STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385162	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Newport	835 SW 11th Street Newport, OR 97365

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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 it was determined the facility failed to ensure resident preferences were communicated for 1 of 1 sampled resident (#31) reviewed for choices. This placed residents at risk for lack of honored preferences. Findings include:Resident 31 was admitted to the facility in 5/2023 with diagnoses including stroke and aphasia (a disorder that impairs the ability to communicate).The 5/26/25 Annual MDS revealed Resident 31 had a BIMS assessment score of 13 (cognitively intact), was occasionally understood, and placed high importance on her/his bathing and bedtime preferences.A 5/29/25 revised care plan indicated Resident 31 required assistance from one staff member for bathing. No documented preferences regarding the resident's bathing or bedtime routine were identified.A 6/24/25 Social Services Quarterly Review indicated Resident 31 was cooperative with staff, exhibited no behavioral concerns, and the review was completed by Staff 16 (DNS).On 8/4/25 at 11:03 AM, Resident 31 communicated she/he preferred to sleep until 8:30 AM and was frequently awakened earlier than desired.On 8/5/25 at 2:20 PM, Staff 7 (CNA) stated Resident 31's daily routine was important to her/him. Staff 7 was aware Resident 31 preferred to sleep in, the resident became upset when awakened early, and acknowledged that some CNAs were unaware of the resident's preferences.On 8/6/25 at 10:46 AM, Staff 13 (CNA) stated he provided a shower to Resident 31 that morning before breakfast based on information received from other staff regarding the resident's shower preference. Staff 13 reported difficulty understanding Resident 31's preferences due to the lack of detailed information in her/his care plan.On 8/6/25 at 3:37 PM, Staff 5 (Activities Director) stated she interviewed Resident 31 regarding her/his preferences and was instructed to update the care plan only for recreational activities.On 8/7/25 at 9:18 AM, Staff 2 (Interim DNS/RNCM) acknowledged there was insufficient oversight to address Resident 31's preferences. Staff 2 expected Resident 31 to have a person-centered care plan that clearly outlined her/his routine and preferences.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to notify the physician after holding blood pressure medications based on decreased blood pressure for 1 of 5 sampled residents (#6) reviewed for unnecessary medications. This placed residents at risk for adverse side effects to medications. Findings include:Resident 6 was admitted to the facility in 3/2025 with diagnoses including a cerebral infarction (stroke) and hypertension (high blood pressure).A review of physician orders revealed a 5/25/25 order for Metoprolol Tartrate (a medication to treat high blood pressure) 100 mg two times a day, notify MD for further instructions and hold if blood pressure is less than 100/55.A review of Resident 6's 7/2025 MAR revealed Metoprolol was held: 7/4/25 AM dose held due to a blood pressure of 98/48 7/6/25 AM dose held, no blood pressure charted in [DATE]/14/25 AM dose held due to a blood pressure of 84/47 7/15/25 AM dose held due to a blood pressure of 98/52 7/25/25 AM dose held due to a blood pressure of 99/56 7/26/25 AM dose held due to a blood pressure of 105/54 7/27/25 AM dose held due to a blood pressure of 100/50 7/30/25 AM dose held due to a blood pressure of 100/54 7/30/25 AM dose held due to a blood pressure of 103/53 7/31/25 PM dose held due to a blood pressure of 99/52A review of Resident 6's 8/1/25 through 8/4/25 MAR revealed Metoprolol was held for the following reasons: 8/2/25 PM dose held due to a blood pressure of 104/46 8/3/25 AM dose held due to a blood pressure of 105/82 8/4/25 AM dose held due to a blood pressure of 113/44A review of Resident 6's medical record revealed no evidence the primary care provider was notified when the Metoprolol was held.On 8/7/25 at 2:40 PM, Staff 3 (LPN Resident Care Manager) stated if Resident 6's Metoprolol was held due to low blood pressure, the charge nurse would be notified, and they would put the information in the provider's communication book, so he was aware the medication was held and why it was held. An observation of the provider's communication book was completed with Staff 3 and revealed no communications to the provider related to holding Resident 6's Metoprolol.On 8/7/25 at 2:48 PM, an observation of the 7/2025 pages of the provider's communication book with Staff 2 (Interim DNS/RNCM) revealed no communication to the provider related to holding Resident 6's Metoprolol. Staff 2 stated she was not sure if the staff called the provider and failed to chart it. Staff 2 stated the expectation was if a medication is held, the provider would be notified.On 8/7/25 at 3:39 PM, Staff 15 (Physician Assistant) stated he did not remember if he was notified of the Metoprolol for Resident 6. Staff 15 stated he would lower the dose of Resident 6's Metoprolol due to the low blood pressures.

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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 reviews it was determined the facility failed to provide nail care to dependent residents for 1 of 2 sampled dependent residents (#6) reviewed for ADLs. This placed residents at risk for lack of dignity. Findings include: Resident 6 was admitted to the facility in 3/2025 with diagnoses including a cerebral infarction (stroke) and hemiplegia (paralysis) of the left side of the body.On 8/4/25 at 10:59 AM, Resident 6 stated her/his fingernails needed to be trimmed. Resident 6's fingernails were observed to be long, jagged, and dirty and her/his big toenails were observed to be long and jagged.On 8/7/25 at 11:13 AM, Staff 19 (CNA) stated residents received nail care on shower days. Staff 19 stated she completed nailcare for Resident 6 two weeks ago after a shower.On 8/7/25 at 2:40 PM Resident 6's fingernails and toenails were observed with Staff 3 (LPN Resident Care Manager). Resident 6's fingernails were observed to be long, jagged, and dirty and her/his big toenails were observed to long and jagged. Staff 3 stated the CNA staff were expected to provide nail care with showers and as needed in between showers.

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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 observation, interview, and record review it was determined the facility failed to monitor for changes in skin for 1 of 1 sampled resident (31) reviewed for choices. This placed residents at risk for delayed treatment and unmet needs. Findings include: A 3/31/25 revised facility Wound Management Guideline revealed when a resident was identified to have a new skin alteration, the nurse was to obtain treatment orders, monitor the skin alteration, and document progress on the TAR.Resident 31 was admitted to the facility in 5/2023 with diagnoses including stroke and aphasia (a disorder that impairs the ability to communicate).The 5/26/25 Annual MDS indicated Resident 31 had a BIMS assessment score of 13 (cognitively intact), had no skin issues, and was sometimes difficult to understand.A 5/29/25 revised care plan revealed Resident 31 was at risk for skin impairment. Staff were to report changes regarding the resident's skin and identify potential causes.A review of the 6/2025 TAR revealed no new skin issues for Resident 31 during weekly skin audits.A 6/23/25 Late Entry Note Text indicated Resident 31 was not interested in seeing a specialist out of town for her/his scalp lesion and denied pain or itching to her/his scalp lesion.A 7/5/25 Physician's Progress Note revealed Resident 31 had a 5 cm dark lesion on the top of her/his scalp with no rash.Review of Resident 31's clinical record on 8/4/25 revealed no additional notes related to Resident 31's lesion on her/his scalp.On 8/4/25 at 10:54 AM, Resident 31 was observed to touch and point to her/his scalp and indicated concern through her/his facial expression and repetitive action of touching her/his head.On 8/5/25 at 4:23 PM, Staff 9 (Registered Nurse) stated she was aware of Resident 31's skin lesion on her/his scalp and did not monitor it.On 8/5/25 at 4:28 PM, Staff 3 (LPN-Resident Care Manager) stated she was unaware of any further follow-up from the resident's physician. Staff 3 acknowledged Resident 31's skin lesion on her/his scalp was not monitored at the time it was discovered to ensure there were no further changes.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview. and record review, it was determined the facility failed to complete a baseline care plan and provide ongoing behavioral health needs for 1 of 3 sampled residents (#46) reviewed for mood and behavior. This placed residents at risk for unmet behavioral health needs and decrease in their quality of life. Findings include: Resident 46 was admitted to the facility on [DATE] with diagnoses including depression.An 8/2/25 Progress Note revealed Resident 46 had suicidal ideations and was sent to the hospital for evaluation. An 8/3/25 Progress note revealed Resident 46 returned to the facility at approximately 2:00 AM and it was determined she/he was not at risk for imminent harm to her/himself or others.An 8/2/25 After Visit Summary indicated Resident 46 was not at risk for imminent harm to her/himself or others and Resident 46 declined completing a safety plan but agreed to complete a follow up call with Mental Health on 8/3/25.On 8/6/25 at 10:34 AM, Resident 46 stated she/he was not having suicidal ideations currently and Resident 46 stated no one needed to worry, she/he had, no way to do it anyways. On 8/6/25 at 11:45 AM, Staff 17 (CNA) stated she was unaware of Resident 46's suicidal ideation and the information was not on the Kardex (care plan for CNAs).On 8/6/25 at 11:51 AM, Staff 18 (CNA) stated she was assigned as Resident 46's CNA on 8/6/25 and Resident 46 made statements of feeling sad and wanting to go home. Staff 18 stated she was unaware Resident 46 had suicidal ideations over the weekend, it was not on the Kardex, and she did not receive the information from shift report.A review of Resident 46's care plan and Kardex revealed no evidence of a mental health or suicidal ideation care plan or safety interventions.A review of Resident 46's medical record revealed no evidence of a follow up call to Mental Health on 8/3/35.On 8/6/25 at 12:22 PM, Staff 2 (Interim DNS/RNCM) stated she was unaware the After Visit Summary and mental health notes were in the chart and she had not read them yet. Staff 2 stated she was informed the follow up from Resident 46's hospital visit was completed. Staff 2 stated her expectation was upon return from the hospital Resident 46 would be placed on every 15-minute checks, her/his care plan and Kardex updated immediately, and the call from Mental Health would have been completed on 8/3/25 per the After Visit Summary. Staff 2 acknowledged Resident 46's care plan and Kardex were not updated and the call to Mental Health had not occurred. Staff 2 acknowledged the facility failed to follow up on Resident 46's mental health needs.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review it was determined the facility failed to obtain fasting serum blood sugars as ordered for 1 of 5 sampled residents (#5) reviewed for medications. This placed residents at risk for uncontrolled blood sugars. Findings include: Resident 5 was admitted to the facility in 3/2025 with diagnoses including diabetes and diabetic neuropathy (nerve pain).The 3/25/25 hospital Orders at Discharge indicated Resident 5 was to receive daily insulin (medication used to manage blood sugar levels) injections and have Fasting Serum Blood Sugars (FSBS) monitored (a method used to measure blood glucose levels after a period without food).A 6/2/25 revised care plan indicated Resident 5's diabetic medication was to be monitored for side effects and effectiveness, and FSBS were to be completed as ordered.The 7/2025 and 8/2025 Diabetic Administration Records revealed no documented FSBS results for Resident 5.On 8/4/25 at 11:19 AM, Resident 5 stated she/he was a diabetic, received insulin, and expressed concern her/his FSBS were rarely monitored.On 8/6/25 at 12:30 PM, Staff 8 (LPN) acknowledged the hospital discharge order for Resident 5's FSBS was missed during the admission process. Staff 8 stated FSBS were typically obtained weekly for diabetic residents.On 8/6/25 at 1:37 PM, Staff 3 (LPN-Resident Care Manager) stated she expected Resident 5 to have FSBS orders in place and followed.On 8/8/25 at 8:41 AM, Staff 2 (Interim DNS/RNCM) stated nurse managers were expected to review new resident orders within 24 hours to ensure accuracy.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review it was determined the facility failed to ensure adequate staffing for meal service for 1 of 1 facility kitchen. This placed residents at risk for nutritional complications and adverse effects related to diabetic management. Findings include: A 1/30/25 Meal Time, Ticket Separation, and Dining Room memo directed CNAs and Dietary staff to communicate promptly when food or nursing staff assigned to assist with meals were delayed. The scheduled lunch start time was 11:30 AM.On 8/4/25 at 12:03 PM, Staff 8 (LPN) stated lunch was scheduled to be served at 11:30 AM in the main dining room and at 12:00 PM in other dining areas.On 8/4/25 at 12:38 PM the meal cart arrived at the North Hall Dining Room (dining room where residents received meal assistance).On 8/4/25 at 12:44 PM (74 minutes after the scheduled start of lunch service), the final hall meal cart arrived.On 8/7/25 at 10:41 AM, Staff 4 (Dietary Manager) acknowledged the kitchen was very late with meal service on 8/4/25. Staff 4 confirmed meals were routinely delayed one to two times per week, with delays of up to 45 minutes.On 8/7/25 at 11:30 AM, Staff 6 (Cook) stated the final meal cart was expected to be completed by 12:15 PM. Staff 6 was observed to continue to cook vegetables for the lunch meal.On 8/7/25 at 11:53 AM, Staff 10 (LPN) stated he was rarely notified of late meals and was not informed the lunch meal would be delayed on 8/7/25. Staff 10 stated delayed meals impacted diabetic medication administration for residents who required medications prior to meals.On 8/7/25 at 12:15 PM, Staff 6 was observed assembling resident meals and stated the final meal cart was late.On 8/7/25 at 12:19 PM, Staff 4 began to assist Staff 6 with meal tray service.On 8/7/25 at 12:35 PM, the final meal cart left the kitchen (65 minutes after the scheduled start of lunch service).On 8/7/25 at 1:48 PM, Staff 4 stated he was unable to assist Staff 6 effectively due to limited space in the kitchen. Staff 4 acknowledged the facility's kitchen meal service system required improvement.On 8/7/25 at 2:25 PM and 8/8/25 at 8:32 AM, Staff 1 (Administrator) acknowledged there were no clearly defined expectations for meal service timing between nursing and dietary staff. Staff 1 expected the facility to deliver meals on time through coordinated teamwork, improved communication, and increased kitchen efficiency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to maintain a sanitary kitchen environment and ensure adequate plumbing for the ice machine for 1 of 1 facility kitchen. This placed residents at risk for cross-contamination and food borne illnesses. Findings include:On 8/7/25 at 9:55 AM the following areas were observed in the kitchen:-A white painted cabinet door under the sink in the food preparation area had exposed wood and black marks around the door edge. When the cabinet door was rubbed, paint was easily removed. -The baseboard under a counter was detached from the cabinet. Black debris between the baseboard and the cabinet was visible and not accessible for cleaning. -The ice machine was directly plumbed from the outside with no one inch air gap. Under the ice machine was a metal plate attached to the floor. A one-inch-wide rim of black debris was observed around the metal plate on the floor. On 8/7/25 at 10:41 AM and 10:58 AM, Staff 4 (Dietary Manager) acknowledged there were a lot of uncleanable surfaces in the kitchen, the ice machine was not properly installed, and the expectation was to have a kitchen with all stainless-steel cabinets and new floors to address kitchen sanitation.On 8/7/25 at 2:39 PM, Staff 20 (Corporate Maintenance) stated he expected the ice machine to have a one-inch air gap for correct installation to ensure no sewage backflow.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review it was determined the facility failed to ensure residents were fully informed and understood the binding arbitration agreement for 1 of 1 facility reviewed for binding arbitration agreements. This placed residents at risk of being uninformed of their legal rights. Findings include:The facility's undated Patient and Facility Arbitration Agreement stated, the parties understand and agree that by entering this arbitration agreement they are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and jury. On 8/4/25 at 10:19 AM, Staff 16 (DNS) stated all residents had signed the Patient and Facility Arbitration Agreement. On 8/7/25 at 3:31 PM, Staff 1 (Administrator) stated the facility offered a Patient and Facility Arbitration Agreement to residents upon admission. Staff 1 stated Staff 14 (Medical Records Director) was responsible for the process of explaining the agreement to residents upon admission. On 8/7/25 at 3:39 PM, Staff 14 stated she was responsible to provide residents with information related to the facility's Patient and Facility Arbitration Agreement upon admission. Staff 14 further stated her explanation of the agreement to residents included they can go to court if we have violated their rights. On 8/7/25 at 3:48 PM, Staff 1 acknowledged the facility was not providing correct information regarding binding arbitration agreements to residents.