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	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	2360 Chambers Street Eugene, OR 97405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined the facility failed to maintain medical records for 2 of 3 sampled residents (#s 6 and 37) reviewed for advanced directives. This placed residents at risk for incomplete medical records. Findings include:1. Resident 6 was admitted to the facility in 12/2024 with diagnoses including end stage kidney disease.On 1/13/26 at 10:28 AM, a review of Resident 6's medical record revealed an untitled form signed by Resident 6 on 3/29/25 which indicated Resident 6 wanted to initiate an advance directive.On 1/13/26 at 3:00 PM, a review of Resident 6's medical record revealed the untitled form signed by Resident 6 on 3/29/25 was no longer found in the electronic medical record.On 1/13/26 at 3:47 PM, Staff 4 (Regional Nurse Consultant) stated she deleted the untitled forms from Resident 6's, Resident 37's, and 19 additional active residents' medical records. Staff 4 stated she deleted the untitled forms because they were not official corporate forms. Staff 4 acknowledged medical records were expected to be retained and not deleted.2. Resident 37 was admitted to the facility in 12/2024 with diagnoses including diabetes.On 1/13/26 at 11:01 AM, a review of Resident 37's medical record revealed an untitled form signed by Resident 37 on 12/24/24 which indicated Resident 37 had an advance directive and would bring it into the facility within 72 hours.On 1/13/26 at 3:05 PM, a review of Resident 37's medical record revealed the untitled form signed by Resident 31 on 12/24/24 was no longer found in the electronic medical record.On 1/13/26 at 3:47 PM, Staff 4 (Regional Nurse Consultant) stated she deleted the untitled forms from Resident 6's, Resident 37's, and 19 additional active residents' medical records. Staff 4 stated she deleted the untitled forms because they were not official corporate forms. Staff 4 acknowledged medical records were expected to be retained and not deleted.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review it was determined the facility failed to ensure residents or resident representatives received education regarding the potential side effects of the pneumococcal and influenza vaccines for 5 of 5 sampled residents (#s 3, 10, 13, 14, and 30) reviewed for immunizations. This placed residents at risk for lack of information. Findings include:1. Resident 3 was admitted to the facility in 6/2025 with diagnosis of hemiparesis (one-sided weakness) following a stroke. Resident 3's record revealed the resident was offered but declined a PCV20 vaccine on 6/18/25. The Declination of Influenza or Pneumococcal Vaccination form signed by Resident 3 on 6/18/25 did not include education on the potential side effects of the pneumococcal vaccine.Resident 3's record revealed the resident received an influenza vaccine 9/22/25.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the influenza or pneumococcal vaccines.2. Resident 10 was admitted to the facility in 6/2019 with diagnosis of severe morbid obesity.Resident 10's immunization record revealed the resident received an influenza vaccine on 9/23/25. The immunization record indicated education on the potential side effects of the influenza vaccine did not occur.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the influenza vaccine.3. Resident 13 was admitted to the facility in 10/2025 with diagnosis of diabetes with hyperglycemia. Resident 13's immunization record revealed the resident was offered a PCV20 and an influenza vaccine on 10/14/25 and chose to decline both.The Declination of Influenza or Pneumococcal Vaccination form signed by Resident 13 on 10/14/25 did not include education on the potential side effects of the pneumococcal and influenza vaccines.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the influenza or pneumococcal vaccines.4. Resident 14 was admitted to the facility in 11/2025 with diagnosis of rheumatoid arthritis.Resident 14's record revealed the resident was offered a PCV20 and an influenza vaccine on 11/6/25 and chose to decline both. The Adult Vaccination Declination Form verbally reviewed with resident on 11/6/25 did not include education on the potential side effects of the pneumococcal and influenza vaccines.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the influenza or pneumococcal vaccines.5. Resident 30 was admitted in 5/2024 with diagnosis of Diabetes.Resident 30's immunization record revealed the resident was offered a PCV20 vaccine and declined it on 11/5/25.The Adult Vaccination Declination Form reviewed verbally with Resident 30 on 11/5/25 did not include education on the potential side effects of the pneumococcal vaccine. Resident 30's immunization record revealed the resident received an influenza vaccine on 9/22/25. The immunization record indicated education on the potential side effects of the influenza vaccine did not occur.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the influenza or pneumococcal vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined the facility failed to ensure residents or resident representatives received education regarding the potential side effects of the COVID-19 vaccine for 5 of 5 sampled residents (#s 3, 10, 13, 14, and 30) reviewed for immunizations. This placed residents at risk for lack of information. Findings include:1. Resident 3 was admitted to the facility in 6/2025 with diagnosis of hemiparesis (one-sided weakness) following a stroke. Resident 3's immunization record revealed she/he received a COVID-19 vaccine on 10/8/25.The Vaccine Consent Form signed by Resident 3 on 9/19/25 did not include education on the potential side effects of the COVID-19 vaccine.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the COVID-19 vaccine.2. Resident 10 was admitted to the facility in 6/2019 with diagnosis of severe morbid obesity.Resident 10's immunization record revealed the resident was offered a COVID-19 vaccine on 9/19/25 and chose to decline. The Declination of COVID-19 Vaccination form did not include education on the potential side effects of the COVID-19 vaccine.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the COVID-19 vaccine.3. Resident 13 was admitted to the facility in 10/2025 with diagnosis of diabetes with hyperglycemia. Resident 13's immunization record revealed the resident was offered a COVID-19 vaccine on 10/14/25 and chose to decline. The Declination of COVID-19 Vaccination Form did not include education on the potential side effects of the COVID-19 vaccine.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the COVID-19 vaccine.4. Resident 14 was admitted to the facility in 11/2025 with diagnosis of rheumatoid arthritis.Resident 14's immunization record revealed the resident was offered a COVID-19 vaccine on 11/6/25 and chose to decline. The Adult Vaccination Declination Form verbally reviewed with resident on 11/6/25 did not include education on the potential side effects of the COVID-19 vaccine.5. Resident 30 was admitted in 5/2024 with diagnosis of diabetes.Resident 30's immunization record revealed the resident was offered a COVID-19 vaccine on 11/5/25 and chose to decline.The Adult Vaccination Declination Form verbally reviewed with resident on 11/5/25 did not include education on the potential side effects of the COVID-19 vaccine.In an interview on 1/16/26 at 11:30 AM, Staff 25 (IP) confirmed no education was provided related to the possible adverse side effects of the COVID-19 vaccine.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review the facility failed to ensure the resident's rights to make decisions regarding her medication administration for 1 of 1 of resident (# 25) reviewed for insulin. This place residents at risk for not being able to make choices about their health care. Findings include:Resident 28 was admitted to the facility in 9/2025 with diagnoses including type 2 diabetes mellitus.Resident 28's 12/10/25 Brief Interview for Mental Status revealed a BIMS of 15 (cognitively intact).On 1/12/26 at 1:40 PM, Resident 25 stated she/he had discussions with some of the nurses about her/his insulin because she/he wanted it administered before meals and it often was given after her/his dinner in the evenings. On 1/15/26 at 10:15 AM, Staff 10 (CNA) stated Resident 25 told her multiple times she/he wanted her/his insulin administered before meals. Staff 10 stated she reported the concern to nursing staff. On 1/16/26 at 12:53 PM, Staff 9 (LPN) stated a CNA told her Resident 25 was unhappy because she/he had not been administered her/his insulin before meals. Staff 9 stated she had not followed up with the physician about Resident 25's concern. On 1/16/26 at 1:10 PM, Staff 2 (DNS) stated when nurses became aware Resident 25 was requesting to have insulin administered before meals, they should have notified the physician to ensure Resident 25's insulin orders could be changed.

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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. Based on interviews and record review it was determined the facility failed to ensure advanced directives were completed per resident preference for 2 of 3 sample residents (#s 6 and 37) reviewed for advanced directives. This placed residents at risk for healthcare decisions to conflict with resident wishes. Findings include:1.Resident 6 was admitted to the facility in 12/2024 with diagnoses including end stage kidney disease and diabetes.A review of Resident 6's medical record revealed an untitled form signed by Resident 6 on 3/29/25 which indicated Resident 6 wanted to initiate an advance directive.A record review revealed no evidence of an advance directive in Resident 6's medical record.On 1/13/26 at 1:41 PM, Staff 3 (Regional Nurse Consultant) stated Resident 6 did not have an advance directive completed.On 1/20/26 at 12:00 PM, Staff 2 (DNS) stated staff were expected to follow up with residents regarding initiating and/or obtaining their advance directive.Resident 37 was admitted to facility in 12/2024 with diagnoses including diabetes and heart failure.A review of Resident 37's medical record revealed an untitled form signed by Resident 37 on 12/24/24 which indicated Resident 37 had an advance directive and would provide it to the facility in 72 hours.A record review revealed no evidence of an advanced directive in Resident 37's medical record.On 1/13/26 at 1:41 PM, Staff 3 (Regional Nurse Consultant) stated Resident 37 did not have an advance directive completed.On 1/20/26 at 12:00 PM, Staff 2 (DNS) stated staff were expected to follow up with residents regarding initiating and/or obtaining their advance directive.2.Resident 37 was admitted to facility in 12/2024 with diagnoses including diabetes and heart failure.A review of Resident 37's medical record revealed an untitled form signed by Resident 37 on 12/24/24 which indicated Resident 37 had an advance directive and would provide it to the facility in 72 hours.A record review revealed no evidence of an advanced directive in Resident 37's medical record.On 1/13/26 at 1:41 PM, Staff 3 (Regional Nurse Consultant) stated Resident 37 did not have an advance directive completed.On 1/20/26 at 12:00 PM, Staff 2 (DNS) stated staff were expected to follow up with residents regarding initiating and/or obtaining their advance directive.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure the resident was free of unnecessary psychotropic medications for 1 or 1 resident (#15) reviewed for pain management. This placed residents at risk for receiving unnecessary psychotropic medications and chemical restraint. Findings include: Resident 15 was admitted to the facility in 6/2025 with diagnoses including insomnia. Resident 15's 12/18/25 Brief Interview for Mental Status revealed a BIMS of 15 which indicated Resident 15 was cognitively intact.A review of the resident's clinical record indicated an order for 50 mg of trazodone had been entered in the Medical Administration Record (MAR) on 12/17/25.A review of the resident's clinical record indicated an order for 50 mg of trazodone had been entered in the Medical Administration Record (MAR) on 1/7/26 in addition to the existing order.On 1/13/26 at 10:30 AM, Resident 15 stated she/he thought she/he had received extra doses of trazodone and had not been able to do anything but sleep for two days. Resident 15 stated she/he was upset because she/he had been too sleepy to attend her/his physical therapy session and therapy was very important to her/him. On 1/14/26 at 2:14 PM, Witness 1 (Family Member) stated last week when she talked to Resident 15 she/he had been in tears and told Witness 1 she/he was so tired she/he couldn't function. Witness 1 called the facility and spoke to Staff 17 (CMA) who told her Resident 15's trazodone had been increased by 50 mg on 1/7/26 and 1/8/26.On 1/15/26 at 8:45 AM, Staff 17 stated when she saw there was a second order for 50 mg of trazodone in Resident 15's clinical record on 1/9/26 she checked with the resident and did not administer the medication. Staff 17 stated she noticed the extra dose had been administered on 1/7/26 and 1/8/26. Staff 17 stated she notified the nurse on duty of the duplicate order and again notified the nurse on duty the following day when she saw the order was unchanged in the system. On 1/15/25 at 1:30 PM, Staff 19 (LPN) stated she was unsure of the date but had looked at pending orders to teach Staff 18 (RN) how to enter orders. She stated she remembered there was a pending order for trazodone and she had Staff 18 enter the order in the clinical record. Staff 19 stated she was unaware there was an additional process to verify the orders before confirming them. On 1/16/2026 at 10:14 AM, Staff 18 stated Staff 19 had been training her on how to enter orders. Staff 18 stated she logged into the computer but had not realized she was actually creating an order and had not paid attention to the resident or medication information. On 1/16/26 at 8:17 AM, Staff 2 (DNS) stated the order was an error and should have been deleted, not confirmed. Staff 2 stated nurses should be verifying orders when they implemented them.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, interview, and record review it was determined the facility failed to report allegations of abuse and neglect to the State Survey Agency for 1 of 3 sampled residents (#60) reviewed for abuse and accidents. This placed residents at risk for further abuse and neglect. Findings include: Resident 60 was admitted to the facility in 7/2024 with diagnoses including heart failure and kidney disease.The 3/4/25 Annual MDS indicated Resident 60 was cognitively intact.A care plan dated 12/24/25 indicated if Resident 60 accusatory comments about family, and/or staff not treating her/him well and denying her/his medications, staff must alert the nurse so they may assess for signs and symptoms of urinary tract infection since this had been the case in the past.On 1/12/26 at 2:13 PM Resident 60 indicated a CNA/CMA abused her/him. Resident 60 stated the staff member spoke meanly and was rough with her/him and she/he felt abused. Resident 60 stated the staff member treated her/him like a bad dog. Resident 60 stated Staff 11 (LPN) was aware the staff member treated her/him badly but had not stopped the staff member. Resident 60 stated she/he was afraid of retaliation from the staff member and being discharged from the facility. On 1/12/26 at 2:16 PM Staff 11 stated the staff member she heard being rude to Resident 60 was Staff 26 (CNA/CMA). Staff 11 stated Staff 26's demeanor changed if she felt rushed or if she had a bad day. Staff 11 stated she heard Staff 26 be rude to other residents and other staff members observed this behavior as well, but she did not report the behavior to management.On 1/12/26 at 2:42 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified Resident 60 stated she/he felt abused by Staff 26. Staff 1 indicated this was the first he had heard of Resident 60 feeling abused by Staff 26. On 1/12/26 at 2:52 PM Staff 1 and Staff 2 stated their expectation when a resident felt abused by a staff member was for staff to notify both of them immediately. Staff 2 stated staff must notify the provider and family and ensure the safety of all residents.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review it was determined the facility failed to provide care-planned eating assistance for 1 of 4 sampled residents (#14) reviewed for nutrition. This placed residents at risk for reduced nutritional intake and decline in positioning. Findings include:Resident 14 was admitted to the facility in 11/2025 with diagnoses including rheumatoid arthritis, dementia, and unspecified deformity of the fingers.A 11/11/25 admission MDS indicated Resident 14's BIMS score was nine which indicated she/he had moderately impaired cognition. Resident 14 required setup and cleanup assistance for eating.A 11/6/25 Care Plan indicated Resident 14 required setup assistance for eating. Observations on 1/12/26 from 12:12 PM to 1:10 PM revealed Resident 14 arrived in the facility main dining room for lunch at 12:30 PM. Resident 14 received her/his meal at 12:42 PM. Resident 14 was seated in a wheelchair at a dining table, and the meal was not within her/his reach. Resident 14 was observed leaning forward in the chair two to three times, bringing her/his trunk closer to the dining table with effort, then sat back in the wheelchair. Staff in the dining room did not approach Resident 14 until 1:04 PM when assistance was provided in repositioning her/his feet on the wheelchair footrests. Staff removed Resident 14's meal at 1:10 PM without asking if she/he was done eating. Staff assisted Resident 14 back to her/his room. During lunch service Resident 14 did not have any food or drink while in the dining room.Observations on 1/13/26 from 1:16 PM to 2:05 PM revealed Resident 14 was positioned in bed with the head of the bed elevated, and the overbed table was across her/his body from the left side of the bed. The lunch meal tray was on the overbed table. Resident 14 stated she/he had missed breakfast and was hungry. Resident 14's right knee was in a bent position which limited the overbed table position towards Resident 14's left side. Resident 14's tray had one beverage with the lid removed, one beverage with the lid on, the lid was removed from the soup, and the meal included an open plate stewed beef and a baked potato. Resident 14's baked potato was uncut, and the containers of butter and sour cream were unopened. Resident 14's utensils were to the far-left side of the meal tray, and she/he reached them with difficulty after several tries with her/his right hand. Resident 14 attempted to use a fork to cut into the baked potato but only speared the potato on the fork. Resident 14 was then observed taking a bite of beef with some effort to reach and secure the food on her/his fork. When Staff 8 (CNA) removed the tray at 2:05 PM very little food was consumed, and all the unopened items remained unopened and uneaten. The uneaten baked potato was observed lying on the tray to the right of the plate. Resident 14 drank the entire opened beverage.In an interview on 1/13/26 at 2:05 PM, Staff 8 indicated Resident 14 could not cut her/his potatoes, apply butter to items on the tray, or open containers. On 1/14/26 at 2:20 PM Staff 9 (LPN) stated staff were expected to set up meals by placing the tray in front of the resident, cutting the meat, removing all lids, and making sure the resident had everything she/he needed within reach.On 1/20/26 at 11:38 AM, Staff 2 (DNS) stated staff were expected when setting up a meal to ensure food items were within reach, to remove the cover from the plate and open all containers and lids. Staff 2 stated staff were also encouraged to offer as a courtesy to cut foods if the resident wanted assistance.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review it was determined the facility failed to provide ADL care to dependent residents for 1 of 1 sampled resident (#11) reviewed for ADLs. This placed residents at risk for lack of nail care. Findings include: Resident 11 was admitted to the facility in 1/2024 with diagnoses including below the knee amputation, legal blindness, and diabetes.Resident 11's 1/29/26 Annual MDS indicated the resident had moderate cognitive impairment.The 2/1/24 care plan indicated Resident 11 had ADL self-care performance related to legal blindness, heart failure, and limited mobility, required one staff member to set-up and offer location of items on her/his overbed table and plate, and was able to feed and drink independently. Resident 11 preferred to eat with her/his hands.The 12/2025 TAR indicated Resident 11's nails were trimmed on 12/24/25.The 12/2025 TAR indicated diabetic nail care weekly every evening shift every Wednesday for diabetes.The 1/2026 task document indicated on 1/8/26 Resident 11 had a shower.On 1/12/26 at 10:34 AM, 1/13/26, and 1/14/26 at 12:30 PM, Resident 11 was observed to have long nails with dark brown debris under them. On 1/13/26 at 12:30 PM, Resident 11 was observed eating lunch with her/his hands and continued to have dark brown debris under them.On 1/13/26 at 1:34 PM, Staff 13 (CNA) acknowledged the resident's nails were long and had brown debris under them, Staff 13 did not offer Resident 11 a washcloth to clean her/his hands, she stated she would alert Resident 11's care giver the resident's nails needed to be cleaned.On 1/14/26 at 12:44 PM, Staff 5 (LPN/Resident Care Manager) acknowledged Resident 11's nails were long and had dried brown debris under them. Staff 5 stated her expectation was for nurses to check resident's nails weekly, especially diabetics and perform trimming, cleaning and filing as needed. Staff 5 asked Resident 11 if she could perform nail care, and the resident agreed.On 1/16/26 at 2:32 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Regional Nurse Consultant) stated if a resident refused care by a staff member, staff should ask another staff member to try and approach the resident. Staff 3 stated staff should alert the nurse of the refusals and keep trying to provide care to the resident. Staff 2 stated the expectation was for nurses to document every refusal Resident 11 had.

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	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Eugene	2360 Chambers Street Eugene, OR 97405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined the facility failed to ensure staff provided two-person assistance when transferring a resident and failed to ensure a environment remained free from accident hazards for 2 of 4 sampled resident (#s 31 and 42) reviewed for accidents. This placed residents at risk for accidents. Findings include: Resident 31 was admitted to the facility in 12/2025 with diagnoses including dementia. A 12/5/25 care plan indicated Resident 31 was at risk for falls and padded fall mats were to be placed at both sides of the bed when Resident 31 was in bed. On 1/13/26 at 9:27 AM, Resident 31 was observed in bed without a fall mat on the left side of her/his bed. On 1/14/26 at 9:01 AM, Resident 31 was observed in bed with the left side of the bed fall mat on the floor, but not next to Resident 31's bed. On 1/14/26 at 2:43 PM, Resident 31 was observed in bed without a fall mat on the left side of her/his bed. On 1/14/26 at 2:45 PM, Staff 4 (CNA) stated Resident 31 was at risk for falls and was to have fall mats on the floor next to her/his bed while Resident 31 was in bed. Staff 4 confirmed Resident 31 did not have a fall mat on the left side of her/his bed and Staff 4 placed the fall mat on the left side of Resident 31's bed. On 1/15/26 at 1:31 PM, Resident 31 was observed in bed, the fall mat for the left side of her/his bed was folded up and leaning against the foot of the bed. On 1/16/26 at 10:26 AM, Staff 5 (LPN Resident Care Manager) stated Resident 31 was at risk for falls and rolled out of bed when she/he first admitted . Staff 5 stated Resident 31 was care planned to have fall mats on the floor on both sides of the bed when she/he was in bed. Staff 5 stated staff were expected to follow the care plan. 2. Resident 42 was admitted to the facility in 5/2025 with diagnoses including stroke and weakness. A 5/23/25 care plan revealed Resident 42 required two-person assistance with transfers using FWW (Front Wheeled Walker). A 7/21/25, fall investigation revealed at approximately 10:00 AM Staff 15 (Former CNA) indicated she took Resident 42 to her/his room after a shower. Staff 15 grabbed Resident 42's FWW and assisted her/him to stand. Resident 42 felt her/his legs weaken, lost balance, and fell to the floor. Staff 15 did not review the care plan. -On 7/22/25 Staff 16 (Former LPN) was notified and indicated no injuries were found on the resident. -The investigation indicated during training, CNAs were taught to read the care plan for the residents' care needs. Staff 15 transferred Resident 42 without assistance when the care plan clearly stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she/he was a two-person transfer. -The Root Cause Analysis indicated the biggest contributing factor was Resident 42 was a two person assist with her/his FWW and Staff 15 did not check the care plan. On 1/14/26 4:24 PM Staff 15 stated she transferred Resident 42 to her/his wheelchair with the FWW, and the resident stood up and slid to the floor. Staff 15 stated she did not review the care plan which indicated Resident 42 was a two-person transfer with a FWW before she transferred her/him. On 1/14/26 4:25 PM Staff 16 stated Staff 15 notified her she gave resident 42 a shower and attempted to transfer her/him back to her/his wheelchair when the resident fell. Staff 16 stated Resident 42 was care planned as a two person assist with transfers and Staff 15 completed the transfer alone. On 1/15/26 at 3:02 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Regional Nurse Consultant) acknowledged Resident 42 was a two person transfer which was on her/his care plan. Staff 2 stated expectations were for staff to always look at the care plan before providing care for residents. Staff 3 stated the expectation was for an allegation of abuse or neglect to be reported to the State Survey Agency timely.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observations, interviews, and record review it was determined the facility failed to provide specialized rehabilitation services for 1 of 2 sampled residents (#31) reviewed for positioning. This placed residents at risk for decline in physical ability. Findings include:Resident 31 was admitted in 12/2025 with diagnoses including dysphagia (difficulty swallowing) and dementia.A review of Resident 31's 12/14/25 hospital discharge summary indicated Resident 31 had orders for PT, OT, and ST.A review of Resident 31's medical record revealed no evidence of PT, OT, or ST documentation since 12/14/25.On 1/12/26 at 12:21 PM, Resident 31 was observed up in a wheelchair that was tilted back, without a headrest, and without footrests. Resident 31's head was observed to hang off the back of the wheelchair without support and Resident 31's feet were not supported.On 1/16/26 at 10:26 AM Staff 5 (LPN Resident Care Manager) stated Resident 31 was re-admitted to the facility on an altered textured diet due to dysphagia, but stated Resident 31 was not re-admitted with orders for PT, OT, or ST.On 1/16/25 at 11:07 AM, Staff 6 (Speech Therapist) stated Resident 31 had dysphagia and should have been seen by ST.On 1/16/26 at 11:09 AM, Staff 7 (Therapy Manager) stated he was not notified of Resident 31's order for PT, OT, and ST.On 1/16/26 at 11:24 AM, Staff 5 acknowledged Resident 31's discharge summary indicated orders for PT, OT, and ST and stated Resident 31 should have been seen by therapy per orders at admission.On 1/20/26 at 12:00 PM, Staff 2 (DNS) stated therapy was expected to be provided per orders.