STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385132	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of King City	16485 SW Pacific Highway Tigard, OR 97224

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review it was determined the facility failed to respond timely to a change of condition for 1 of 3 sampled residents (#4) reviewed for change of condition. This placed residents at risk for a decline in overall functioning. Findings include:The facility's 3/2018 Acute Condition Changes-Clinical Protocol policy documented the nurse shall assess and document/report the following baseline information: vital signs, neurological status, current pain level, level of consciousness, and onset, duration and severity of condition. Resident 4 was re-admitted to the facility in 12/2025 with diagnoses including multiple sclerosis and opioid use. Resident 4's Quarterly MDS dated 1/2026 documented a BIMS score of 15 indicating the resident was cognitively intact. Resident 4's assessment also indicated she/he had chronic pain.The 11/25/25 Blood Pressure Summary Report documented Resident 4's blood pressure was 86/53 at 5:00 AM by Staff 6 (LPN). Resident 4's 11/25/25 Progress Note at 6:50 AM, indicated Staff 6 charted Resident 4's blood pressure as 70/50. Staff 6 called provider and 911. No additional information was documented. On 2/18/26 at 2:32 PM, Staff 6 (LPN) stated she had cared for Resident 4 during the night shift on 11/24/25 through 11/25/25. Staff 6 stated the morning of 11/25/25 staff was unable to wake Resident 4. Staff 6 stated Resident 4's blood pressure was abnormal and low. Staff 6 called the provider then called 911. A Fire and Rescue Public Incident Report documented that a call from the facility was received on 11/25/25 at 6:46 AM stating Resident 4 was found with altered mental status. Paramedics arrived at the facility at 6:50 AM. Staff 6 (LPN) reported to the paramedics that Resident 4 was found altered at 5:00 AM. Paramedics administered Narcan (an antidote for opioids), and Resident 4's vital signs improved. Resident 4 was transported to the hospital. On 2/20/26 at 10:19 AM, Staff 14 (CNA) stated she had cared for Resident 4 during the night shift on 11/24/25 through 11/25/25. Staff 14 stated Resident 4 appeared to be sleeping through-out the night. Staff 14 stated when she took Resident 4's blood pressure at 5:00 AM it was very low. Staff 14 alerted Staff 6 (LPN) and Resident 4's blood pressure was rechecked and continued to be low. Staff 14 stated Staff 6 assisted her in providing incontinence care to Resident 4. Staff 14 stated it was odd Resident 4 did not wake up during care because the resident usually woke up when staff laid the resident flat. Staff 14 stated Resident 4 sometimes would stay awake for three days and then slept hard. Staff 14 stated Resident 4 did not respond to them. Staff 14 stated Staff 6 called the provider and 911.The 12/2/25 Hospital Discharge Summary revealed Resident 4 was admitted to the hospital for septic shock due to UTI, acute kidney injury, acute metabolic encephalopathy and acute hypoxic/hypercapnic respiratory failure.On 2/20/26 at 2:46 PM, Staff 1 (Administrator) acknowledged there was a delay by staff in responding to Resident 4's change of condition and Resident 4's progress notes did not include the baseline information regarding her/his change of condition.

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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review it was determined the facility failed to acquire the correct route for an emergency (Narcan) medication for 1 of 3 sampled residents (#4) reviewed for pharmaceutical services. This placed residents at risk for not receiving the correct route for their emergency medication. Findings include: Resident 4 was re-admitted to the facility in 12/2025 with diagnoses including multiple sclerosis, diabetes and opioid use. Resident 4's 11/2025 Physician Orders included an order for naloxone HCL (Narcan-an antidote medication for opioids) nasal liquid 4mg/0.1ML to be administered in both nostrils as needed for decreased responsiveness. On 2/19/26 at 12:34 PM, observations of the facility's emergency kit found Narcan as an intravenous route rather than the nasal route as prescribed for Resident 4. On 2/20/26 at 2:46 PM, Staff 1 (Administrator) acknowledged the facility did not have the correct Narcan route administration (nasal) for Resident 4.