for anticoagulant medications for 1 of 5 sampled residents (#18) reviewed for medications. This placed residents at risk for unidentified medication adverse side effects. Findings include: Resident 18 was admitted to the facility in 5/2016 with diagnoses including atrial fibrillation (an irregular heartbeat). A review of Resident 18's physician orders revealed a 7/11/22 order for apixaban, an anticoagulant medication (a blood thinner). A 7/31/24 review of Resident 18's care plan revealed no evidence of a care plan for anticoagulant medication. An 8/2/24 review of Resident 18's medical record revealed no evidence of monitoring for adverse side effects from anticoagulant medications. On 8/2/24 at 1:52 PM Staff 23 (LPN Resident Care Manager) Stated Resident 18 took an anticoagulant medication, apixaban, and should have been monitored for adverse side effects such as bleeding and bruising. Staff 23 confirmed Resident 18 was not monitored for adverse side effects from anticoagulant medications.

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	08/05/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34703 Based on interview and record review it was determined the facility failed to attempt a gradual dose reduction and montior for psychotropic medications for 2 of 5 sampled residents (#s 12 and 15) reviewed for medications. this placed residents at risk for adverse medication reactions. Findings include: 1. Resident 12 admitted to the facility in 3/2024 with diagnoses including anxiety disorder and depression. A review of 7/2024 MAR revealed Resident 12 was administered Lexapro (antidepressant), Trazodone (antidepressant), Xanax (antianxiety) and Buspirone (antianxiety). A review of the 7/2024 behavior monitors revealed interventions but did not list triggers for the resident's behaviors. On 8/1/24 at 10:46 AM Staff 15 (CNA) stated Resident 12 had triggers which made her/his anxiety worse. Staff 15 stated her/his triggers were when therapy comes into her/his room without some notification, if her/his call light was not answered timely, and if she/he feels lonely. Staff 15 stated there were more, but those were the main triggers. On 8/2/24 at 2:24 PM Staff 6 (LPN-Resident Care Manager) stated Resident 12 had triggers which made her/his anxiety and depression worse but they were not listed and staff were not aware of her/his triggers. Staff 6 acknowledged Resident 12 was not monitored appropriately for Lexapro, Trazodone, Xanax, and Buspirone. 26991 2. Resident 15 was admitted to the facility in 11/2016 with a diagnosis of heart disease. 8/8/23 through 10/31/23 Progress Notes revealed Resident 15 did not exhibit behaviors or change in mood. An undated medication report revealed on 10/21/23 Resident 15's Wellbutrin (antidepressant) was increased from 300 mg daily to 450 mg daily. A 12/21/23 Psychotropic Medication review revealed Resident 15 was pleasant to staff and no behaviors or moods were documented for the quarter. The form indicated Resident 15's last Wellbutrin GDR was 12/27/22. A 12/2023 MAR revealed Resident 15 was administered 450 mg daily. A 6/18/24 Psychotropic Medication review revealed Resident 15's last GDR was 12/6/23. (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	08/05/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/2/24 at 8:39 AM Staff 23 (LPN Resident Care Manager)acknowledged the increase in her/his Wellbutrin in 10/2023. A request was made to Staff 23 to provide documentation to justify the increase to the dosage of Wellbutrin and the rationale for no GDR in 12/2023. No additional information was provided.

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	08/05/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 26991 Based on observation and interview it was determined the facility failed to ensure a treatment cart was locked for 1 of 2 units (Shasta Unit). This placed residents at risk for injury. Findings include: On 7/30/24 at 2:23 PM to 2:43 PM a Shasta Unit treatment cart was observed to be unlocked. The cart was in an alcove and one wall of the alcove blocked the view of the cart from the nurse's station. Nursing staff and therapy staff walked by the cart at 2:28 PM, 2:33 PM, and 2:36 PM and did not lock the cart. On 7/30/24 at 2:43 PM Staff 31 (LPN) stated she just came on shift, was not aware the treatment cart was unlocked, and it should be locked.

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	08/05/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41455 Based on observation, interview and record review the facility failed to prepare therapeutic diets for 1 of 3 sampled residents (#267) reviewed for nutrition. This placed residents at risk for compromised nutrition. Finding include: The 7/31/24 posted lunch menu included: Smoke Sausage, Lyonnaise Potatoes and Steamed Cabbage. A Diet Spread Sheet for the 7/31/24 menu indicated residents with a limited salt, phosphate (dietary nutrient) or potassium (dietary nutrient) diet were to be served roasted pork in place of the sausage. 1. Resident 267 was admitted to the facility in 7/2024 with diagnoses including kidney failure and hip fracture. A 7/25/24 physician Order Details indicated Resident 267 was to receive a diet limited in salt, potassium and phosphate. On 8/1/24 at 10:29 AM Resident 267 stated on 7/31/24 the menu option provided for lunch included sausage (a food high in salt and phosphates) which was delivered. Resident 267 stated she/he ate the sausage because it was provided and trusted the facility to provide the correct diet. Resident 267 stated because she/he received dialysis treatments the therapeutic diet was very important. On 8/1/24 at 8:30 AM Staff 13 (Cook) stated he was never trained to provide alternative options for those on restricted diets according the spreadsheet and did not prepare the pork roast on 7/31/24 during lunch that was necessary to fulfill the requirements for therapeutic diets. On 8/5/24 at 9:53 AM Staff 21 (Dietary Manager) acknowledged since a new menu system began around 4/2024 no alternative menu items were purchased to accommodate those on therapeutic diets. Staff 21 stated theraputic diet should be followed. 2. On 7/31/24 at 12:00 PM Staff 13 (Cook) was observed to serve lunch for residents from the food he prepared. No pork roast was observed on the tray line. At approximately 1:10 PM a tray ticket for room [ROOM NUMBER] was observed which indicated a limited salt, potassium and phosphate diet was to be served. The tray ticket included a typed option for chicken or pork roast. Sausage was served with the tray ticket to room [ROOM NUMBER]. On 8/1/24 at 8:30 AM Staff 13 (Cook) stated he was never trained to provide alternative options for those on restricted diets according the spreadsheet and did not prepare the pork roast on 7/31/24 during lunch that was necessary to fulfill the requirements for therapeutic diets. On 8/5/24 at 9:53 AM Staff 21 (Dietary Manager) acknowledged since a new menu system began around 4/2024 no alternative menu items were purchased to accommodate those on therapeutic diets. Staff 21 stated theraputic diet should be followed.

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	08/05/2024

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41455 Based on observation, interview and record review the facility failed to provide food according to residents' meal preferences for 2 of 5 sampled residents (#s 1 and 214) reviewed for food. This placed residents at risk for lack of meal satisfaction. Finding include: The 4/23/24 Resident Council notes indicated residents had concerns about meal preferences that were not provided as requested including: -Residents who asked CNAs for an different menu selection after a meal was delivered often did not receive any replacement. -Residents' meal plates did not contain the foods which were selected by the residents. The 5/21/24 and 6/26/24 Resident Council notes indicated residents continued to have concerns about meal preferences that were not provided as requested and the dietary department was aware. 1. Resident 1 was admitted to the facility in 11/2016 with diagnoses including anemia and acute kidney failure. On 7/30/24 at 7:50 AM Resident 1 stated she/he often did not receive what she/he ordered for meals. On 7/31/24 11:10 AM Staff 21 (Dietary Manager) stated she was aware of issues with residents who did not receive food they ordered which should not occur. On 8/2/24 at 1:34 PM Resident 1's lunch meal tray was observed with only pasta and asparagus on the plate. The printed menu and tray ticket indicated Resident 1 selected the pasta, asparagus and potatoes. Resident 1 stated errors with her menu choices often occurred. Resident 1 also stated because of her/his own self-limiting special diet it was very important for her/him to receive the foods that were ordered. 2. Resident 214 was admitted to the facility in 2024 with diagnoses including stroke and anxiety. A 7/22/24 revised care plan indicated Resident 214 disliked mushy vegetables, beets, mushrooms, eggs, peas and carrots and requested small portions. 7/29/24 at 1:14 PM Resident 214 stated she/he does not want beets, peas and carrots but continued to receive them despite what was written on her/his ticket even during the current week. On 7/31/24 11:10 AM Staff 21 (Dietary Manager) stated she was aware of issues with residents who did not receive food they ordered which should not occur. 3. The 7/31/24 posted lunch menu included: Smoke Sausage, Lyonnaise Potatoes and Steamed Cabbage. (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	08/05/2024

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 11:10 AM Staff 21 (Dietary Manager) stated she was aware and acknowledged there were issues with their new menu system and tray ticket accuracy since the menu system was implemented around 4/2024. At approximately 1:07 PM a meal tray ticket for room [ROOM NUMBER] was observed which indicated the resident requested potatoes and cabbage only. The meal tray also included sausage which was not requested by the resident. On 7/31/24 at 1:11 PM Staff 21 (Dietary Manager) stated the kitchen ran out of sausage during meal service, a resident in room [ROOM NUMBER] received no sausage despite her/his request for sausage and there was no sausage available for the sample meal tray. On 7/31/24 at approximately 1:36 PM a sample meal tray was received and did not include sausage on the sample tray.

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	08/05/2024

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 26991 Based on interview and record review it was determined the facility failed to ensure residents understood the meaning of an arbitration agreement (disputes are resolved with a neutral party and not in court) for 3 of 3 sampled residents (#s 9, 53, and 165) reviewed for arbitration. This placed residents at risk for being uninformed of their legal rights. Findings include: 1. Resident 9 was admitted to the facility in 5/2024 with a diagnosis of Parkinson's disease. A 5/14/24 admission MDS revealed Resident 9 was cognitively intact. A Patient and Facility Arbitration Agreement revealed Resident 9 signed the agreement on 5/9/24. On 7/31/24 at 12:15 PM Resident 9 stated she/he remembered signing a large number of papers at the time of her/his admission but did not recall anything about arbitration. On 7/31/24 at 12:25 PM Staff 9 (Admissions) stated she reviewed the arbitration agreement when she had a resident or resident representative sign the admission paperwork. Staff 9 stated she did not follow-up with residents after they signed the papers to ensure they understood what was signed. She was not sure if Resident 9 fully understood the agreement so she called Witness 2 (Family) and reviewed the arbitration document with her/him and Resident 9 signed the papers. On 7/31/24 at 4:23 PM Witness 2 stated did not know what an arbitration agreement was and only talked to the the facility about financial eligibility issues. 2. Resident 53 was admitted to the facility in 6/2024 with a diagnosis of heart disease. A Patient and Facility Arbitration Agreement revealed Resident 53 signed the agreement on 6/5/24. A 6/9/24 admission MDS revealed Resident 53 was cognitively intact. On 7/31/24 at 10:31 AM Resident 53 stated she/he had no idea what an arbitration agreement was. On 7/31/24 at 12:25 PM Staff 9 (Admissions) stated she reviewed the arbitration agreement with a resident when she had the resident or resident representative fill out the admission paperwork. If she felt a resident did not understand the agreement she called a resident's representative. Staff 9 stated she did not follow-up with residents after they signed the papers to ensure they understood the arbitration agreement. 3. Resident 165 was admitted to the facility in 7/2024 with a diagnosis of Parkinson's disease. A Patient and Facility Arbitration Agreement revealed Resident 165 signed the agreement on 7/19/24. A 7/23/24 admission MDS revealed Resident 156 was cognitively intact. (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	08/05/2024

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 8:05 AM Resident 165 stated she/he did not recall signing an arbitration agreement. Resident 165 stated an arbitration agreement was when another person spoke on your behalf. On 7/31/24 at 12:25 PM Staff 9 (Admissions) stated she reviewed the arbitration agreement with a resident when she had the resident or resident representative sign the admission paperwork. If she felt a resident did not understand the agreement she called a resident's representative. Staff 9 stated she did not follow-up with residents after they signed the papers to ensure they understood the arbitration agreement.

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	08/05/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001 Based on observation, interview, and record review it was determined the facility failed to follow appropriate infection control procedures, had delayed infection control implementation, inappropriate cohorting of residents for 1 of 1 facility. This deficient practice was determined to be an immediate jeopardy situation and the deficiency resulted in the spread of COVID 19. This placed residents at risk for continued spread of potential deadly infectious diseases. Findings include: According to the CDC website dated 6/2024 health care providers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). According to the CDC website dated 3/2024 patients with suspected clostridium difficile should be placed in a singe-patient room, if a single-patient room is not available patients with confirmed clostridium difficile may room together. On 7/29/24 at 9:30 AM Staff 1 (Administrator in Training) informed surveyors upon entrance that the facility is in a COVID outbreak, 4 staff and 5 residents, there was no sign on the door to indicate a COVID outbreak. Staff 1 stated 4 staff and 5 residents tested positive on 7/29/24. On 7/29/24 at 10:57 AM the dispensers in the hall near rooms 507, 513, 517 and 520 had no sanitizer in them. On 7/29/24 at 12:01 PM Staff 4 (CNA) entered room [ROOM NUMBER], a COVID 19 precaution room, without eye protection. On 7/29/24 at 12:14 PM Staff 4 removed her dirty gown, gloves and mask, then proceeded to place a clean mask on. Staff 4 failed to perform hand hygiene after taking off the dirty mask and before putting on a clean mask. On 7/29/24 at 12:26 PM Staff 5 (LPN) was observed checking Resident 20's CBG. Resident 20 was on enteric (intestinal)contact precautions. Staff 5 exited the room with her dirty gloves still on and stated she was going to remove the dirty gloves after she sanitized the CBG monitor. Staff 5 sanitized the CBG monitor, removed the dirty gloves and used alcohol based sanitizer to clean her hands. When asked why Staff 5 did not wash hands with soap and water per the verbiage on the enteric precaution sign, Staff 5 stated she did not need to use soap and water because she did not change Resident 20. On 7/29/24 at 12:29 PM Witness 11 (Family) asked about staff wearing N95 masks. Witness 11 stated she was not notified the facility was in a COVID 19 outbreak and she would not have brought her son into the facility had she notified. (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	08/05/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/29/24 at 12:46 PM Staff 26 (CNA) was observed delivering a lunch tray to Resident 20. Resident 20 was on enteric contact precautions. Staff 26 removed her dirty PPE and used alcohol based sanitizer upon exiting the room. When asked why Staff 26 did not wash her hands with soap and water, Staff 26 stated there was no need to wash with soap and water if not touching, down below and stated Resident 20 was on precautions for her/his catheter. On 7/29/26 at 12:46 PM Staff 4 was observed assisting Resident 43 with eating her/his lunch in a room with COVID 19 and enteric precautions. without wearing eye protection. Staff 4 stated she was informed she did not need to wear eye protection when providing care to Resident 43 since she/he had not tested positive for COVID 19, only her/his roommate had tested positive for COVID 19. On 7/26/24 at 1:08 PM Staff 34 (Infection Preventionist) stated staff entering a room on precautions for COVID 19, staff are expected to wear a gown, gloves, a mask and eye protection. Staff 34 stated when staff exit a room on COVID 19 precautions, staff are expected to remove their dirty PPE, including their mask, perform hand hygiene and then put a clean mask on. Staff 34 stated upon entering a room in enteric contact precaution room, staff are expected to wear a gown and gloves, and upon exiting the room staff are expected to remove the gown and gloves and wash their hands with soap and water. On 7/29/24 at 2:25 PM Staff 39 (housekeeping) stated she was aware there were multiple dispensers out of hand sanitizer in the COVID positive hall. Staff 39 stated she was unable to refill the dispensers because the facility had been out of hand sanitizer for a week. On 7/29/24 at 2:26 PM Staff 37 (CNA) was observed without eye protection while in a room on COVID 19 precautions. Staff 37 stated he does not wear eye protection and stated he usually wore his glasses with blinders on the side and acknowledged his glasses did not have blinders on them now. On 7/30/24 at 8:30 AM Staff 42 (CNA) was observed removing a dirty face shield, placing the dirty face shield in the clean PPE cart and without changing his face mask. On 7/30/24 at 12:57 PM Witness 10 (family) was observed in the facility without a face mask on. Witness 6 stated no one stopped her as she walked down the 500 hall and stated she was not informed of the COVID 19 outbreak in the facility. On 7/30/24 at 1:00 PM Staff 8 (CNA) was observed exiting room [ROOM NUMBER], a COVID 19 precaution. Staff 8 removed her dirty mask and placed on a clean mask without performing hand hygiene in between. Staff 34 was standing next to Staff 8 and had not intervened. Staff 8 acknowledged she should have performed hand hygiene before she obtained a clean mask and stated the clean cart of PPE was now contaminated, the clean PPE needed to be disposed of and the PPE cart needed to sanitized prior to being restocked. On 7/30/24 at 1:00 PM a cart was observed to have used COVID tests on the bottom shelf. Staff 34 acknowledged the used COVID 19 tests and stated he was going to throw them away when COVID testing was completed. (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	08/05/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/30/24 at 1:28 PM Staff 40 (CNA) was observed exiting room [ROOM NUMBER], which was on COVID 19 precautions, wearing dirty PPE. Staff 40 went into the hall and put dirty dishes in a cart located in the hallway. Staff 40 stated he was trained to wear the same PPE worn in a COVID 19 precaution room when placing dirty dishes into the cart in the hallway. Staff 40 was observed going back to room [ROOM NUMBER], where he removed his dirty gown, gloves, and eye protection. Staff 40 was observed walking down the hall with his dirty mask on. Staff 40 stated he was looking for a new mask and then he located a new mask in the PPE cart outside room [ROOM NUMBER]. On 7/30/24 at 2:07 PM Staff 34 stated the first staff and resident tested positive for COVID 19 on 7/25/24 and two more residents tested positive on 7/30/24. Staff 34 stated Resident 35 was placed on enteric precautions on 6/11/24 related to suspicion of clostridium difficile (a type of bacteria that can cause inflammation of the colon). Resident 30 was moved into Resident 35's room on 6/14/24, and Resident 35 tested positive for clostridium difficile on 6/17/24. Staff 34 stated Resident 30 should not have been moved in with Resident 35 due to the contagious risk of clostridium difficile. On 7/30/24 at 2:29 PM Staff 31 (Housekeeper) was observed exiting room [ROOM NUMBER], a COVID 19 precaution room. Staff 31 did not complete hand hygiene after she removed dirty surgical mask. Staff 31 was observed touching clean the laundry and entering into room [ROOM NUMBER] with the potentially contaminated laundry. On 7/30/24 at 6:31 PM Staff 43 (dietary aid) was observed washing dishes and walking through the kitchen with no face mask on. On 7/30/24 at 6:38 PM Staff 1, Staff 10 (Regional Nurse), Staff 2 (Administrator) and Staff 2 (DNS) were notified of the immediate jeopardy situation related to infection control. On 7/30/24 at 8:53 PM an acceptable immediate risk removal plan to address the serious risk to residents' health and welfare was received and implemented by the facility. The plan indicated the following facility actions: -The DNS and Administrators were educated on the COVID 19 Policy, Outbreak Checklist and COVID 19 Infection Control Manual. -The Infection Preventionist was placed on suspension due to the enormity of the deficiencies. -The new Infection Preventionist was educated on the COVID 19 Policy, Outbreak Checklist and COVID 19 Infection Control Manual and skills demonstrated. -New Infection Preventionist will be educated on the COVID 19 Policy, Outbreak Checklist and COVID 19 Infection Control Manual upon hire. -Starting on 7/30/24 all staff were educated on the COVID 19 Policy, Outbreak Checklist and COVID 19 Infection Control Manual for continued compliance of these policies, with emphasis on proper PPE usage and hand hygiene for each type of infection. -All staff will wear N95 masks while in resident care areas, and in COVID positive rooms will wear a N95 mask, gown, sanitized or disposable goggles and gloves when providing direct patent care and remove all these items before they leave COVID positive room and a new N95 mask will be placed. (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	08/05/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-DNS will put face shields on all the COVID 19 isolation carts to replace the need to use goggles exclusively. Staff were educated regarding the face shields usage and disposal. A few clean goggles were left in the isolation carts in case of need. -Starting 7/30/24 wide base resident testing will be completed every 2-3 days and as symptoms are present until the facility goes two weeks without any positive tests. -Starting 7/30/24 wide base staff testing will happen before staff members start their shift and as symptoms present until the facility goes two weeks without any positive test. -The SSD called the first emergency contact for each resident and informed them of the current COVID outbreak. -All new residents will be informed of the current COVID outbreak before admission the the facility. -A sign was place on all entrance doors to inform visitors about the COVID 19 outbreak and was placed next to the sign in sheet in the lobby. -Facility acquired hand sanitizer to fill all dispensers and extra to make sure it is accessible to staff for proper hand hygiene. The DNS and designees will conduct spot checks of proper hand hygiene, donning and doffing PPE, signage and equipment cleansing at least three times per shift per day for one week. Then once daily for one week. then once a week for 4 weeks. then once a month for four months. Any discrepancies will be brought to the QAPI team for further review. -The DNS or designee will review the 24-hour report and bowel care list Monday through Friday, Saturday and Sunday will be reviewed on Monday, for any symptoms of clostridium difficile, and to ensure policies had been followed correctly. Any discrepancies will be brought to the QAPI team for further review. On 7/31/24 at 9:28 AM Staff 25 (NA) stated she had just received training on infection control procedure and hand hygiene on 7/31/24 a few minutes before the interview. At 9:30 AM Staff 25 was observed exiting a room on COVID 19 precautions, Staff 25 failed to change her mask upon exit from the room. Staff 25 stated she was not trained on the need to change her mask after exiting a COVID 19 precaution room. Staff 25 was observed getting a clean mask, she held the clean mask in one hand while she removed her dirty mask with the other hand, she applied her clean mask with one hand while holding her dirty mask with the other hand, she balled up dirty mask in her hand, walked down the hall and threw away her dirty mask in a room that was not on precautions for COVID 19. Staff 25 had not performed hand hygiene until reminded to do so. On 7/31/24 at 9:51 AM Staff 11 (CNA) stated she tested herself for COVID 19 prior to working on 7/31/24. Staff 11 stated she was trained by Staff 6 (LPN Unit Manager/IP) to swab each nostril 3 times. On 7/31/24 at 9:53 AM Staff 32 (Housekeeper) stated she was tested for COVID 19 by Staff 33 (Housekeeping Manager) prior to start of work on 7/31/24. (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	08/05/2024

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/31/24 at 9:55 AM Staff 33 stated she was trained to perform COVID 19 tests by Staff 2 and to swab each nostril three times. A review of the COVID 19 testing instructions on 7/31/24 at 10:00 AM revealed each nostril needed to swabbed five times for 15 seconds. On 7/31/24 at 10:10 AM the COVID 19 testing instructions were reviewed with Staff 10 (Regional Nurse). Staff 10 acknowledged each nostril needed to be swabbed five times for 15 seconds and stated all staff and residents would be retested on [DATE]. On 7/31/24 at 3:15 PM it was determined the immediacy was removed after verification of completion of the immediate jeopardy removal plan.

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	08/05/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 26991 Based on interview and record review it was determined the facility failed to ensure antibiotics were indicated for 1 of 3 sampled residents (#4) reviewed for UTIs. This placed residents at risk for developing drug resistant organisms. Findings include: Resident 4 was admitted to the facility in 1/2024 with a diagnosis of MS (multiple sclerosis: lack of electrical impulses from the brain to the body creating impaired body functions). 3/2024 and 4/2024 MARs revealed Resident 4 was administered antibiotics for a possible UTI from 3/30/24 through 4/5/24. A 3/31/24 Lab Results form revealed Resident 4's UA did not require a culture. Resident 4's clinical record revealed there was no rationale for the continuation of antibiotics when there was no indication Resident 4 had a UTI. On 8/2/24 at 10:17 AM Staff 6 (LPN Resident Care Manager) verified there was no rationale documented in Resident 4's clinical record to indicate the benefit of the continuation of antibiotics outweighed the risks.

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	08/05/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47001 Based on interview and record review it was determined the facility failed to provide immunizations, consents and declinations for 3 of 5 sampled residents (#s 3, 20, and 22) reviewed for immunizations. This placed residents at risk for infections. Findings include: 1. Resident 3 was admitted to the facility in 12/2018 with diagnoses including congestive heart failure (a condition in which the heart cannot pump enough blood). An 8/5/44 review of Resident 3's immunizations revealed she/he received the COVID 19 vaccination on 12/23/20, 1/13/21 and 10/19/21, no evidence of COVID 19 boosters were administered after 10/19/21. An 8/5/24 review of Resident 3's medical record revealed no evidence of signed consents for the COVID 19 vaccinations received on 12/23/20, 1/13/21 and 10/19/21 and no evidence any COVID 19 booster vaccinations were offered, administered or declined after 10/19/21. On 8/5/24 at 10:35 AM Staff 1 (Administrator in Training) stated the vaccination offerings, consents and declinations were kept in a binder. Staff 1 was unable to locate Resident 3's consents for the COVID 19 vaccinations on 12/23/20, 1/13/21 and 10/19/21 and was unable to locate evidence Resident 3 was offered or declined any COVID vaccination boosters after 10/19/21. 2. Resident 20 was admitted to the facility in 3/2017 with diagnoses including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems). An 8/5/24 review of Resident 20's medical record revealed no evidence she/he was offered a pneumonia vaccination. On 8/5/24 at 10:35 AM Staff 1 (Administrator in Training) stated vaccination offerings, consents and declinations were kept in a binder. Staff 1 was unable to locate evidence Resident 20 was offered or refused a pneumonia vaccination. 3. Resident 22 was admitted to the facility in 12/2021 with diagnoses including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems). A 8/5/24 review of Resident 22's immunizations revealed she/he was administered a COVID 19 vaccination booster on 12/13/23. An 8/5/24 review of Resident 22's medical record revealed no evidence of a consent for the 12/13/23 administration of the COVID 19 vaccination booster. On 8/5/24 at 10:35 AM Staff 1 (Administrator in Training) stated vaccination offerings, consents and declinations were kept in a binder. Staff 1 was unable to locate Resident 22's consent for the COVID 19 vaccination booster.

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	08/05/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 47001 Based on observation and interview it was determined the facility failed to ensure a call light was accessible for 2 of 3 sampled residents (#s 20 and 48) reviewed for hospice and pressure ulcers. This placed resident at risk for unmet needs. Findings include: 1. Resident 20 was admitted to the facility in 2/2020 with diagnoses including hemiplegia (paralysis of one side of the body) of the left nondominant side. On 7/31/24 at 11:12 AM Resident 20 was observed in bed, her/his call light hung off the left side of the bed between the mattress and side rail towards the floor. Resident 20 had softly yelled for help whenever a staff member walked past her/his room. On 7/31/24 between 11:12 AM and 11:26 AM multiple staff were observed to have walked past Resident 20's room without stopping or assisting Resident 20. On 7/31/24 at 11:26 AM Staff 33 (Housekeeping Manager) was observed cleaning Resident 20's door. Resident 20 asked for help to scratch her/his back and Staff 33 stated she could not assist but would get assistance. On 7/31/24 between 11:26 AM and 11:48 AM multiple staff were observed to have walked past Resident 20's room without stopping or assisting Resident 20. Resident 20 continued to yell out softly whenever a staff member walked past her/his door. On 7/31/24 at 11:48 the surveyor asked Staff 7 (CNA) if Resident 20's call light was in reach. Staff 7 stated it was not in reach, and then Staff 7 went into Resident 20's room to provide assistance. On 8/2/24 at 8:47 AM Resident 20 was observed in bed, her/his call light hung off the left side of the bed towards the floor between the mattress and side rail. On 8/2/24 at 9:39 AM Resident 20 was observed in bed, her/his call light continued to hang off the left side of the bed towards the floor between the mattress and side rail. On 8/2/24 at 9:46 AM Resident 20's call light was observed to still be hanging off the left side of the bed towards the floor between the mattress and side rail. Staff 4 (CNA) confirmed Resident 20's call light was not within reach and then fixed the call light so Resident 20 could reach it. On 8/2/24 at 10:25 AM Staff 23 (LPN Resident Care Manager) confirmed residents' call light were required to be within reach at all times. 34703 2. Resident 48 was admitted to the facility in 3/2024 with diagnoses including paranoid schizophrenia (mental disorder), chronic bed confinement, and hospice care. (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	08/05/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 48's 3/14/24 care plan indicated the resident is moderate risk for falls related to a history of falls. The resident is bedbound with impaired mobility, and is non-verbal. Interventions were to keep call light within reach while in bed. Observations from 7/29/24 through 8/1/24 on day and evening shifts Resident 48's call light was in a dresser drawer and not within reach. On 7/31/24 at 11:36 AM Staff 28 (LPN) stated the resident was able to use her/his call light. Staff 28 verified the resident's call light was not within reach. On 8/1/24 at 11:26 AM Staff 17 (LPN) stated the resident was able to use her/his call light. Staff 17 verified the resident's call light was in the nightstand drawer and not within reach. On 8/2/24 at 9:35 AM Staff 23 (LPN-Resident Care Manager) stated Resident 48's call light should be within reach at all times and was not.

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	08/05/2024

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 26991 Based on interview and record review it was determined the facility failed to ensure CNAs received 12 hours of training for 3 of 5 sampled staff (#s 3, 4, and 7) reviewed for staffing. Findings include: Review of CNA training records revealed: -Staff 3 was hired in 7/2016 and did not have 12 hours of training for the last one year. -Staff 4 was hired in 7/2022 and did not have 12 hours of training for the last one year. -Staff 7 was hired in 9/2021 and did not have 12 hours of training for the last one year. On 8/1/24 at 8:30 AM Staff 2 (DNS) verified Staff 3, 4, and 7 did not have 12 hours of training in the last year.