STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385185	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Riverpark of Eugene	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.

(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 - 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 ensure resident care equipment was monitored as recommended for 1 of 3 sampled residents (#12) reviewed for accidents. Resident 12 experienced a fall from a broken shower chair, sustained rib fractures, and a closed head injury. Findings include: Resident 12 was admitted to the facility in 9/2024 with diagnoses including stroke. A 5/14/25 Fall investigation revealed Staff 12 (CNA) was providing Resident 12 with a shower. Resident 12's shower chair broke and Resident 12 fell onto the shower room floor, complaining of head and right rib pain. Resident 12 was sent to the hospital. A 5/14/25 hospital After Visit Summary revealed Resident 12 was diagnosed with a rib fracture, a closed head injury, and a bruise. A review of the undated shower chair owner's manual revealed the chair was to be checked at least monthly for glued fittings by attempting to pull the polyvinyl chloride (type of plastic) out of the fittings. The pipes on the shower chair needed to be checked for cracking, fractures, or other damage at least monthly. A Work History Report printed on 7/9/25 revealed no inspections of shower chairs were completed in 2024 or 2025. On 7/8/25 at 12:35 PM, Resident 12 stated on 5/11/25 the shower chair came apart and two CNAs put the chair back together. On 5/14/25 she/he received a shower and the chair collapsed causing fractured ribs. On 7/8/25 at 2:03 PM, Staff 11 (CNA) stated on 5/11/25 Resident 12 was in the shower chair and Staff 10 (CNA) noticed a piece was coming apart on the chair. Staff 11 stated they transferred Resident 12 to her/his wheelchair and Staff 10 took the shower chair to the maintenance room. Attempts to reach Staff 10 on 7/8/25 and 7/9/25 were unsuccessful. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/8/25 at 2:24 PM, Staff 8 (Maintenance Lead) stated on 5/12/25, there was a shower chair in the boiler room. Staff 8 stated there was no note on the chair and no work order was received for the chair. Staff 8 stated he did a visual inspection and figured a work order would come in. The shower chair was gone from the boiler room on 5/13/25. Staff 8 stated he did not do anything with the chair. On 7/9/25 at 10:37 AM, Staff 12 stated she obtained the shower chair from the shower room on 5/14/25 and placed Resident 12 in the shower chair. Staff 12 did not hear any cracking noises when setting Resident 12 into the chair or while taking her/him to the shower room. After the shower was completed, Staff 12 rolled the chair toward her so she could dry Resident 12's feet and the shower chair collapsed. On 7/9/25 at 11:09 AM, Staff 1 (Administrator) stated during the investigation they identified the process for broken equipment needed to be more streamlined. The deficient practice was identified as Past Noncompliance based on the following: On 5/16/25, the deficient practice was identified by the facility and was corrected when the facility completed an investigation and identified system failures of using the same equipment which previously was broken. The Plan of Correction included: -Broken shower chair was removed and discarded. -A facility wide audit and inspection of all shower chairs was completed. A new process was implemented for logging equipment inspections as well as a new tagging process for equipment requiring maintenance. -Facility wide education was provided to staff on equipment safety checks, the process for when equipment needed maintenance, and the new tagging process for equipment requiring maintenance. -Audits were completed for random staff knowledge on equipment not functioning properly and audits of shower chairs' functional status were completed on the following dates: 5/23/25, 5/30/25, 6/6/25, 6/7/25, 6/13/25, 6/20/25, 6/27/25, and 7/3/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 2. Resident 16 was admitted to the facility in 7/2022 with diagnoses which included stroke. A 5/5/25 Bowel and Bladder Evaluation indicated Resident 16 was a candidate for scheduled toileting (timed voiding). A 5/5/25 quarterly MDS indicated Resident 16 was cognitively intact. A 6/3/25 care plan revealed Resident 16 was incontinent of bowel and bladder. Resident 16 had a history of urgency incontinence. Interventions included assisting with using the bathroom before breakfast and after lunch per preference to anticipate needs, resident used briefs, provide incontinentence care as needed, and provide peri care (cleaning of the genital area) after an incontinent episode. A public complaint was received on 6/23/25 alleging in 6/2025 Resident 16 was not cleaned properly after a bowel movement. The brief was clean, but Resident 16 had dried feces over groin area, buttocks and down her/his thighs. On 7/8/25 at 9:16 AM, Witness 1 (Complainant) stated twice in 6/2025 she found Resident 16 with dried feces on her/him. Witness 1 stated the first instance involved dried feces on her/his back, causing skin irritation. Witness 1 stated Staff 6 (CNA) came in, saw the dried feces on Resident 16, and cleaned her/him. The second instance involved dried feces on Resident 16's groin area. On 7/8/25 at 12:42 PM, Resident 16 stated staff would put her/him in a wheelchair and she/he would be in it all day with no incontinentence care unless she/he advocated for assistance. On 7/8/25 at 1:23 PM, Staff 6 (CNA) stated in 6/2025 he came on shift and assisted Resident 16 because she/he had dried feces on her/him and some dry skin flakes on her/his buttocks. Staff 6 stated Resident 16 was not fully cleaned following the previous incontinent episode. On 7/8/25 at 1:31 PM, Staff 5 (CNA) stated there was a day in 6/2025 when Resident 16 had explosive diarrhea and she was changing Resident 16's shirt and pants all day long. On 7/9/25 at 8:32 AM, Staff 7 (CNA) stated Resident 16 was difficult to clean after a bowel movement. Staff 7 stated she did not leave Resident 16 unclean after incontinentence care and there were times when she could only get 90 percent of Resident 16's feces off her/him because she/he would refuse additional cleaning. Staff 7 reported it to the nurse and let the next CNA know during the shift change. On 7/9/25 at 11:04 AM and 12:25 PM, Staff 1 (Administrator) stated she would expect staff to clean a resident thoroughly unless a resident refused. If a resident refused, CNA staff were expected to report the refusal to the nurse. Staff 2 (DNS) stated she expected the nurse to document if the resident refused incontinentence care in case there was a skin issue. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review it was determined the facility failed to provide adequate incontinentence and catheter care for 2 of 3 sampled residents (#s 14 and 16) reviewed for catheter care. This placed residents at risk for unmet care needs, skin breakdown and loss of dignity. Findings include: 1. Resident 14 was admitted to the facility in 12/2022 with diagnoses including chronic venous hypertension with ulcer and inflammation of bilateral lower extremity. A 12/2024 Annual MDS indicated Resident 14 was cognitively intact. A 12/16/24 signed order instructed staff to provide catheter care each shift. A 6/2025 TAR instructed staff to provide catheter care each shift. Catheter care was not completed during the night shift on 6/6/25. A FRI received on 6/9/25 alleged on 6/6/25 Resident 14 was not provided incontinentence care. On 7/8/25 at 9:05 AM, Resident 14 stated she/he notified staff she/he needed her/his brief changed on 6/6/25. Staff 14 (CNA) stated she could not provide care immediately and would return. On 7/8/25 at 4:10 PM, Staff 13 (CNA) stated during night shift on 6/6/25 he went to check on Resident 14 around 11:00 PM. Resident 14 was not changed for nine hours. Resident 14's catheter bag was full and was not checked on night shift. On 7/9/25 at 11:00 AM, Staff 10 (CNA) stated Resident 14 reported Staff 14 (CNA) answered her/his call light and stated she would return and never did on 6/6/25. Staff 10 and Staff 13 assisted Resident 14 with the brief change on the next shift. Staff 10 stated it was evident Resident 14 was not provided catheter or incontinentence care during the night shift on 6/6/25. Messages were left with Staff 14 (CNA) twice on 7/8/25 and twice on 7/9/25. Calls were not returned. On 7/9/25 at 11:32 AM, Staff 1 (Administrator) acknowledged Resident 14 was not provided incontinentence care and the expectation was to provide care each shift.