STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385126	A. Building B. Wing	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere at Three Fountains	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)
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, interview, and record review it was determined the facility failed to ensure a community use glucometer was cleaned with EPA (Environmental Protective Agency) approved disinfectant for 1 of 4 Halls, (Hall 2) reviewed for infection control. This placed residents at risk for cross contamination. Findings include: The facility's 10/2025 Glucometer Cleaning policy revealed staff were to clean glucometers with a bleach germicidal wipe or equivalent. On 7/7/26 at 7:46 AM Staff 3 (LPN) was observed to clean a community used glucometer with an alcohol pad. Staff 3 was stopped prior to entering another resident's room. Staff 3 stated he always used the alcohol pads to clean the glucometers. Staff 3 identified the following residents who had CBG checks for Hall 2: Residents 7, 13, 63, 68, 71, and 99. a. Resident 7 was admitted to the facility in 6/2026 with a diagnosis of diabetes. Resident 7's clinical record did not indicate she/he had a BBP (bloodborne pathogen). b. Resident 13 was admitted to the facility in 6/2026 with a diagnosis of diabetes. Resident 13's clinical record did not indicate she/he had a BBP. c. Resident 63 was admitted to the facility in 6/2026 with a diagnosis of diabetes. Resident 63's clinical record did not indicate she/he had a BBP. d. Resident 68 was admitted to the facility in 6/2026 with a diagnosis of diabetes. Resident 68's clinical record did not indicate she/he had a BBP. e. Resident 71 was admitted to the facility in 6/2026 with a diagnosis of diabetes. Resident 71's clinical record did not indicate she/he had a BBP. f. Resident 99 was admitted to the facility in 7/2026 with a diagnosis of diabetes. Resident 99's clinical record did not indicate she/he had a BBP. On 7/7/26 at 8:38 AM Staff 2 (DNS) stated staff were to use bleach wipes to clean the community use glucometers.

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 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. Based on observation and interview it was determined the facility failed to ensure furniture was in good repair for 1 of 1 facility reviewed for physical environment. This placed residents at risk for an unhomelike environment. Findings include: During an observation on 7/9/26 at 2:03 PM with Staff 19 (Maintenance Director) the armchairs in rooms 10, 16, 18, 42, and 44 were observed to have torn fabric with exposed cloth material on the armrests. The torn material on the chairs was at least one inch in diameter. The general sitting area by the front entrance had two chairs with multiple cracks in the synthetic leather on the seat covering exposing the cloth material and one armchair with missing synthetic leather exposing cloth material. Staff 19 stated the furniture was not in good repair. Staff 18 stated staff were to notify maintenance when furniture was ripped. Staff 19 stated he was not notified of the torn furniture. On 7/9/26at 12:56 PM Staff 1 (Administrator) stated if there were tears in the furniture staff were to remove the furniture.

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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 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 observation, interview, and record review it was determined the facility failed to ensure a resident was assisted with oral hygiene for 1 of 2 sampled residents (#81) reviewed for ADLs. This placed residents at risk for lack of oral care. Findings include: Resident 81 was admitted to the facility in 6/2026 with a diagnosis of a fracture. Resident 81's 6/29/26 admission MDS revealed she/he was cognitively intact and required assistance with ADLs including oral hygiene. Resident 81's 6/25/26 Care Plan indicated she/he required the assistance of one person for personal hygiene and mobility. On 7/6/26 at 3:02 PM Resident 81 stated since admission to the facility, staff did not provide her/him a toothbrush for oral care or offer to assist her/him with oral hygiene. During an observation on 7/7/26 at 4:08 PM with Staff 7 (CNA) Resident 81's toothbrush was observed in its original plastic wrapper in a basin by her/his sink. Resident 81 stated she/he had a bed bath today, but no one offered to help her/him brush her/his teeth. On 7/7/26 at 4:36 PM Staff 8 (CNA) stated she was Resident 81's assigned CNA on 7/7/26, day shift. Staff 8 stated Resident 81 had a toothbrush by her/his room sink but she did not assist Resident 81 with oral care during the morning shift. On 7/9/26 at 11:56 AM Staff 2 (DNS) stated residents were to be offered oral care at least two times a day, in the morning and in the evening.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review it was determined the facility failed to ensure a resident was provided accommodations for activities for 1 of 1 sampled resident (#81) reviewed for activities. This placed residents at risk for lack of meaningful engagement. Findings include: Resident 81 was admitted to the facility in 6/2026 with a diagnosis of a fracture. Resident 81's 6/29/26 admission MDS revealed she/he was cognitively intact, and her/his hearing was Highly impaired. Resident 81 was assessed to not use hearing aids. Resident 81's 6/29/26 Activity Profile revealed she/he liked to watch older television shows. Resident 81's 6/25/26 through 7/7/26 Self Directed Activity form revealed she/he watched television on 7/2/26. During observations on 7/7/26 at 10:38 AM, 7/7/26 at 1:42 PM, 7/7/26 at 3:37 PM, 7/8/26 at 8:13 AM, and 7/8/26 at 11:32 AM Resident 81 was observed in bed with her/his eyes shut and her/his television was not on. On 7/6/26 at 2:16 PM Resident 81 stated she/he could not hear the television when she/he wanted to watch it. On 7/8/26 at 8:48 AM Staff 4 (LPN Resident Care Manager) stated if a resident was hard of hearing and wanted to listen to the television, the facility asked the family to bring in a headset for the resident's use. On 7/8/26 at 8:52 AM Staff 5 (Social Services) stated Resident 81 was very hard of hearing and staff had to stand really close to her/his right ear to communicate. Staff 5 stated she was not aware Resident 81 had concerns related to listening to the television. On 7/8/26 at 11:40 AM Staff 18 (Activity Director) stated Resident 81 resided on the skilled unit and residents who resided on the skilled unit were usually in the facility for a short period of time. Staff 18 stated Resident 81 preferred to stay in her/his room. Staff 18 also stated she did not offer Resident 81 a headset so she/he could hear the television. On 7/8/26 at 11:50 AM Staff 6 (Social Services) stated if a resident was hard of hearing the facility provided headsets so they could watch and hear their television. On 7/8/26 at 12:04 PM Staff 2 (DNS) stated the facility should have provided headsets for residents who could not hear the television.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to obtain physician orders for use and maintenance of a CPAP (Continuous Positive Airway Pressure) for 1 of 3 sampled residents (#76) reviewed for hospice and respiratory care. This placed residents at risk for improper air support. Findings include:Resident 76 was admitted to the facility in 6/2026 with diagnoses including sleep apnea (temporary cessation of breathing during sleep) and stroke.There was no documentation in the admission MDS, or the care plan to indicate plan Resident 76 utilized a CPAP (Continuous Positive Airway Pressure; a machine that uses mild air pressure to keep breathing airways open).Random observations from 7/6/26 through 7/10/26 on day and evening shifts revealed Resident 76 had a CPAP in her/his room on her/his nightstand.On 7/6/26 at 12:50 PM, Resident 76 stated she/he had a friend bring the CPAP to the facility a day after admission on [DATE], but staff did not clean the mask or tubing daily and the mask did not fit well.On 7/8/26 at 8:18 AM, Staff 13 (CNA) stated she was aware Resident 76 had a CPAP but she did not clean the mask or hose. On 7/8/26 8:20 AM, Staff 14 (CNA) stated she was aware Resident 76 had a CPAP since admission and washed the mask one time. On 7/8/26 at 8:31 AM, Staff 10 (RN) stated she was aware Resident 76 had a CPAP and filled the chamber with water a few times but did not clean the mask or tubing.On 7/8/26 at 2:38 PM Staff 9 (LPN Resident Care Manager) confirmed Resident 76 did not have an order for the CPAP or for the cleaning and caring of the CPAP equipment.