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	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Riverpark of Eugene	425 Alexander Loop Eugene, OR 97401

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, it was determined the facility failed to ensure narcotic drug records were in order and a count of all controlled drugs was maintained for 6 of 6 medication carts reviewed for medication administration. This placed residents at risk for drug diversion. Findings include:The 1/2023 Ordering and Receiving Controlled Medications policy indicated, The pharmacy or nursing care center prepares an individual resident-controlled substance log for each controlled substance medication prescribed for a resident. This log is placed in the Narcotic book to be counted after every shift.On 1/31/26, the North Hall narcotic book revealed 17 times out of 186 counting opportunities facility staff did not verify the narcotic count was correct.On 2/24/26, the North Hall narcotic book revealed 29 times out of 150 counting opportunities facility staff did not verify the narcotic count was correct.On 1/31/26, the South Hall narcotic logbook revealed 17 times out of 186 counting opportunities facility staff did not verify the narcotic count was correct.On 2/24/26, the South Hall narcotic logbook revealed 57 times out of 150 counting opportunities facility staff did not verify the narcotic count was correct.On 1/31/26, the Central Hall narcotic logbook revealed 17 times out of 186 counting opportunities facility staff did not verify the narcotic count was correct.On 2/24/26, the Central Hall narcotic logbook revealed 29 times out of 150 counting opportunities facility staff did not verify the narcotic count was correct.On 2/25/26 at 1:10 PM, Staff 2 (DNS) acknowledged two staff members were to count the narcotics after every shift and sign the narcotic logbook together verifying the narcotic count was correct.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to ensure a resident was informed in writing of the risks and benefits of a restraint and service dog denial for 2 of 9 sampled residents (#s 98 and 99) reviewed for accidents and choices. This placed residents at risk for not being informed. Findings include: 1. Resident 98 was admitted to the facility in 12/2025 with diagnoses including Parkinson's disease (progressive nerve disorder resulting in uncontrolled muscle tremors), anxiety, and panic disorder. The facility's undated admission Packet indicated before any service animal may be denied access to the facility or allowed to remain with their Patient/handler, a detailed written assessment of the reasons for the denial must be completed including all reasons why the service animal may not remain.The 12/9/25 Medication Profile by hospice revealed no documentation Resident 98 had a service animal.The 12/15/25 admission MDS revealed Resident 98 had a BIMS score of 15 (cognitively intact). A 12/18/25 Hospice Note revealed Resident 98 requested medications every two hours to address the resident's anxiety because she/he was anxious without her/his dog. A revised 12/19/25 care plan indicated animals were very important to have around for Resident 98 and interventions for the resident's negative behaviors and trauma included speaking to her/him about her/his dog. An undated Request to have Service Animal at Facility document identified Resident 98's care plan and abilities were reviewed, and it was determined the resident was not safe to care for her/his service animal in the facility. An attendant was required to meet the needs of her/his service animal during visits. On 2/24/26 at 11:15 AM, Witness 1 (Complainant) stated Resident 98 received no written notification why her/his service animal was not allowed to remain in the facility. On 2/26/26 at 9:40 AM, Staff 15 (LPN) stated Resident 98's service animal visited weekly, the service animal was for the resident's emotional support, and the resident was unsteady and a fall risk. On 2/27/26 at 9:27 AM, Staff 14 (Admissions Coordinator) stated she had a conversation with hospice prior to Resident 98's admission and verbally explained the resident's service animal could not remain in the facility. Staff 14 stated she was unsure if the verbal denial for the service animal was communicated to Resident 98 and indicated the resident had different expectations about her/his service animal once she/he arrived. Staff 14 acknowledged no written information about the denial for Resident 98's service animal was provided, and the facility was responsible to provide adequate communication to Resident 98. On 2/27/26 at 1:19 PM, Staff 1 (Administrator) confirmed communication to hospice or Resident 98 about the denial for the resident's service animal was not in writing and she expected the facility to follow their own policy.2. Resident 99 was admitted to the facility in 10/2025 with diagnoses including brain cancer and personality disorder. A 10/16/25 facility Elopement Risk Evaluation revealed Resident 99 was a moderate risk for elopement. The 10/22/25 admission MDS revealed Resident 99 used a Wander Guard (electronic alarm system) daily and had a BIMS score of 6 (severely cognitively impaired). The 10/2025 TAR revealed Resident 99 had orders for a Wander Guard and to verify placement on the resident's left ankle every shift. A review of Resident 99's clinical record revealed no evaluation or consent for the resident's Wander Guard.On 2/27/26 at 1:09 PM, Staff 2 (DNS) stated Resident 99's Wander Guard was attached to the resident because she/he was at risk of exiting the building which was unsafe for the resident due to her/his cognition. Staff 2 confirmed Resident 99 was able to consent and was not evaluated or provided the option to consent to have a Wander Guard. On 3/2/26 at 9:11 AM, Staff 3 (Regional Director of Clinical) acknowledged the use of the Wander Guard for Resident 99 was a potential restraint and required an evaluation and consent for use.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review the facility failed to facilitate the resident's right to make choices about their diet for 1 of 4 (#5) residents reviewed for choices. This put residents at risk for lack of self-determination. Findings include: Resident 5 was admitted to the facility in 2023 with a diagnosis of chronic respiratory failure.A review of Resident 5's 12/2025 BIMS Assessment revealed she/he was cognitively intact. On 2/23/26 at 10:46 AM, Resident 5 stated she/he requested multiple times to be re-evaluated by the speech therapist because she/he was prescribed a minced and moist diet, which included many pureed foods. Resident 5 stated she/he refused to eat pureed foods and wanted a diet with no pureed foods. Resident 5 stated she/he had been waiting several months to be re-evaluated by the speech therapist. A review of the resident's clinical record revealed she/he requested her/his diet be re-evaluated at Care Conferences completed in 7/2025 and 1/2026.A Progress Note on 7/30/25 revealed Resident 5 reported she/he did not like his/her current diet. Resident 5's Annual MDS completed 10/2025 revealed Resident 5 had declined weight and mid-arm circumference checks and was at risk for weight loss, muscle loss, weakness and delayed wound healing. An 11/25/25 Progress Note revealed the resident reported poor appetite due to disliking her/his food.On 2/27/26 at 12:35 PM, Staff 32 (SLP) stated she had not re-evaluated Resident 5's swallowing. Staff 32 stated she had not completed a Risk/Benefit Assessment with the resident. On 2/27/26 at 1:40 PM, Staff 6 (Resident Care Manager/LPN) stated she had not completed a Risk/Benefit Assessment with Resident 15 related to her/his diet. She stated a Risk/Benefit Assessment should have been completed. On 2/27/26 at 1:59 PM, Staff 2 (DNS) stated when a resident wants something that is medically contraindicated staff should try and reach a mutually agreeable solution with the resident and a Risk/Benefit Assessment should be completed with the resident.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review it was determined the facility failed to conduct a Significant Change MDS assessment for 1 of 4 sampled residents (#47) reviewed for nutrition. This placed residents at risk for unassessed needs. Findings include:Resident 47 was admitted to the facility in 7/2025 with diagnoses including Amyotrophic Lateral Sclerosis (ALS is a disease that destroys the connection between the brain and muscles).An 10/2025 Quarterly MDS indicated Resident 47 did not have swallowing issues and did not have significant weight loss.A 12/19/25 Progress Note indicated Resident 47 was not safe to swallow and recommendations were made for Resident 47 to be NPO (have nothing by mouth) and have a nasal gastric (NG) tube (a tube placed down the nose, to the stomach) placed for alternate means to obtain nutrition.A 1/12/26 Progress Note indicated Resident 47 was NPO since 12/19/25 which included food and medications, Resident 47 refused an NG tube, and Resident 47 lost 20 pounds since 10/2025.A review of Resident 47's weight indicated she/he weighed 140.6 pounds on 10/7/25 and 121 pounds on 1/7/26.A 1/20/2026 Quarterly MDS indicated Resident 47 had issues with swallowing and significant weight loss.A 2/13/26 Progress Note indicated Resident 47 had an NG tube placed and tube feeding was started.A review of Resident 47's medical record revealed no indication a Significant Change MDS was completed.On 2/26/26 at 12:49 PM, Staff 23 (RN MDS Coordinator) stated a Significant Change MDS is completed when a resident had a decline in two or more areas that did not resolve in two weeks. Staff 23 stated she was unsure if Resident 47 had a change in swallowing ability.On 2/26/26 at 1:24 PM Staff 24 (SLP) stated Resident 47 had a change in her/his ability to swallow safely in 12/2025.On 2/27/26 at 12:31 PM, Staff 2 (DNS) stated a Significant Change MDS was expected to be completed when a resident had a decline in two or more areas that do not resolve in two weeks. Staff 2 stated Resident 47 had a change in swallowing ability in 12/2025 and significant weight loss in 1/2026. Staff 2 acknowledged Resident 47 should have had a Significant Change MDS completed in 1/2026.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review it was determined the facility failed to provide care and services to maintain oral hygiene for 1 of 5 sampled residents (# 3) reviewed for ADLs. This placed residents at risk for reduced oral health. Findings include: Resident 3 was admitted to the facility in 11/2016 with diagnoses including epilepsy (seizure disorder).The 8/6/25 Care Plan for Resident 3 indicated a need for reminders and set up for oral care.A 2/11/26 quarterly MDS assessment revealed Resident 3 required setup or cleanup assistance for oral hygiene and had a BIMS score of 15, indicating she/he was cognitively intact. On 2/23/26 at 12:41 PM Resident 3 stated staff were directed to help her/him with brushing her/his teeth twice a day but did not. Resident 3 indicated she/he no longer requested oral hygiene assistance because she/he was told no by staff so frequently.On 2/24/26 at 10:35 AM Resident 3 estimated the last time she/he received help brushing her/his teeth was 1/2026. Resident 3 stated she/he had no idea where a toothbrush was since she/he had not used one recently. On 2/24/26 at 10:41 AM Resident 3's overbed table, nightstand, restroom, and in-room sink were searched but no toothbrush was located. Atop the nightstand was an oral care basin containing toothpaste.On 2/25/26 at 10:31 AM Resident 3 reported it didn't happen when asked if she/he got her/his teeth brushed in the evening of 2/24/26 or the morning of 2/25/26. Resident 3 indicated she/he still did not have a toothbrush. The oral care basin was again observed on top of Resident 3's nightstand and contained toothpaste but no toothbrush.On 2/25/26 at 12:47 PM Staff 27 (CNA) reported he had not yet assisted Resident 3 with oral hygiene that day. Staff 27 was unable to locate a toothbrush in Resident 3's room or bathroom. Staff 27 indicated oral hygiene supplies were usually kept in or on the nightstand. On 3/2/26 at 11:22 AM, Staff 2 (DNS) stated the expectation was for staff to offer oral hygiene opportunities at least twice a day to residents. Staff 2 confirmed Resident 3 was not provided oral hygiene as expected.

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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 observation, interview and record review it was determined the facility failed to provide care and services to maintain grooming and oral hygiene for 2 of 5 sampled residents (#s 5 and 57) reviewed for ADLs. This placed residents at risk for unmet ADL needs. Findings include: Resident 5 was admitted to the facility in 2023 with a diagnosis of chronic respiratory failure. Resident 5's 10/2025 Annual MDS indicated she/he was cognitively intact. A review of Resident 5's Care Plan completed 1/2026 indicated she/he required the assistance of staff for personal hygiene. On 2/23/26 Resident 5 was observed with unbrushed, matted hair. On 2/23/26 at 10:48 AM, Resident 5 stated staff do not brush her/his hair daily. Resident 5 stated she/he wanted the knots brushed out of the hair on the back of her/his head and she/he could not do it. On 2/27/26 at 9:28 AM, Staff 23 (CNA) stated he cared for Resident 5 that morning and the previous day and did not brush Resident 5's hair. On 2/27/26 10:46 AM, Staff 33 (CNA) stated she never brushed Resident 5's hair when providing care for her/him. On 2/27/26 at 11:01 AM, Staff 34 (CNA) stated she never brushed Resident 5's hair when providing care for her/him. On 2/27/2026 at 1:59 PM, Staff 2 (DNS) stated her expectation was for staff to offer to brush residents' hair daily. 2. Resident 57 admitted to the facility in 6/2025 with diagnoses including type two diabetes mellitus with diabetic neuropathy. The 7/3/25 Care Plan indicated Resident 57 required reminders and setup assistance with oral care. A 12/22/25 quarterly MDS revealed Resident 57 required setup or cleanup assistance for oral hygiene and had a BIMS score of 15 indicating intact cognition. On 2/23/26 at 2:50 PM Resident 57 stated staff did not assist her/him with oral hygiene despite requests. On 2/24/26 at 11:34 AM, Resident 57 stated she/he required total assistance from staff with tooth brushing. When asked where the oral hygiene supplies were located, the resident indicated she/he did not know and had never seen a toothbrush in her/his room. On 2/24/26 at 11:41 AM and 2/25/26 at 10:59 AM no toothbrush or toothpaste were located on Resident 57's overbed table, in the nightstand, or at a sink in resident's room or restroom. A dry toothbrush and facility issued toothpaste were located at the bottom of a large plastic bin on the top (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shelf of the closet across the room. The oral hygiene items were not visible as the bin was filled with large personal care items including body wash, deodorant, and an unopened box of toothpaste brought by the resident's family for her/his use. On 2/25/26 at 12:48 PM Staff 27 (CNA) stated so far in the shift (6:00 AM to 2:00 PM) he had not assisted Resident 57 with brushing her/his teeth. Staff 27 was not able to locate oral hygiene items in Resident 57's room. Staff 27 acknowledged brushing teeth is an expected part of daily care for residents. On 3/2/26 at 11:22 AM, Staff 2 (DNS) stated the expectation was for staff to offer oral hygiene opportunities at least twice a day to residents. Staff 2 confirmed Resident 57's experience did not meet this expectation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review it was determined the facility failed to follow physician orders for 3 of 8 sampled residents (#s 10, 11, and 57) reviewed for edema, care planning, and unnecessary medications. This placed residents at risk for unidentified conditions. Finding include: Resident 57 was admitted to the facility in 6/2025 with a diagnosis of type 2 diabetes mellitus. A review of Resident 57s clinical record revealed an order for hydrocodone-acetaminophen, a pain reliever, to be administered up to twice daily as needed for pain. The resident's MAR for 2/20/26 revealed two doses of hydrocodone-acetaminophen were recorded on 2/20/26. A review of the facility's narcotic administration log revealed Resident 57 received 3 administrations of hydrocodone-acetaminophen on 2/20/26. Resident 57 was not available for an interview. On 3/2/26 at 7:49 AM, Staff 39 (LPN) stated she administered a dose of hydrocodone-acetaminophen to Resident 57 at 10:49 PM on 2/20/26. Staff 39 stated she was able to enter the administration in the resident's MAR, so she was not aware two doses of the medication had already been administered to Resident 57 for the day. On 3/2/26 at 8:55 AM, Staff 38 (CMA) stated he administered hydrocodone-acetaminophen to Resident 57 at 2:49 PM and just before Resident 57 went to bed at approximately 8:30 PM. Staff 38 stated he neglected to enter his second administration of hydrocodone-acetaminophen to Resident 57 in the MAR. On 3/2/26 at 12:40 PM, Staff 2 (DNS) stated her expectation was staff would immediately enter all medications into the MAR when they were administered. 2. Resident 10 was admitted to the facility in 10/2025 with diagnoses including heart failure and a stroke. A 1/8/26 Physician Order revealed orders for daily weights and to call the provider if Resident 10 gained two to three pounds over a two-day period or five pounds in one week. A review of Resident 10's weights revealed the following: -2/7/26 weight was 176.6 pounds -2/9/26 weight was 180.2 pounds -2/13/26 weight was 181.4 pounds -2/14/26 weight was 186 pounds (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 10's medical record revealed no evidence the provider was notified of Resident 10's weight gain. On 2/25/26 at 12:23 PM, Staff 9 (LPN) stated from 2/7/26 through 2/9/26 Resident 10 gained 3.6 pounds and from 2/13/26 through 2/14/26 Resident 10 gained 4.6 pounds. Staff 9 stated Resident 10's provider was not notified of the weight gains. On 3/2/26 at 12:07 PM, Staff 2 (DNS) stated staff were expected to notify the provider of weight gain per the orders. 3. Resident 11 was admitted to the facility on [DATE] with diagnoses including a stroke and alcoholic cirrhosis (liver disease). A review of admission orders revealed a 1/26/26 order for weekly basic metabolic panel labs (a blood test that measures eight different substances in your blood). A review of Resident 11's 2/2026 MAR revealed the weekly basic metabolic panel labs were charted as not being completed on 2/2/25, 2/9/26, and 2/16/26 by Staff 31 (LPN). On 2/25/26 at 1:43 PM Staff 22 (LPN Resident Care Manager) acknowledged Resident 11 was admitted with orders for a weekly basic metabolic panel lab and stated the labs were not completed as ordered. On 2/25/26 at 1:50 PM, Staff 31 stated Resident 11 did not have the weekly basic metabolic panel lab completed on 2/2/26, 2/9/26, or 2/16/26 because he had not been trained on obtaining blood samples for labs. On 3/2/26 at 11:55 AM, Staff 2 (DNS) stated labs are expected to be completed as ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to accurately assess a resident, thoroughly investigate and follow care plan interventions for elopement for 2 of 3 sampled residents (#s 99 and 102) reviewed for accidents. This placed residents at risk for elopement. Findings include:1. Resident 102 admitted to the facility on [DATE] with diagnoses including non-displaced type II dens fracture (stable fracture of the second cervical vertebra requiring neck immobilization), metabolic encephalopathy (brain dysfunction due to systemic metabolic disturbance), and delirium due to medical condition (acute, fluctuating confusion caused by illness). A 1/17/26 Elopement investigation revealed Staff 17 (CNA) was notified by a pedestrian that an elder person with a wheelchair was outside in the street crying and needed help. Staff 17 located Resident 102 standing behind her/his wheelchair holding onto it saying she/he was freezing and wanted to go home. Resident 102 was in the road about 20 feet from a busy intersection. Resident 102 was confused, resisted help but eventually sat in her/his wheelchair and allowed staff to bring her/him back to the facility. Staff 17 stated she was unsure how long Resident 102 was outside, but she/he was freezing cold and was not wearing a coat. On 2/25/26 at 6:24 PM, Staff 21 (LPN) reported she reviewed Resident 102's medical record prior to completing the admission Elopement Risk Evaluation. Staff 21 stated she was aware the resident had severe cognitive impairment, with fluctuating cognition, and the resident was not consistently aware of her/his surroundings. On 2/26/26 at 9:26 AM, Staff 18 (CNA) stated Resident 102 was frequently confused and agitated during her shifts and made multiple attempts to exit the facility. Staff 18 stated she reported Resident 102's behaviors to a nurse. Staff 18 further stated the resident's exit-seeking behavior was hard not to notice. Staff 18 reported on 1/17/26 at approximately 8:00 PM, she became aware Resident 102 was outside the facility unsupervised and assisted other staff to bring the resident back inside. Staff 18 estimated the resident had been outside for approximately 20 minutes before staff located her/him. Staff 18 further stated when Resident 102 was found, the resident was not wearing a jacket or shoes and appeared cold, wet, and confused. On 2/26/26 at 9:50 AM, Staff 15 (LPN) stated Resident 102 exhibited significant confusion and agitation. Staff 15 stated Resident 102 wandered throughout the facility in her/his wheelchair and attempted to exit through the front door on at least one occasion. On 2/26/26 at 2:54 PM, Staff 17 (CNA) stated Resident 102 exhibited exit-seeking behaviors shortly after admission and attempted to exit the facility multiple times. Staff 17 stated management was aware of the behavior. Staff 17 stated on 1/17/26, while on break, a pedestrian informed her that a resident was outside hysterical and cold. Staff 17 located Resident 102 near a busy intersection. Staff 17 stated the resident was cold, shaking, and was not wearing a jacket or shoes. On 2/26/26 at 4:26 PM, Staff 19 (RN) confirmed Resident 102's cognition fluctuated and stated the resident attempted to exit the facility on 1/17/26 earlier in the day. Staff 19 stated she did not believe the resident required a wander guard prior to the elopement. On 3/2/26 at 10:26 AM, Staff 2 (DNS) and Staff 3 (Regional Director of Clinical) acknowledged the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility did not reassess Resident 102's elopement risk after staff became aware of exit-seeking behaviors. 2. Resident 99 was admitted to the facility in 10/2025 with diagnoses including brain cancer and personality disorder. A 10/16/25 facility Elopement Risk Evaluation revealed Resident 99 was a moderate risk for elopement with no history of wandering or elopement. The instructions for the evaluation indicated it was to be completed with any significant change or as needed. A 10/20/25 revised care plan indicated Resident 99 was an elopement risk, staff were to provide frequent checks for the resident, she/he used a wheelchair for mobility, the resident was encouraged to attend activities to provide a distraction, and to evaluate her/his needs if the resident appeared to seek the exit. The 10/22/25 admission MDS revealed Resident 99 used a Wander Guard (electronic alarm system) daily and had a BIMS score of 6 (severely cognitively impaired). A 10/25/25 Elopement investigation revealed Staff 12 (CNA) went on break at 2:20 PM, returned at 2:50 PM, and was informed Resident 99 was taken to activities by Staff 13 (CNA). Staff 12 found the resident in the parking lot, and it was determined the resident entered the door security code to exit the building. On 2/26/26 at 9:19 AM, Staff 9 (RN) stated after she completed the initial elopement assessment for Resident 99, Staff 9 indicated she noticed increased agitation by the resident who wanted to smoke more often. Staff 9 stated she wrote nursing notes and acknowledged a revised elopement risk evaluation was warranted and was not completed. On 2/26/26 at 10:20 AM, Staff 12 stated Resident 99 required close supervision prior to her/his elopement. Staff 12 revealed the resident attempted to get out the door a lot but never exited without someone who was available to take the resident for a walk. Staff 14 stated there were multiple times she saw Resident 99 use the security code to get outside. On 2/26/26 at 12:40 PM and 2:50 PM, Staff 6 (Resident Care Manager-LPN) stated staff were required to have Resident 99 within their line of sight. Staff 6 stated additional interventions were implemented to address Resident 99's increased agitation and exit seeking behaviors and confirmed a new elopement assessment was not completed, needed supervision did not occur when staff went on break at the time of the resident's elopement, and Staff 6 did not verify the thoroughness of the investigation. On 2/26/26 at 1:08 PM, Staff 13 (CNA) stated Resident 99 became aggressive while Staff 14 was on break, so he traded the task to supervise the resident to another staff. On 2/26/26 at 3:09 PM, Staff 7 (activity assistant) stated Resident 99 often came and left from activities, and he was not informed Resident 99 was an elopement risk which required additional care for the resident. On 2/26/26 at 3:45 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged a thorough investigation was expected to understand who last saw the resident and what occurred prior to the (continued on next page)

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	385185	A. Building B. Wing	03/02/2026

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Avamere Riverpark of Eugene	425 Alexander Loop Eugene, OR 97401

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement. On 3/2/26 at 9:11 AM, Staff 3 (Regional Director of Clinical) expected staff to follow Resident 99's plan of care.

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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. Based on interview and record review it was determined the facility failed to provide care and services to prevent a UTI for 1 of 1 sampled resident (#8) reviewed for urinary tract infections. This placed resident at increased risk for recurrent UTIs. Findings include: Resident 8 admitted to the facility in 11/2025 with diagnoses including urinary retention (a condition related to the inability to completely empty the bladder when voiding). On 2/23/26 at 10:48 AM, Witness 2 (family member) indicated Resident 8 had four or more UTIs in the past year.A progress note dated 11/20/25 indicated Resident 8 required an appointment with a urologist specializing the treatment of urinary retention. Staff 16 (Social Services Director) scheduled Resident 8 for a urologist appointment on 12/2/25 and arranged transportation. Resident 8's clinical record contained no documented evidence she/he was seen by the urologist as planned on 12/2/25. Resident 8 was diagnosed with UTIs on 12/26/25, 2/17/26, and 2/24/26.On 3/2/26 at 11:15 AM, Staff 2 (DNS) stated Resident 8 was referred to the urologist to help manage her/his recurring UTIs. Staff 2 confirmed Resident 8 missed the 12/2/25 appointment and the facility did not reschedule the missed appointment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 address call lights in a timely manner for 2 of 6 sampled residents (#s 22 and 47) reviewed for staffing. This placed residents at risk for delayed care. Findings include: 1. Resident 47 was admitted to the facility in 7/2025 with diagnoses including Amyotrophic Lateral Sclerosis (ALS is a disease that destroys the connection between the brain and muscles). A review of call light audits for Resident 47 revealed the following call lights on greater than 30 minutes: -11/2/2025 one hour and five minutes -11/7/2025 35 minutes -11/13/25 33 minutes -11/14/25 41 minutes -11/21/25 one hour and 12 minutes An 11/21/25 complaint alleged staff were ignoring Resident 47's call light. A 1/4/26 revised care plan indicated Resident 47 was to have cares in pairs. A 1/26/26 Grievance Communication Form indicated on 1/25/26 Resident 47 requested to use the restroom at 9:36 PM and did not receive assistance until 10:15 PM. The conclusion indicated Resident 47 did have a longer wait time because when she/he requested assistance staff were not available due to, a bunch of call lights in overtime two so Resident 47 waited in the front lobby and staff were not aware of her/his location. On 2/24/26 at 6:42 AM, Resident 47's call light was observed on. On 2/24/26 at 7:15 AM, Staff 10 (CNA) was observed to answer Resident 47's call light. Staff 10 acknowledged Resident 47's call light was on for more than 30 minutes and stated there were no staffing issues this shift but Resident 47 needed two staff members to provide assistance and everyone was busy. On 3/2/26 at 9:21 AM Staff 35 (CNA) stated the facility was continuously short CNA staff which makes the shift, hectic. On 3/2/26 at 9:33 AM Staff 36 (LPN) stated the facility was short CNA staff, quite a few nights. Staff 36 stated she assisted the CNAs with answering call lights, but it got busy and residents got frustrated. On 3/2/26 at 9:37 AM Staff 37 (CNA) stated the facility has been short CNA staff. Staff 37 stated when they were short CNAs, it would get busy, the nurses would try to help answer call lights, but they also had a job to complete. Staff 37 stated when they were short CNAs rounds took longer than (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two hours to complete. On 2/26/26 at 9:32 AM, Staff 2 (DNS) stated the call lights would go into overtime after being on for seven and a half minutes and would go into overtime two after being on for 15 minutes. 2. Resident 22 was admitted to the facility in 5/2025 with diagnoses including traumatic brain injury and chronic pain. The 2/10/26 Quarterly MDS indicated Resident 22 had a BIMS score of 15 (cognitively intact) and the resident's pain occasionally interfered with her/his daily activities. A 2/10/26 revised Care Plan indicated Resident 22 required one staff to assist her/him with all transfers. If staff were uncomfortable with transfers or the resident was unsafe, two staff were permitted to transfer the resident. Resident 22 was occasionally incontinent of bowel and bladder. A 2/13/26 Summary Call Data by Room/Bed report revealed, at 3:55 PM, Resident 22's call light was answered after 30 minutes. A 2/14/26 Grievance Communication Form revealed Resident 22 indicated her/his call light was not answered timely on 2/13/26 after the resident soaked her/his bed with water and required assistance. A 2/18/26 Grievance Communication Form revealed Resident 22 voiced concerns during a care conference of long call lights during resident smoke breaks. A 2/23/26 Summary Call Data by Room/Bed report revealed, at 6:33 PM, Resident 22's call light was answered after 25 minutes. On 2/23/26 at 1:41 PM, Resident 22 stated there were issues with long call lights when residents had smoke breaks. Resident 22 stated she/he often required toilet assistance when assistance was requested. A 2/24/26 Grievance Communication Form revealed Staff 4 (CNA) informed Resident 22 she was going on a break and told another CNA to address the resident's call light. On 2/24/26 at 2:36 PM, Staff 5 (CNA) stated a few weeks earlier Staff 28 (CNA) did not want to answer Resident 22's call light while Staff 5 took residents to smoke around 4:00 PM. Staff 5 stated Resident 22 and Staff 28 had a disagreement the previous day. Staff 5 confirmed Resident 22 waited 30 minutes for care which was provided when Staff 5 returned. On 2/27/26 at 1:35 PM, Staff 2 (DNS) stated Staff 28 removed himself from Resident 22's care without communicating to the charge nurse. Staff 2 expected staff to address call lights timely through improved communication. On 3/2/26 at 11:50 AM, Resident 22 stated Staff 4 went on break and left her/his call light on to alert another CNA that she/he required assistance. Resident 22 stated she/he was in pain by the time assistance was provided. On 3/2/26 at 11:57 AM, Staff 4 confirmed the CNA who did not answer Resident 22's call light timely (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/23/26 was previously fired by Resident 22 from her/his care. Staff 4 stated communication between staff did not occur to answer Resident 22's call light timely. On 3/2/26 at 12:29 PM, Staff 2 stated she compared the multiple grievances filed for Resident 22 and acknowledged the root cause of long call lights for the resident was not addressed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to ensure residents did not receive unnecessary medications for 1 of 5 sampled residents (#4) reviewed for unnecessary medications. This placed residents at risk for side effects related to blood pressure medications. Findings include:Resident 4 was admitted to the facility in 12/2022 with diagnoses including heart failure and arterial fibrillation (an irregular heartbeat). A review of orders revealed a 6/11/24 order for metoprolol succinate (a medication used to treat high blood pressure), hold for a heart rate less than 60 beats per minute. A review of Resident 4's 1/2026 MAR revealed Resident 4 was administered metoprolol succinate with a heart rate less than 60 beats per minute on:-1/10/26 heart rate was 59 per minute-1/22/26 heart rate was 59 per minute-1/24/26 heart rate was 52 per minute-1/29/26 heart rate was 52 per minute A review of Resident 4's 2/2026 MAR revealed Resident 4 was administered metoprolol succinate with a heart rate less than 60 beats per minute on:-2/10/26 heart rate was 56 per minute-2/12/26 heart rate was 58 per minute On 2/25/26 at 10:03 AM, Staff 32 (LPN) stated she administered Resident 4 the metoprolol succinate on 1/10/26,1/24/26, 1/29/26, 2/10/26 and 2/12/26 and acknowledged Resident 4's heart rate was less than 60 beats per minute on those dates, and the metoprolol succinate should have been held per orders.On 2/25/26 at 11:51 AM, Staff 9 (RN) stated on 1/22/26 Resident 4's HR was 59 and she administered the metoprolol succinate.On 2/27/26 at 11:38 AM, Staff 7 (LPN Resident Care Manager) stated staff were expected to hold the metoprolol succinate if Resident 4's heart rate was less than 60 beats per minute per orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview it was determined the facility failed to ensure medications, were stored properly for 1 of 3 medication carts reviewed. This placed residents at risk for reduced medication effectiveness. Findings include:On 2/25/26 South Hall medication cart observations revealed Resident 15's insulin had been removed from the refrigerator and was not dated. Staff to 22 (LPN) confirmed the insulin should've been dated after staff removed the insulin from the refrigerator. Resident 6's insulin dated 2/18/26 was observed unopened on the medication cart. Staff 22 confirmed the insulin should've been kept refrigerated until used.On 2/25/26 at 4:01 PM, Staff 3 (Regional Director of Clinical) stated all nursing staff are expected to follow proper medication storage requirements, including refrigeration and dating of insulin.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review it was determined the facility failed to ensure resident records were complete and accurate for 1 of 5 sampled residents (#57) reviewed for ADLs. This placed residents at risk for inaccurate medical records. Findings include:1. Resident 57 admitted to the facility in 6/2025 with diagnoses including type two diabetes mellitus with diabetic neuropathy. On 2/23/26 at 2:50 PM Resident 57 stated staff did not assist her/him with oral hygiene despite resident requests. On 2/24/26 at 11:34 AM, Resident 57 stated she/he required total assistance from staff to brush her/his teeth. When asked where the oral hygiene supplies were located, this resident indicated she/he did not know and had never seen a toothbrush in her/his room.On 2/27/26 at 9:11 AM Resident 57 reported she/he received assistance with brushing her/his teeth once that week on day shift on 2/25/26. Resident 57 stated she/he was not offered additional opportunities for oral hygiene.Resident 57's 2/24/26 Task: GG-Oral Hygiene report indicated oral hygiene was completed by Staff 25 (CNA) during the day shift (6:00 AM to 2:00 PM).On 2/25/26 at 4:17 PM Staff 25 stated she did not complete oral hygiene with Resident 57 on 2/24/26.Resident 57's 2/26/26 Task: GG-Oral Hygiene report indicated Staff 26 (CNA) assisted with oral hygiene during the evening shift (2:00 PM to 10:00 PM).On 2/27/26 at 10:13 AM Staff 26 stated he did not assist Resident 57 with brushing her/his teeth that week. On 3/2/26 at 11:22 AM Staff 2 (DNS) confirmed it was not acceptable for staff to document completion of care if it was not done.