

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/05/2025
NAME OF PROVIDER OR SUPPLIER  Avamere Rehabilitation of Lebanon		STREET ADDRESS, CITY, STATE, ZIP CODE  350 S. 8th Lebanon, OR 97355	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41453</p> <p>Based on interview and record review it was determined the facility failed to follow resident rights for 1 of 3 sampled residents (# 2) reviewed for resident rights. This placed residents at risk for lack of dignity. Findings include:</p> <p>Resident 2 admitted to facility in 7/2024, with diagnoses including dementia.</p> <p>A 1/2025 Quarterly MDS Assessment indicated Resident 2 was moderately cognitively impaired.</p> <p>The facility's abuse investigation dated 10/3/24 indicated the following:</p> <p>-Staff 4 (CNA) changed Resident 2's soiled shirt. Resident 2 had told Staff 4 to leave her/him alone and not change her/his shirt.</p> <p>-On 10/3/24 Resident 2 stated the lady took her/him to the room and ripped Resident 2's shirt off. Resident 2 stated they refused to have their shirt removed.</p> <p>-On 10/3/24 Staff 4 (CNA) stated she went into Resident 2's room to change her/his shirt. The shirt was a lot dirtier than just wiping it off. Staff 4 stated she explained this to Resident 2, but the resident fought and cussed at her while she changed the resident's shirt. Staff 4 notified Staff 5 (LPN) that Resident 2 was very upset about their shirt being changed.</p> <p>-On 10/4/24 Staff 5 (LPN) stated Staff 4 (CNA) told her that Resident 2 was mad because she made Resident 2 change their shirt.</p> <p>On 5/2/25 at 6:05 AM, Staff 3 (CNA) stated she heard about the incident and recalled the education received by all staff afterward. Staff 3 stated Staff 4 should have gotten a second CNA or the nurse and not complete the task on her own.</p> <p>On 5/2/25 at 7:06 AM, Staff 6 (CNA/RA) stated she remembered Resident 2 crying. Resident 2 told her something about a girl and her/his shirt. Staff 6 indicated she was unsure what occurred but knew something wrong had happened. Staff 6 stated she informed the nurse of the situation.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/25 at 9:12 AM, Staff 8 (LPN/RCM Assistant) stated at the time of the incident Resident 2 appeared in distress. Staff 8 stated Resident 2 never used the words abuse, and when asked only repeated the details of the incident, but it was clear Resident 2 was forced to do something she/he did not want to do. Staff 8 recalled two days later Resident 2 no longer had any recollection of the incident.</p> <p>Attempts to contact Staff 4 (CNA) were unsuccessful and Staff 4 did not return the surveyor's calls.</p> <p>On 5/5/25 at 11:00 AM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed the information of the incident was accurate and the failure to maintain resident rights had occurred.</p>