

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Oregon City		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Division Street Oregon City, OR 97045	
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 - 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 interview and record review it was determined the facility failed to provide adequate supervision and assistance to prevent a fall with injury for 1 of 2 sampled residents (#8) reviewed for falls. As a result, Resident 8 sustained a fractured arm. Findings include:Resident 8 was admitted to the facility in 5/2025, with diagnoses including neck fracture.Resident 8's 5/27/25 Care Plan revealed the resident had limited mobility due to her/his neck fracture and required a two-person transfer assist for toileting. Resident 8's 5/31/25 MDS revealed she/he was cognitively intact and had a BIMS of 15 out of 15.A 6/25/25 Facility Investigation Report (FRI) revealed Resident 8 fell and sustained a fracture of her/his right arm after Staff 20 (CNA) attempted to transfer Resident 8 from the commode by herself. The facility determined Staff 20 had not followed Resident 8's care plan, which indicated the resident was a two-person transfer assist for toileting.A 6/27/25 Hospital Discharge Summary revealed that Resident 8 sustained a right arm fracture as a result of her/his fall at the facility. On 8/20/25 at 2:40 PM, Resident 8 stated Staff 20 had attempted to assist her/him from the commode when she/he slipped and fell to the floor, causing her/him to fracture her/his arm. Resident 8 stated that per her/his care plan, she/he required two-person assistance for transfers and toileting. On 8/27/25 at 2:37 PM, Staff 3 (RCM) stated Resident 8 required two-person assistance with transfers and toileting, and confirmed Staff 20 failed to follow the resident's care plan, which led to Resident 8 sustaining a fracture of the right arm. The surveyor attempted to interview Staff 20 on 8/26/25 and 8/27/25 but was unable to reach them.On 8/29/25 at 10:00 AM, Staff 1 (Administrator) and Staff 3 confirmed Staff 20 did not follow Resident 8's care plan related to transfers with toileting, which led to Resident 8's fall, where she/he sustained a fractured right arm. The deficient practice was identified as Past Noncompliance based on the following:On 6/26/25, the deficient practice was identified by the facility to be corrected when the facility completed a root cause analysis of the incident and determined there was a failure to follow a resident's care plan. The Plan of Correction included:Resident 8's care plan was reviewed and revised to address any additional risk factors.A facility-wide audit of all residents with fall risk care plans was conducted to ensure interventions were current and being followed by staff.All nursing staff were re-educated on the importance of following the individualized resident care plans.Supervisors conducted random spot checks to verify compliance with care plans.The DNS performed weekly audits of care plan implementation for residents at risk for falls for three months. Results were reviewed in the Quality Assurance and Performance Improvement (QAPI) committee meetings, and corrective actions were taken as needed, including ongoing monitoring.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 385125
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