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	05/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, it was determined the facility failed to reduce the risk of a potential accident hazard for 1 of 3 sampled residents (#1) reviewed for accidents. This placed residents at risk for accidents. Findings include:Resident 1 was admitted to the facility in 3/2026 with diagnoses including diabetes, foot ulcer and chronic pain. A 4/4/26 admission MDS indicated Resident 1 was cognitively intact. A 4/23/26 After Visit Summary indicated post-anesthesia/sedation instructions to not stay alone, a responsible person should be with you as you may be lightheaded, experience dizziness, and sleepiness. On 5/1/26 the State Survey agency received a public complaint alleging Resident 1 did not have a staff member accompany the resident to the medical appointment. The resident needed assistance with her/his wheelchair going long distances, up inclines and over bumps. On 5/8/26 at 8:29 AM, Resident 1 stated she/he had day surgery for her/his foot on 4/23/26. Staff 16 (CNA) accompanied her/him to the surgery, but the facility later picked up Staff 16. Resident 1 stated no one waited for her/him to assist her/him back to the facility after surgery. Resident 1 stated she/he had to return to the facility by herself/himself after being under anesthesia. On 5/12/26 at 9:23 AM, Staff 16 stated on 4/23/26 she accompanied Resident 1 to her/his surgery appointment, but she was not with Resident 1 to assist her/him with transport back to the facility. On 5/12/26 at 11:55 AM, Staff 8 (Social Services Coordinator) stated at some point Staff 16 was picked up from Resident 1's surgery appointment and Resident 1 did not have a staff member to accompany her/him back to the facility after she/he had surgery. On 5/12/26 at 12:51 PM, Staff 1 (Administrator) stated she expected staff to escort Resident 1 while transporting back from surgery to the facility.

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
	385168	A. Building B. Wing	05/12/2026

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 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 interview and record review it was determined the facility failed to provide sufficient staffing to meet resident needs in a timely manner for 3 of 4 sampled residents (#s 1, 2 and 5) reviewed for call light times. This placed residents at risk for unmet needs. Findings include:The facility's 4/29/26 Quality Assurance Resident Council meeting minutes indicated resident's call lights were not answered timely. Attached to the report were the Bi-Monthly Resident Counsel Questions. One question asked whether staff respond to call lights within a 10-minute time frame; the documented response was no. Another question asked whether there were enough staff to meet residents' needs, and the documented response was no. 1. Resident 1 was admitted to the facility in 3/2026 with diagnoses including diabetes and chronic pain. A 3/30/26 care plan indicated Resident 1 was at high risk for falls. The Call Data Report for call light wait times from 4/1/26 through 4/7/26 indicated the following:-On 4/4/26 at 4:16 PM, Resident 1's call light wait time was 20 minutes and at 6:52 PM the call light wait time was 25 minutes.-On 4/5/26 at 10:35 AM, Resident 1's call light wait time was 23 minutes. A 4/4/26 admission MDS indicated Resident 1 was cognitively intact. On 5/1/26 the State Survey agency received a public complaint alleging Resident 1's call light was not answered timely and on one occasion it took staff over 30 minutes to respond. On 5/8/26 at 8:29 AM, Resident 1 stated around the first part of 4/2026 call light wait times were long and there were not enough staff to assist the residents timely. On 5/12/26at 11:18 AM, Staff 18 (CNA) stated residents complained of long call light wait times. Staff 18 stated she did not feel the facility staffed enough CNAs for the acuity of the residents. Staff 18 stated on 4/5/26 at 10:35 AM, she could have been providing another resident with a shower and that was why Resident 1's call light time was 23 minutes long. On 5/12/26 at 11:41 AM, Staff 17 (CNA) stated the facility was most likely short-staffed on 4/4/26. Staff stated that around 4:00 PM CNAs assisted residents up for dinner, and around 7:00 PM CNAs assisted residents for bed. Staff were busy during these times and call light wait times could have been longer. On 5/12/26 at 12:51 PM, Staff 1 (Administrator) stated the expectations for staff for call light wait times was 10 minutes or less. 2. Resident 2 was admitted to the facility in 9/2019 with diagnoses including diabetes, anxiety and chronic pain. A revised Care Plan dated 6/13/24 indicated Resident 2 had alteration to musculoskeletal status due to contractures to both legs. Staff were to anticipate and meet needs; call light was to be in reach while in bed; and staff were to respond promptly to all requests for assistance. A 2/5/26 Quarterly MDS indicated Resident 2 was cognitively intact. The Call Data Report for call light wait times from 4/8/26 through 4/12/26 indicated the following:-On 4/8/26 at 11:03 AM, Resident 2's call light wait time was 25 minutes.-On 4/9/26 at 8:18 AM, Resident 2's call light wat time was 35 minutes; at 12:56 PM 34 minutes; at 3:17 PM 23 minutes; at 5:41 PM 29 minutes; at 7:13 PM: 64 minutes; and at 9:54 PM 38 minutes.-On 4/11/26 at 3:34 PM, Resident 2's call light wait time was 26 minutes; at 4:49 PM 41 minutes; at 7:04 PM 49 minutes; and at 8:59 PM 48 minutes.-On 4/12/26 at 7:07 AM, Resident 2's call light wait time was 26 minutes. A 4/9/26 Verbal Aggression Received Investigation indicated Resident 2 exited her/his room, went to the medication cart, and was yelling potty, potty time and she/he wanted to use the restroom. On 5/11/26 at 8:51 AM, Resident 2 stated when staff did not come and answer her/his call light timely, she/he would go out to get them. On 5/12/26 at 8:44 AM, Staff 19 (CNA) stated residents complained of long call light wait times all the time. Staff 19 stated she saw residents who are continent have an incontinent episode because they could not hold it long enough. Staff 19 stated Resident 2 became verbally abusive to staff when she/he waited. Resident 2 yelled she/he wet her/his brief while waiting for staff to come and assist. On 5/12/26 at 8:59 AM, Staff 20 (CNA) stated she did not feel the facility had enough staff to meet the needs of the residents. Staff 20 stated Resident 2 required two staff to assist, and sometimes it was difficult to find another staff member to assist. On 5/12/26 at 12:51 PM, Staff 1 (Administrator) stated the expectations for staff (continued on next page)

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	05/12/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for call light wait times were 10 minutes or less. 3. Resident 5 was admitted to the facility in 4/2021 with diagnoses including diabetes and anxiety. A 2/11/26 Quarterly MDS indicated Resident 5 was moderately cognitively impaired. Resident 5 was dependent on staff for transfers. A 4/9/26 Grievance Communication Form indicated Resident 5 pushed her/his call light for two hours and no one came to assist. Resident 5 documented that she/he was supposed to be a resident and not a prisoner. The Call Data Report for call light wait times from 4/10/26 through 4/17/26 indicated the following:-On 4/10/26 at 6:13 PM, Resident 5's call light wait time was 37 minutes.-On 4/11/26 at 5:15 PM, Resident 5's call light wait time was 34 minutes; at 7:06 PM 34 minutes; and at 7:41 PM 40 minutes.-On 4/16/26 at 4:45 PM, Resident 5's call light wait time was 27 minutes. On 5/8/26 at 11:37 AM, Resident 5 stated call light wait times continued to be a problem. Resident 5 stated when there was long call light wait times, staff told her/him they were busy. Resident 5 stated she/he worried about what would happen if she/he had an emergency. On 5/12/26 at 9:51 AM, Staff 22 (CNA) stated she was concerned about evening shift staffing as there was not enough staff for the needs of the residents. Staff 22 stated mealtimes were busy, and she had observed negative resident outcomes due to waiting, such as having incontinent episodes when a resident was continent. Staff 22 stated Resident 5 was a two-person assist and at times it was difficult to find another staff member to assist, so Resident 5's call light wait times could be long. On 5/12/26 at 9:58 AM, Staff 23 (CNA) stated approximately 40 percent of the time the facility was not staffed to meet the needs of the residents for the last couple of years. Staff 23 stated at times she will be on her lunch and the other CNAs do not answer her assigned resident's call light. Another reason resident call light wait times are long was that she was providing a resident with a shower. On 5/12/26 at 12:51 PM, Staff 1 (Administrator) stated the expectations for staff for call light wait times were 10 minutes or less.

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	05/12/2026

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 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 lab samples for 1 of 3 sampled residents (#10) reviewed for change of condition. This placed residents at risk for a delay in treatment. Findings include:Resident 10 was admitted to the facility in 3/2026 with diagnoses including kidney disease. A 4/2/26 Nursing Note indicated the physician called to inform Staff 26 (RN) there were STAT (immediately) laboratory orders for complete blood count and leukocytosis (elevated white blood cell count). A 4/3/26 Order Note indicated Staff 24 (RN) had attempted two times to obtain the STAT CBC sample but was unable to do so. On 5/12/26 at 10:28 AM, Staff 24 stated she normally wrote a note if she could not obtain a lab sample and pass it on to the next shift. Staff 24 stated a physician-ordered lab test should have been completed on the same day as the order. On 5/12/26 at 12:14 PM, Staff 26 stated the facility received numerous STAT laboratory orders. Staff 26 stated she was often switched from one side of the facility to another, and she may not have completed the order. There was no documented evidence in Resident 10's clinical record the 4/2/26 STAT laboratory order was completed. On 5/12/26 at 12:59 PM, Staff 2 (DNS) stated she expected physician orders to be followed in a timely manner. STAT laboratory orders were expected to be completed within two to four hours.