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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385185 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/28/2024 |
| NAME OF PROVIDER OR SUPPLIER Avamere Riverpark of Eugene | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Alexander Loop Eugene, OR 97401 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>25504</p> <p>Based on observations, interview and record review it was determined the facility failed to follow physician orders and follow the care plan for 3 of 10 sampled residents (#s 3, 5 and 9) reviewed for medications and ADLs. This placed residents at risk for unmet care needs. Findings include:</p> <p>1. Resident 9 was admitted to the facility in January 2023 with diagnoses including chronic pain syndrome.</p> <p>Review of a physician order dated 1/5/23, revealed the resident was to receive Morphine (narcotic pain medication) 100 mg three times a day. The resident was to receive the Morphine at 8:00 AM, 2:00 PM and 9:00 PM.</p> <p>Review of a progress note dated 10/11/23 at 5:12 AM, revealed the facility was out of the resident's Morphine and the resident was upset and cursing at the nurse.</p> <p>Review of an October 2023 MAR revealed the resident was not administered Morphine on 10/11/23 at 8:00 AM.</p> <p>Review of a progress note dated 12/11/23 at 4:59 AM, revealed the facility was out of the resident's Morphine and the resident was upset. At 11:11 AM, Resident 9 reported a pain level of 10/10 and was administered PRN pain medication.</p> <p>Review of a December 2023 MAR revealed the resident was not administered Morphine on 12/11/23 at 8:00 AM.</p> <p>Observation on 3/20/24 at 10:04 AM, revealed Resident 9 was in bed and appeared in no acute distress and did not appear to be in pain.</p> <p>In an interview on 3/20/24 at 10:04 AM, Resident 9 said the facility did not administer 1-2 doses of Morphine. Resident 9 said the facility did not re-order the medication timely which caused the facility to run out of her/his medication. The resident indicated this caused her/him increased pain.</p> <p>In an interview on 3/28/24 at 8:30 AM, Staff 1 (Administrator) and Staff 2 (DNS) both acknowledged the resident did not receive Morphine pain medication as ordered by the resident's physician.</p> <p>2. Resident 3 was admitted to the facility in July 2023 with diagnoses including vascular dementia.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of a care plan dated 10/14/23, revealed the resident required assistance with ADLs due to dementia and a history of falls. Interventions included one person assist with bathing.</p> <p>Review of a progress note dated 2/2/24 at 11:16 PM, revealed the resident was found unresponsive to commands and heart rate at 140. The note indicated the resident was removed from the bathtub, taken to the resident's room, dried and dressed. Staff would continue to monitor.</p> <p>Review of an incident report/investigation dated 2/2/24, revealed the resident was left alone in the bathtub from 9:30 PM through 10:55 PM, and was found unresponsive. The resident was removed from the bathtub, returned to bed, placed on alert monitoring and the DNS was notified. The investigation revealed Resident 3 was on hospice care and had episodes of unresponsiveness and nonverbal. The resident care plan was reviewed and the care plan was not followed. Resident 3 was awake and responsive at 10:30 PM and back to baseline at 2:00 AM.</p> <p>In an interview on 3/20/24 at 9:45 AM, Resident 3 said she/he was left in the shower by herself/himself but did not remember the date. Resident 3 said he felt stuck and was not harmed.</p> <p>In an interview on 3/26/24 at 8:10 AM, Staff 3 (CNA) said on 2/2/24 the resident was taken to the shower by Staff 4 (CNA) and left in the bathtub from around 9:30-9:45 PM to around 11:00 PM. Staff 3 said the resident was removed from the bathtub by Staff 4 and the charge nurse and was awake but unresponsive and not talking. Staff 4 no longer worked at the facility.</p> <p>In an interview on 3/26/24 at 9:32 AM, Staff 5 (CNA) said on 2/2/24 Staff 4 had checked on the resident in the shower and then took a 30 minute break. Staff 5 said Staff 4 had forgotten Resident 3 was in the bathtub. Staff 5 was aware the resident required one person assist with showers.</p> <p>In an interview on 3/28/24 at 9:00 AM, Staff 2 (DNS) acknowledged the resident's care plan was not followed regarding bathing.</p> <p>3. Resident 5 was admitted to the facility in January 2024 with diagnoses including fibromyalgia.</p> <p>Review of a hospital physician order dated 1/6/24, revealed the resident was to receive colchicine (anti-inflammatory) by mouth daily.</p> <p>Review of a January 2024 MAR revealed the resident did not receive colchicine from 1/7/24 through 1/18/24.</p> <p>In an interview on 3/27/24 at 8:30 AM, Staff 2 (DNS) acknowledged the resident did not receive the colchicine as ordered by the resident's physician due to problems acquiring the medication from the pharmacy.</p> | | |