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	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Lebanon	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)
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 interview and record review, it was determined the facility failed to ensure dependent residents received ADL assistance for bathing for 1 of 3 sampled residents (#7) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include:Resident 7 was admitted to the facility in 10/2025 with diagnoses including dementia and stroke. A 10/21/25 admission MDS indicated Resident 7 had severe cognitive impairment and was dependent on staff for showers. Resident 7's 12/2025 Documentation Survey Report (CNA task report) indicated the resident received bathing on day shift on Wednesdays and Sundays. On 12/24/25 the report was blank for bathing and on 12/28/25 the report documented Resident 7 received bathing and was dependent on staff for assistance. The facility's 12/29/25 investigation documented that Resident 7 did not receive a bath on 12/28/25, and it had been falsely documented the resident received bathing on that day. A Facility Reported Incident form dated 12/31/25, documented on 12/28/25, indicated Staff 5 (CNA) noted providing bathing to Resident 7, however, Staff 5 did not provide any type of bathing to the resident. Resident 7's 3/2026 Documentation Survey Report showed no documentation the resident received any type of bathing on 3/11/26. On 3/16/26 at 12:14 PM and 3/17/25 at 9:01 AM, attempts to contact Staff 5 were unsuccessful. On 3/17/26 at 9:55 AM, Staff 7 (CNA) stated on 12/28/25 she watched Staff 5 lay Resident 7 down. Staff 7 asked Staff 5 about her/his bathing and Staff 5 told Staff 7 she would complete Resident 7's bathing in the evening. Staff 7 stated she could not do Resident 7's bathing in the evening as she moved to a different hall on evening shift. On 3/16/26 at 12:27 PM, Staff 21 (CNA) stated usually if bathing was not documented in the resident's record, bathing did not occur. On 3/17/26 at 12:17 PM, Staff 31 (Regional Nurse) stated staff should provide scheduled bathing to residents.

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 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 obtain orders and provide treatment for non-pressure skin wounds for 1 of 3 sampled residents (#2) reviewed for change of condition. This placed residents at risk for worsening wounds. Findings include:Resident 2 was admitted to the facility in 10/2025 with diagnoses including diabetes and non-pressure chronic ulcer on the left foot. The hospital Physician Admissions Orders dated 10/29/25 documented an ulcer of the left second toe, limited to breakdown of skin and pain of the toe. A 10/30/25 admission Nursing Database assessment recorded scabs on Resident 2's 2nd and 4th toes and the top of her/his left foot. A 11/6/25 admission MDS indicated Resident 2 had a non-pressure chronic ulcer on the left foot. No physician orders or treatment were found in Resident 2's clinical records for her/his left foot ulcer from 10/30/25 through 11/15/25. A Nursing Care Note dated 11/16/25 documented staff sent a message to the physician which indicated Resident 2's left second toe had a scab and treatment was initiated. On 3/17/26 at 11:32 AM, Staff 28 (Agency LPN) stated she could not remember whether she had confirmed physician orders for treatment when she completed the 10/30/25 admission Nursing Database assessment. Staff 28 stated the normal practice would be if there were no orders on admission, the physician would need to be contacted for clarification. On 3/17/26 at 12:11 PM, Staff 31 (Regional Nurse) stated staff should ensure physician orders existed for a resident with skin wounds.