STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385168	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Lebanon	350 S. 8th Lebanon, OR 97355

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to respond timely to a resident's grievance for 1 of 2 sampled residents (#8) reviewed for missing property. This placed residents at risk for unresolved concerns. Findings include: A Grievance Policy last revised 1/2017 revealed the facility would promptly address grievances. The grievance would be addressed within five days of its receipt. The Grievance official, administrator, or department head would contact the concerned party to inform them of the resolution of their concern. Resident 8 was admitted to the facility in 4/2021 with a diagnosis of diabetes. Resident 8's 5/14/25 quarterly MDS revealed she/he was cognitively intact. Resident 8's Missing Property investigation initiated on 7/11/25 revealed when she/he went to take money out of her/his wallet, there was only 20 dollars instead of 65 dollars in her his wallet. Resident 8 reported there should have been three 20-dollar bills and five one-dollar bills. With the resident's permission, staff looked in Resident 8's wallet and observed one 20-dollar bill and some loose change. On 7/14/25 Staff 3 (LPN Resident Care Manager) indicated theft was ruled out because Resident 8 made multiple statements, Resident 8 was offered to lock her/his remaining money in a safe, and Staff 4 (Social Services) was notified. On 7/21/25 at 12:30 PM Resident 8 stated she/he reported her/his money was missing and no one told her/him if the money would be reimbursed. On 7/21/25 at 12:44 PM Staff 3 stated she spoke to Resident 8 multiple times and the amount of money she/he reported missing kept changing. Staff 3 stated after she completed her/his investigation she notified Staff 4. Staff 3 indicated she was not sure if Resident 8 was going to be reimbursed her/his money or not.On 7/22/25 at 9:48 AM Staff 4 stated last week she was told Resident 8 was going to be reimbursed her/his lost money, so she/he did not communicate the findings with Resident 8. On 7/22/25 at 2:19 PM Staff 1 (Administrator) acknowledged the Grievance policy revealed staff were to resolve a resident's concerns within five days of receipt of the issue and staff did not notify Resident 8 of the resolution of her/his reported missing money timely.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review it was determined the facility failed to ensure a resident's cell phone was not stolen for 1 of 2 sampled residents (#3) reviewed for missing property. This placed residents at risk for loss of property. Findings include:Resident 3 was admitted to the facility in 8/2023 with a diagnosis of a stroke. Resident 3's 2/19/25 quarterly MDS revealed she/he was cognitively intact. Resident 3's 4/7/25 Theft investigation revealed Resident 3 reported her/his cell phone was missing. Resident 3 reported on the evening of 4/6/25 she/he used the phone to call her/his spouse and after the call was completed placed the phone on her/his bedside table. The investigation included staff interviews verifying Resident 3 had her/his phone the evening of 4/6/25. Resident 3's spouse filed a police report the following day. Resident 3's spouse was able to use a phone locator and Resident 3's phone was a few blocks from the facility. A 5/10/25 letter from Witness 1 revealed a request for reimbursement for the lost phone and for the purchase of a new phone. A 5/16/25 bank check Pay to the Order to Witness 1 revealed the dollar amount requested by Witness 1 on 5/10/25.On 7/21/25 at 11:19 AM Resident 3 stated she/he always kept her/his phone in her/his room when she/he was in the room or on a lanyard around her/his neck. Resident 3 stated on 4/6/25 she/he called her/his spouse and placed her/his phone on the bedside table and then went to sleep. Resident 3 stated no one came in her/his room except staff and at times her/his roommate's visitors. Resident 3 stated Witness 1 was able to find the approximate location of the phone the next day, and it was about eight blocks from the facility. Witness 1 (via phone) stated the facility investigated the incident and reimbursed her/him in a timely manner. On 7/21/25 at 2:54 PM Staff 17 (CNA) stated Resident 3 always had her/his phone either around her/his neck with a lanyard or on her/his bedside table. Resident 3 did not leave the facility unless she/he had an appointment and when she/he left the facility, she/he always took her/his phone. Staff 17 stated he recalled Resident 3 had her/his phone the evening of 4/6/25 and it was missing the next day. The deficient practice was identified as Past Noncompliance based on the following: -4/7/25 Resident 3 reported a missing cell phone.-4/7/25 A FRI was submitted, and an investigation was initiated-A facility wide search for Resident 3's phone was unsuccessful-4/8/25 a police report was filed.-4/9/25 Resident 3's spouse was notified of the reimbursement procedure-5/10/25 a request for reimbursement was submitted by Witness 1.-5/16/25 reimbursement was provided to Witness 1.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review it was determined the facility failed to provide adequate staffing to meet resident needs for 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet needs. Findings include:1. Resident 3 was admitted to the facility in 3/2025 with diagnoses including dementia and stroke. A 5/2025 Documentation Survey Report revealed Resident 3’s showers were typically provided during the evening shifts. The resident was scheduled to receive a shower on 5/27/25, and there was no documentation Resident 3’s shower was completed. The 5/27/25 Direct Care Staff Daily Report indicated five CNAs worked during the evening shift with a facility census of 56 residents. A 6/2/25 public complaint was received which alleged, on 5/27/25, each CNA had 12 residents during the evening shift due to call outs, and it was possible resident showers were not provided. A 6/12/25 revised care plan indicated Resident 3 required one person to assist with bathing. On 7/21/25 at 12:14 PM, Staff 13 (LPN) stated she recalled 5/27/25 as a “terrible” day. Staff 13 stated the facility was understaffed, she answered numerous call lights, and there was a lack of assistance from management to help on the floor. Staff 13 stated she often skipped breaks and stayed after hours to complete her charting when there was a lack of CNA staffing. On 7/21/25 at 2:20 PM, Staff 6 (CNA) stated on 5/27/25 the staff were unable to complete Resident 3’s shower due to insufficient staff. Staff 6 stated showers were frequently missed for residents due to unresolved facility staffing issues. On 7/21/25 at 3:54 PM, Staff 4 (Social Service Director) confirmed on 5/27/25 efforts were made to contact agency staff resources, and no staff responded to the request for assistance. Staff 4 acknowledged staff not working when scheduled remained an issue. On 7/22/25 at 2:20 PM, Staff 1 (Administrator) stated the facility’s issues related to staffing and meeting the needs of residents remained a concern and a focus since 12/2024. Staff 1 confirmed resident needs were not met on 5/27/25 since the facility was short-staffed. Staff 1 acknowledged additional staffing resources were necessary to meet resident needs. 2. A public complaint received on 2/4/25 alleged the facility did not provide adequate staffing on 2/1/25. A review of the 2/1/25 Daily Nursing Assignment revealed there were five CNAs scheduled to work from 2:00 PM to 10:00 PM, one CNA to float between 2:00 PM and 4 PM, and two CNAs scheduled to work 6:00 PM to 10:00 PM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 11:21 AM, Resident 4 stated she/he preferred to go to bed between 7:00 PM and 8:00 PM. Resident 4 stated there were frequently not enough CNAs scheduled and management did not help the CNAs when there were not enough CNAs. Resident 4 stated the CNAs would give up their lunch and breaks to provide care to the residents when they were short staffed. On 7/21/25 at 10:09 AM Witness 7 (Complainant/Former CNA) stated on 2/1/25 there were not enough CNAs scheduled for evening shift causing residents to get to bed late, missed showers, and residents were unable to get oral care due to staffing. Witness 7 stated she was Resident 4’s CNA on 2/1/25 and she did not put Resident 4 to bed until approximately 9:30 PM on 2/1/25. On 7/21/25 at 12:03 PM Staff 16 (CNA) stated the facility was short CNAs every day in 2/2025 and when they were short CNAs, he would have to prioritize care and sometimes showers would not get completed. Staff 16 stated he was Resident 5’s CNA on 2/1/25. Staff 16 stated if he did not chart a shower was completed, the shower was not completed. A review Resident 5’s 2/2025 Documentation Survey Report revealed no documentation Resident 5 received her/his scheduled shower on 2/1/25. On 7/21/25 at 12:23 PM, Staff 12 (Former Staff Coordinator/CNA) stated she was unable to remember if the facility was short CNAs on 2/1/25 but stated the facility was short on CNAs a lot. Staff 12 stated the facility continued to admit new residents even though there were not enough CNAs. On 7/21/25 at 1:20 PM, Staff 3 (LPN Resident Care Manager) stated she was sure the facility was short CNAs in 2/2025, but she could not remember specific dates. Staff 3 acknowledged when the CNAs worked short, they were unable to complete all required tasks. On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility had not provided adequate CNA staff to provide for residents’ needs on 2/1/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering. 3. A review of the 7/19/25 Direct Care Staff Daily report revealed the following: -On 7/19/25 day shift the census was 65 and there were eight CNAs scheduled. -On 7/19/25 evening shift the census was 64 and there were five and one half CNAs scheduled. A review of Oregon CNA ratios revealed the following: -Dayshift with a census of 65 required 10 CNAs. -Dayshift with a census of 63 required nine CNAs. -Evening shift with a census of 64 required seven CNAs. -Evening shift with a census of 63 required seven CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 11:21 AM, Resident 4 stated there were frequently not enough CNAs scheduled and management would not help the CNAs when there were not enough CNAs. Resident 4 stated the CNAs would give up their lunch and breaks to provide care to the residents when they were short staffed. On 7/21/25 at 12:23 PM, Staff 12 (Former Staffing Coordinator/CNA) stated the facility had a ton of CNA shortages, but the facility kept admitting new residents even though there were not enough staff. On 7/21/25 at 12:32 PM, Staff 15 (LPN) stated the staffing was getting better, but the last week was the worst. Staff 15 stated they were short CNAs a lot but especially on 7/19/25. Staff 15 stated the census was going up and the facility did not have the staff to care for the residents. On 7/21/25 at 1:20 PM Staff 3 (LPN Resident Care Manager) stated the facility was short CNAs off and on throughout the year. Staff 3 stated she was on call on 7/19/25 and there were not enough CNAs for day and evening shifts. Staff 3 stated the CNA staff informed her they needed help, and she attempted to find coverage but was unable to. On 7/21/25 at 4:35 PM, Staff 7 (CNA) stated they frequently worked without enough CNAs on day shift and evening shift. Staff 7 stated she could complete all required tasks but frequently stayed late to finish. On 7/22/25 at 11:15 AM Staff 8 (RN) stated they were short CNAs on 7/19/25. Staff 8 stated another nurse called the on-call nurse, Staff 3, and Staff 2 (DNS) to request help. Staff 8 stated, “no managers came in to help us, they just left us short staffed.” On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility had not provided adequate CNA staff to provide for residents’ needs on 7/19/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering. a. Resident 9 was admitted to the facility in 1/2024 with a diagnosis of a stroke. Resident 9’s Care Plan Report revealed she/he required one person assistance for bathing. Resident 9’s 4/17/25 quarterly MDS revealed she/he was moderately cognitively impaired, was able to participate in the mood interview, and was able to express her/his needs. Resident 9’s 7/2025 ADL report revealed she/he was to be bathed on Wednesdays and Saturdays. There was no documentation for 7/19/25, Saturday, to indicate if bathing was provided. On 7/21/25 at 1:14 PM Staff 18 (CNA) stated Resident 9 did not receive a shower on 7/19/25 due to short staffing. On 7/22/25 at 1:21 PM Resident 9 indicated she/he did not receive a shower on 7/19/25, and she/he did not decline a shower. Resident 9 also indicated she/he was not happy she/he did not receive a shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/25 at 9:53 AM Staff 3 (LPN Resident Care Manager) stated on 7/19/25 she was aware showers were not provided due to staffing, including Resident 9’s shower, and “make-up” showers were provided on 7/21/25. On 7/22/25 at 10:09 AM Staff 2 (DNS) stated she was aware there were concerns related to short staffing, staff were not able to complete charting, but she was not aware bathing was not being completed. On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility had not provided adequate CNA staff to provide for residents’ needs on 7/19/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering. b. Resident 10 was admitted to the facility in 7/2018 with a diagnosis of a stroke. Resident 10’s 5/16/25 annual MDS revealed she/he was cognitively impaired and required extensive assistance with bathing. Resident 10’s 7/2025 ADL report revealed she/he was to be bathed on Wednesdays and Saturdays. On 7/19/25, Saturday, it was documented Resident 10 refused bathing. On 7/22/25 at 9:45 AM Staff 5 (CNA) stated Resident 10 did not refuse to bathe on 7/19/25 but there were no options to document staff did not have time to provide bathing. Staff 5 stated they did not have enough staff, and she did not have time to provide Resident 10 her/his bath. Staff 5 stated Resident 5 was provided a make-up bath on 7/21/25. On 7/22/25 at 9:53 AM Staff 3 (LPN Resident Care Manager) stated on 7/19/25 she was aware showers were not provided due to staffing, including Resident 10’s shower, and “make-up” showers were provided on 7/21/25. On 7/22/25 at 10:09 AM Staff 2 (DNS) stated she was aware there were concerns related to short staffing, staff were not able to complete charting, but she was not aware bathing was not being done. On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility had not provided adequate CNA staff to provide for residents’ needs on 7/19/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering. c. Resident 11 was admitted to the facility in 2/2017 with a diagnosis of cancer. Resident 11’s 11/26/24 annual MDS revealed she/he had limited mobility and required the assistance of one staff for bathing. Resident 11’s 5/24/25 quarterly MDS revealed she/he was cognitively intact. Resident 11’s ADL report revealed she/he was to be bathed on Wednesdays and Saturdays. It was documented Resident 11 refused to shower on 7/19/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 2:05 PM Resident 11 stated on Saturday, 7/19/25 the staff were short staffed and very busy, and she/he did not refuse to take a shower. Resident 11 stated she/he received a “make-up” shower today. On 7/21/25 at 7:40 PM Staff 19 (CNA) stated the facility worked short staffed on 7/19/25 and Resident 11 was not provided a shower. Resident 11 did not refuse to take a shower, but there were no additional code options to document indicating a shower was not provided due to low staffing. On 7/22/25 at 9:53 AM Staff 3 (LPN Resident Care Manager) stated she was aware showers were not provided due to staffing on 7/19/25 and “make-up” showers were provided on 7/21/25, including Resident 11. On 7/22/25 at 10:09 AM Staff 2 (DNS) stated she was aware there were concerns related to short staffing, staff were not able to complete charting, but she was not aware bathing was not being done. On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility had not provided adequate CNA staff to provide for residents’ needs on 7/19/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering. 4. A review of 7/20/25 Direct Care Staff Daily report revealed the following: -On 7/20/25 day shift the census was 63 and there were seven CNAs scheduled. -On 7/20/25 evening shift the census was 63 and there were five CNAs scheduled A review of Oregon CNA ratios revealed the following: -Dayshift with a census of 63 required nine CNAs. -Evening shift with a census of 63 required seven CNAs. On 7/21/25 at 11:21 AM, Resident 4 stated there were frequently not enough CNAs scheduled and management would not help the CNAs when there were not enough CNAs. Resident 4 stated the CNAs would give up their lunch and breaks to provide care to the residents when they were short staffed. On 7/21/25 at 12:23 PM, Staff 12 (Former Staffing Coordinator/CNA) stated the facility had a ton of CNA shortages, but the facility kept admitting new residents even though there were not enough staff. Staff 12 stated on 7/20/25 they had seven CNAs on day shift and five CNAs on evening shift. On 7/21/25 at 12:32 PM, Staff 15 (LPN) stated the staffing was getting better, but the last week was the worst. Staff 15 stated they were short CNAs a lot but especially on 7/20/25. Staff 15 stated the census was going up and the facility did not have the staff to care for the residents. On 7/21/25 at 1:20 PM Staff 3 (LPN Resident Care Manager) stated the facility was short CNAs off and on throughout the year. Staff 3 stated she was on call on 7/20/25 and there were not enough CNAs for day and evening shifts. Staff 3 stated the CNA staff informed her they needed help, and she attempted to find coverage but was unable to. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 2:49 PM, Staff 14 (CNA) stated they worked short a lot, especially on 7/20/25. Staff 14 stated when there was enough CNAs, she would prioritize care and was unable to complete showers, oral care, and personal hygiene. Staff 14 stated there were some days when they were short CNAs and she was only able to change residents, get them up for their meal, and lay them back down in bed after dinner. On 7/21/25 at 4:35 PM, Staff 7 (CNA) stated they frequently worked without enough CNAs on day shift and evening shift. Staff 7 stated she could complete all required tasks but frequently stayed late to finish. On 7/21/25 at 4:45, Staff 5 (CNA) stated they were short CNAs a lot, for the last week they were short one to two CNAs every day. Staff 5 stated the management knew there was not enough staff, and they kept admitting new residents. Staff 5 stated on 7/20/25 they did not have enough CNAs, and she was unable to complete one of two showers she was assigned. On 7/22/25 at 2:20 PM Staff 1 (Administrator) acknowledged the facility did not provide adequate CNA staff to provide for residents’ needs on 7/20/25. Staff 1 stated they had a census cap of 63 related to staffing and he would look at lowering.