

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Avamere at Three Fountains		STREET ADDRESS, CITY, STATE, ZIP CODE  835 Crater Lake Avenue Medford, OR 97504	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>41455</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assessed for self-administration of medications and physician orders were in place for 1 of 5 sampled residents (#13) reviewed for medications. This placed residents at risk for adverse medication-related consequences. Findings include:</p> <p>The 2001 Self-Administration of Medications facility policy indicated, as part of the comprehensive assessment, the interdisciplinary team was to assess each resident's cognitive and physical abilities to determine whether self-administration was safe and appropriate.</p> <p>Resident 13 was admitted to the facility in 9/2024 with diagnoses including cellulitis (bacterial infection) of right lower limb and peripheral vascular disease (reduced circulation of blood in veins).</p> <p>The 12/11/24 Quarterly MDS indicated Resident 13 was cognitively intact, had chronic pain and her/his pain occasionally interfered with her/his sleep and daily activity.</p> <p>The 12/11/24 Vitals and Pain Only Evaluation indicated Resident 13 received PRN pain medications and the resident did not feel her/his pain was an issue.</p> <p>The 1/2025 MAR and TAR revealed no orders for Biofreeze (topical pain relief) or Icy Hot (topical pain relief to treat minor muscle and joint pain).</p> <p>Review of Resident 13's clinical record revealed no assessment for the self-administration of medications.</p> <p>On 1/13/25 at 1:07 PM Staff 32 (CNA) stated Resident 13 had pain in her/his right knee and was observed by Staff 32 to self-administer topical pain medication which was provided by the resident's family. Staff 32 was aware orders for the topical pain medication should be in place and nurses informed.</p> <p>On 1/13/25 at 1:18 PM Resident 13 stated she/he had no unmanaged pain except in her/his knees which she/he addressed with the self-administration of topical pain creams. Resident 13 revealed tubes of Biofreeze and Icy Hot in her/his cabinet drawer at her/his bedside.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25 at 12:33 PM Staff 16 (CMA) confirmed Resident 13's pain was addressed with PRN pain medications in addition to the Biofreeze the resident utilized for knee pain. Staff 16 indicated staff were aware Resident 13 self-administered her/his topical pain medication.</p> <p>On 1/14/25 at 2:27 PM Staff 10 (LPN) stated she was not aware any nurse was informed Resident 13 self-administered any topical pain medications and orders for the medications were not in place.</p> <p>On 1/15/25 at 2:52 PM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Resident 13 was not assessed to self-administer her/his topical pain medication and orders for the medication were needed.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>41455</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a resident was provided restorative services for 2 of 2 sampled residents (#s 13 and 30) reviewed mobility. This placed residents at risk for decrease in range of motion. Findings include:</p> <p>A 7/2017 Restorative Nursing Services facility policy Interpretation and Implementation indicated restorative goals and objectives were to be individualized and outlined in the resident's plan of care to maintain dignity and self-esteem.</p> <p>1. Resident 13 was admitted to the facility in 9/2024 with diagnoses including cellulitis (bacterial infection) of right lower limb and peripheral vascular disease (reduced circulation of blood in veins).</p> <p>The 12/11/24 Quarterly MDS indicated Resident 13 was cognitively intact, had chronic pain, weakness, deconditioning and was at risk for related declines.</p> <p>A 12/6/24 Restorative Program Referral indicated Resident 13 was to maintain her/his current level of functioning with the use of exercise bands as tolerated, stand tolerances in parallel bars and assistance to her/his wheelchair three to five days each week.</p> <p>The 1/7/24 revised care plan indicated Resident 13 was at risk for decreased mobility and was on a maintenance RA program.</p> <p>A 30 day look back of the Nursing Rehabilitation task indicated on 12/20/24 and 1/3/25 services were received by Resident 13 and on 12/27/24 the resident refused services. No additional RA hours were documented.</p> <p>The 12/28/24 and 1/11/25 Weekly Progress Notes by Staff 33 (RA) indicated Resident 13 did not received RA therapy.</p> <p>On 1/12/25 at 9:22 AM Resident 13 stated RA was available to assist with exercise bands for a period of time and then services stopped. Resident 13 indicated Staff 9 (LPN-Resident Care Manager) was notified of the concern.</p> <p>On 1/13/25 at 2:53 PM Staff 39 (PT Assistant) stated therapy would submit RA referrals to Staff 9 to implement. Staff 39 indicated there were times when Resident 13 refused RA services and refusals should be documented.</p> <p>On 1/13/25 at 3:19 PM Staff 9 acknowledged Resident 13 received limited RA services during the last 30 days.</p> <p>On 1/14/25 at 12:06 PM Staff 33 stated she was unable to provide RA services for residents from 12/23/24 through 12/28/24 and during the last seven days because she was scheduled to work as a CNA.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/15/25 at 2:52 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Assistant DNS) stated the facility attempted to schedule RA staff daily but acknowledged, since 12/2024, RA services had not occurred as expected due to lack of available CNAs.</p> <p>2. Resident 30 was admitted to the facility in 10/2024 with diagnoses including diabetes and cellulitis (bacterial infection) of right lower limb.</p> <p>The 11/3/24 Admission MDS indicated Resident 30 was cognitively intact, was at risk for falls, required one staff to assist with mobility using her/his front wheel walker and received no RA services.</p> <p>A 11/23/24 Restorative Program Referral indicated Resident 30 was to maintain her/his current level of function with assisted use of her/his front wheel walker or exercise equipment as tolerated utilizing seated exercises, knee marches, ball squeezes and light hip exercise two to three times each week.</p> <p>The 12/7/24 revised care plan indicated Resident 30 had a RA program related to her/his risk for decreased mobility.</p> <p>A 30 day look back of the Nursing Rehabilitation task indicated on 12/17/24 and 12/25/24 RA services were received by Resident 30. No additional RA hours were documented.</p> <p>The 12/7/24 Weekly Progress Notes by Staff 33 (RA) indicated Resident 30 received one day of RA therapy.</p> <p>The 1/11/25 Weekly Progress Notes by Staff 33 (RA) indicated Resident 30 received no RA services during the week.</p> <p>On 1/14/25 at 12:06 PM Staff 33 stated Resident 30 asked her when RA would begin again and acknowledged the resident received limited RA services.</p> <p>On 1/14/25 at 3:10 PM Resident 30 stated she/he did not receive RA services for three weeks and they were to occur three times weekly. Resident 30 stated she/he voiced her/his concerns to Staff 9 (LPN-Resident Care Manager) who coordinated RA services but RA services were not provided. Resident 30 believed her/his legs were more stiff and painful due to the lack of RA services.</p> <p>On 1/15/25 at 9:13 AM Staff 17 (CNA) stated Resident 30 requested RA services for her/his leg pain and because only RA staff were permitted to provide RA services, he was only able to assist Resident 30 with walking while in her/his room.</p> <p>On 1/15/25 at 1:16 PM Staff 9 confirmed Resident 30 complained about the lack of RA services and acknowledged Resident 30 was a prime candidate for RA services because of her/his high level of function which was important to maintain. Staff 9 stated the facility should have daily RA services available in order to meet the RA schedule of Resident 30.</p> <p>On 1/15/25 at 2:52 PM Staff 1 (Administrator), Staff 2 (DNS), and Staff 3 (Assistant DNS) stated the facility attempted to schedule RA staff daily but acknowledged, since 12/2024, RA services had not occurred as expected due to the lack of available CNAs.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41455</b></p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure transmission-based precautions were followed, surfaces were sanitized and linen was properly transported for 3 of 5 halls reviewed for infection control precautions. This placed residents and staff at risk for cross-contamination. Findings include:</p> <p>The 12/29/21 facility Categories of Transmission-Based Precautions instructed staff:</p> <ul style="list-style-type: none"> <li>-to wear an isolation gown that was securely tied around the staff's neck and back when entering a COVID-19 positive room on special droplet precautions.</li> <li>-to use dedicated, non-critical resident equipment (stethoscopes) when possible to prevent cross-contamination.</li> </ul> <p>The 1/2025 Resident Line Listing Report, COVID-19 indicated 19 residents tested positive during the month including 9 residents who tested positive on 1/13/25.</p> <p>The 1/9/25 Attention Staff: PPE (Personal Protective Equipment) Donning and Doffing Education and Reminders instructed staff to remove their N-95 (droplet protection mask) and eye protection after exiting a COVID-19 positive resident room and replace with a new N-95 mask and eye protection after hand hygiene was performed.</p> <p>1. On 1/14/25 at 9:21 AM room [ROOM NUMBER] was observed to require special droplet precautions. Staff 34 (LPN) exited room [ROOM NUMBER], wore a N-95 mask and face shield out of room [ROOM NUMBER] and hung a contaminated stethoscope on the room door handle towards the hall. Staff 34 did not change her N-95 mask or face shield and removed the stethoscope from the door handle to sanitize the stethoscope without sanitizing the door handle.</p> <p>On 1/14/25 at 9:33 AM room [ROOM NUMBER] was observed to require special droplet precautions. Staff 35 (RN) entered the room and wore a face shield and N-95 mask.</p> <p>On 1/14/25 at approximately 9:38 AM Staff 35 exited room [ROOM NUMBER] and did not change her N-95 mask or face shield. Staff 35 stated she worked in the facility three days and was instructed to wear a N-95 mask and face shield at all times while in the facility with no further instructions. A surveyor directed Staff 35 to read the PPE instructions on the outside of room [ROOM NUMBER]. Staff 35 read the instructions and left to obtain clarification from Staff 34 without changing her N-95 mask or face shield.</p> <p>On 1/14/25 at 9:39 AM Staff 38 (CMA) was observed to exit room [ROOM NUMBER], performed hand hygiene and touched the contaminated door knob. Staff 38 stated he was unaware the door knob was contaminated.</p> <p>On 1/14/25 at 9:50 AM Staff 34 acknowledged she did not change her N-95 mask or face shield as expected and droplet precaution rooms needed a clean area outside the rooms to sanitize equipment and prevent cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/14/25 at 10:05 AM Staff 37 (Housekeeping Director) stated housekeeping staff were not instructed to removed their N-95 masks or face shield when they exited rooms on droplet precautions.</p> <p>On 1/14/25 at 11:00 AM Staff 4 stated she was made aware of the breach in infection control standards when staff exited rooms on droplet precautions and the lack of clean surfaces to ensure proper sanitation of equipment. Staff 4 acknowledged an immediate in-service for staff related to infection control expectations was necessary.</p> <p>2. The 1/2014 Departmental (Environment Services)-Laundry and Linen facility procedure instructed staff to ensure hygienically clean linen by covering clean linen carts.</p> <p>On 1/15/25 at 12:26 PM Staff 36 (Laundry) was observed to deliver personal laundry on a cart near Rooms 59 to 60 without a cover. Staff 36 stated I always deliver this way with no cover. Staff 36 indicated residents' personal laundry did not need a cover and she left residents' personal laundry uncovered and hanging outside rooms on droplet precautions.</p> <p>On 1/15/25 at approximately 1:00 PM Staff 37 (Housekeeping Director) acknowledged linen was to remain covered when in the hall.</p> <p>On 1/16/25 at 8:34 AM Staff 2 (DNS) confirmed the expectation was for all linen carts to be covered when in the hall whether clean linen was general or personal.</p> <p>47001</p> <p>3. On 1/12/25 at 8:28 AM Staff 27 (CNA) was observed exiting a room on COVID 19 precautions. Staff 27 removed a surgical mask which covered an N-95 mask, Staff 27 did not remove the N-95 mask. Staff 27 stated she was trained to cover the N-95 with a surgical mask when entering a COVID 19 precaution room and then remove the surgical mask upon exit. She was not trained to remove the N-95 mask and replace it with a new N-95 mask.</p> <p>On 1/15/25 at 11:35 AM Staff 4 (LPN Infection Preventionist) stated when staff exit a room on COVID 19 precautions, they are expected to remove all PPE, including the N-95 mask, and replace it with a new N-95 mask.</p> <p>4. On 1/13/25 at 9:04 AM Staff 31 (CNA) was observed sitting on a bed in a room on Enhanced Barrier Precautions (EBP) without wearing a gown. Staff 31 stated the resident was on EBP and she should have put on a gown before sitting on the resident's bed.</p> <p>On 1/15/25 at 11:35 AM Staff 4 (LPN Infection Preventionist) stated when staff are caring for a resident on EBP or touching the resident's bed, they are expected to wear a gown and gloves.</p> <p>5. On 1/14/25 at 3:16 PM Staff 28 (CMA) was observed changing her N-95 mask after exiting a room on COVID 19 precautions. Staff 28 was observed removing her dirty N-95 mask and without completing hand hygiene, putting on a clean N-95 mask. Staff 28 stated she should have used sanitizer after she removed the dirty N-95 mask.</p> <p>On 1/15/25 at 11:35 AM Staff 4 (LPN Infection Preventionist) stated staff are expected to sanitize their hands as soon as the N-95 mask comes off their face.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure an antibiotic was indicated for use for 1 of 5 sampled residents (#24) reviewed for unnecessary medications. This placed residents at risk for developing drug resistant organisms. Findings include:</p> <p>Resident 24 was admitted to the facility in 2018 with a diagnosis of anxiety.</p> <p>Progress Notes revealed the following:</p> <p>-12/31/24 Resident 24 reported painful urination and Staff 6 (NP) was notified. Staff 6 provided orders for nursing staff to obtain a urine sample and a culture and sensitivity from Resident 24.</p> <p>-1/1/25 nursing staff obtained Resident 24's urine sample, sent it to the lab, and the results were pending.</p> <p>Resident 24's UA resulted on 1/2/25 and was reviewed by Staff 6 on 1/3/25. A hand written note on the lab form indicated Cipro (antibiotic) was ordered.</p> <p>A 1/3/25 Order Details revealed Staff 6 ordered Ciprofloxacin (generic name for Cipro) two times a day for six days.</p> <p>A 1/6/25 Antibiotic Time Out form revealed Resident 24 was administered Ciprofloxacin for a UTI for initial symptoms of burning with urination. After the start of antibiotics Resident 24 did not have a fever, signs of a UTI, a change in activity, or a change in appetite. The form indicated Staff 6 was notified of Resident 24's status and antibiotics were to be continued.</p> <p>On 1/14/25 at 10:01 AM Staff 4 (IP LPN) stated at times, depending on a resident's medical history and UTI symptoms, antibiotics were started before a urine culture was finalized. Staff were to obtain the culture results and communicate with the resident's medical provider if the course of treatment needed to be changed. Staff 4 stated Resident 24 was started on an antibiotic before the urine culture was completed. After Resident 24's urine culture was received staff reached out to Staff 6 because the lab indicated the sample was incorrectly obtained. Staff 6 was not available and did not see the results of the labs. Staff 4 stated she communicated with Staff 9 (LPN Resident Care Manager) to let her know Staff 6 was not available. Staff 4 stated she reached out to Staff 5 (Resident 24's Physician) and Staff 5 instructed staff to continue the antibiotic because Staff 6 initiated the treatment. Staff 4 stated she did not document the conversation with Staff 5.</p> <p>On 1/14/25 10:37 AM Staff 5 stated she was not notified of Resident 24's urine test results and the lab's inability to run a urine culture. After review of Resident 24's urine results, Staff 5 stated nursing staff did not properly obtain a urine sample and a culture was not performed. If the UA and associated labs were provided to Staff 5 she would have stopped the antibiotics. Staff 5 also stated if Resident 24's only symptom was burning with urination she likely would not have started Resident 24 on antibiotics in the first place.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25 at 11:39 AM Staff 9 stated she was aware nursing staff obtained a urine sample for Resident 24. Staff 9 stated she was notified of the lack of urine culture on day six of the prescribed antibiotic therapy. Staff 9 stated Resident 24's only symptom prior to starting the antibiotic was burning with urination.</p> <p>On 1/14/25 at 2:22 PM Staff 6 stated Resident 24 had a UTI in 12/2024 and was prescribed an antibiotic based on the urine culture. At the end of 12/2024 when nursing staff reported Resident 24 had symptoms of a UTI she had staff obtain an UA and she started an antibiotic which would be susceptible to the organisms which were identified in Resident 24's previous urine culture. Staff 6 stated if she would have seen the results of the 1/3/2025 UA she would have stopped the antibiotics.</p> <p>On 1/14/25 at 2:56 PM, with Staff 2 and Staff 1, Staff 2 stated the facility follows IP protocols and staff were to reach out to the resident's medical provider within 72 hours after an antibiotic was initiated and a specimen culture resulted. Staff 2 stated there was a communication breakdown between Staff 6 and the nursing staff. Staff 2 stated if staff were not able to contact Staff 6 they should have communicated with Staff 5. Staff 2 stated Resident 24's antibiotic should have been stopped but was not.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure CNA staff had 12 hours of annual in-service training for 2 of 5 sampled CNAs (#s 17 and 18) reviewed for staffing. This placed residents at risk for a lack of quality care. Findings include:</p> <p>1. Staff 17's (CNA) training and in-service logs revealed he received 6.75 of 12 required training hours. The 6.75 hours did not include dementia training.</p> <p>On 1/15/25 at 10:48 AM staff 17 acknowledged he did not get the 12 hours of training completed, including dementia training.</p> <p>On 1/15/25 at 10:45 AM and 11:04 AM Staff 2 (DNS) verified Staff 17 worked more than one year in the facility and Staff 3 (Assistant DNS) acknowledged Staff 17 did not have his 12 hours of training in the last one year. Staff 3 sated she and the resident care managers were to monitor the in-service training hours.</p> <p>2. Staff 18's (CNA) training and in-service logs revealed she received 10.25 of 12 training hours in the last one year.</p> <p>On 1/15/25 at 10:45 AM and 11:04 AM Staff 2 (DNS) verified Staff 18 worked more than one year in the facility and Staff 3 (Assistant DNS) acknowledged Staff 18 did not complete her 12 hours of training in the last one year. Staff 3 sated she and the resident care managers were to monitor the in-service training hours.</p> <p>On 1/15/25 at 10:59 AM a call was placed to Staff 18. A return call was not received.</p>