STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385189	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Transitional Care at Sunnyside	4515 Sunnyside Road SE Salem, OR 97302

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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 residents were able to be fully informed in language that she/he can understand of her/his health status and participate in health care decisions for 1 of 7 sampled residents (#39). This placed residents at risk for not being able to fully participate in their own health care. Findings include: Resident 39 was admitted to the facility in 8/2022 with diagnoses including hypertension (high blood pressure). A review of Resident 39's care plan initiated in 9/2022 revealed the resident was Spanish-speaking and stated translation services would be available to her/him. On 6/3/25 at 2:02 PM, Resident 39 stated some staff did not take the time to understand her/him and were impatient when she/he tried to communicate her/his needs. On 6/4/25 at 10:15 AM, Staff 5 (LPN) stated on the morning of 6/4/25 Staff 5 observed Staff 6 (CNA) tell Resident 39 to stop talking while he was attempting to take Resident 39's blood pressure. Staff 5 stated Resident 39 was trying to explain she/he wanted her/his blood pressure taken with the manual cuff rather than the tower. Staff 6 was not using the tablet translator. On 6/5/25 at 7:36 AM, Resident 39 stated she/he was not respected by staff when they did not bother to understand her/his needs or communicate with the resident when providing care. Resident 39 stated she/he was frustrated because Staff 6 did not understand Resident 39 did not like her/his blood pressure taken with the tower monitor and wanted it taken manually. On 6/6/25 at 8:57 AM, Staff 6 stated he was trying to take Resident 39's blood pressure and Resident 39 was getting very upset because the tower monitor was not reading correctly. Staff 6 stated he was blunt and straightforward with Resident 39 and did tell him to stop talking so he could take her/his blood pressure manually. Staff 6 stated he did not use the tablet translator. Staff 6 stated he thought it was unfair to residents that they could not easily communicate their needs when they didn't understand or speak English. On 6/6/25 at 1:04 PM, Staff 2 (DNS) stated staff were expected to use translator tablets. Staff 2 stated she did not provide any recent training on communicating with non-English speaking residents but assumed the training was part of their orientation. Staff 2 stated Staff 6 was placed on leave pending investigation for his interaction with Resident 39.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to provide a written grievance resolution or communication with a resident regarding the resolution of a resident's grievance for 1 of 1 sampled resident (#69) reviewed for dignity. This placed residents at risk for unaddressed concerns and grievances. Findings include: Resident 69 was admitted to the facility in 5/2025 with diagnoses including chronic pain and PTSD (Post Traumatic Stress Disorder). Resident 69's 5/24/25 admission MDS indicated the resident was cognitively intact. The facilities Grievance Policy dated 1/1/17 indicated concerns will be forwarded to the grievance official and appropriate department supervisor for action. The grievance official or department supervisor will contact the concerned resident or representative to inform them of the resolution of their concern. The grievance official and administrator will review the grievance and then forward a copy to the appropriate department manager for action within 72 hours of the receipt. The grievance official and appropriate department supervisor will take immediate action towards resolution of the concern upon receiving a copy of the grievance communication form and will record this action and resolution on the bottom section of the form. The grievance official, administrator or department manager will then contact the concerned party to inform them of the resolution to their concern. On 6/2/25 at 11:02 AM, Resident 69 reported that on 5/28/25 she/he spoke with Staff 2 (DNS) regarding staff not giving her/his pain medication in a timely manner. Resident 69 stated Staff 2 responded by expressing disapproval of residents entering her office to voice complaints about staff. Staff 2 stated she did not have time for this discussion and directed the resident to leave her office. Resident 69 described Staff 2's demeanor as rude and disrespectful. Resident 69 reported feeling she/he was not treated with dignity and respect. Resident 69 stated she/he told two staff members about her/his conversation with Staff 2 and they encouraged her/him to fill out a grievance form and provided one for that purpose. Resident 69 stated she/he completed the grievance communication form handed it to Staff 25 (RN) and she slid it under the administrators office door so they would not be noticed. On 6/4/25 at 9:14 AM, Resident 69 stated staff did not follow up with her/him regarding their grievance. The resident expressed concerns Staff 2 might confront her/him and become upset. Resident 69 also stated Staff 2 did not apologize and she/he felt disrespected. Resident 69 provided a copy of the 5/28/25 Grievance Communication Form which stated the following: The resident reported being prescribed oxycodone (narcotic pain medication) every four hours and alleged nursing staff were an hour late in administering her/his medication. The resident stated they informed a CNA of her/his upcoming physical therapy session and requested the nurse be notified to administer pain medications beforehand. After waiting 45 minutes, the resident reported speaking with Staff 2, who asked the resident to leave her office and expressed disapproval of complaints about the staff. The resident also reported Staff 2 was rude. The resident expressed dissatisfaction with the facilities pain management and rehabilitation services. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 8:44 AM, Staff 22 (CNA) stated last week Resident 69 requested pain medication but waited for an hour, as the nurse was attending to another resident and the medication aid was on lunch. Staff 22 noted Resident 69 was in more pain than usual and became upset, and she/he did not want to participate in physical therapy due to the pain. On 6/5/25 at 9:46 AM, Staff 21 (CNA) stated last week Resident 69 became upset because she/he waited over an hour for her/his pain medication. Resident 69 stated she/he talked to Staff 2 and felt like she lied to her/him. Staff 21 encouraged Resident 69 to fill out a grievance. On 6/6/25 at 8:02 AM, Staff 24 (Social Service Director) stated she was unaware Resident 69 filled out a grievance and she would follow up with the resident. On 6/6/25 at 8:18 AM, Staff 2 confirmed last week she had a discussion with Resident 69 regarding the resident's concerns about pain medication not being administered in a timely manner. Staff 2 reported she completed a risk management form related to the concern and provided staff education. She further stated the resident did not give her a grievance form and she believed the issue was resolved. On 6/6/25 at 1:08 PM, Staff 1 (Administrator) stated he was not aware Resident 69 submitted a grievance. Staff 1 reported his expectation was for all grievances to be brought to his attention as soon as possible and the resident to be contacted or provided with the investigative conclusion to the grievance. Staff 1 stated he would follow up with Resident 69. On 6/6/25 at 1:28 PM, Staff 25 confirmed around 6:00 PM on 5/28/25, Resident 69 approached her and stated she/he was very upset after a conversation with Staff 2. The resident reported she/he was never spoken to in that manner before and felt disrespected. Staff 25 stated Resident 69 completed a grievance form. Staff 25 stated she had a key to Staff 1's office and placed the grievance form in his mailbox. Staff 25 stated staff did not follow up with her regarding any additional information. On 6/6/25 at 3:00 PM, Staff 1 stated he found the missing grievance. Staff 1 confirmed the grievance process was not followed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification, including reserved bed hold payment, at the time of transfer to the hospital for 1 of 1 sampled resident (#18) reviewed for hospitalization. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include: A review of the facility's Bed Holds and Returns Policy dated 10/2022 stated residents, regardless of payer source, are provided written notice about these policies [.] at the time of transfer. Resident 18 was admitted to the facility in 11/2017 with diagnoses including congestive heart failure, COPD (chronic obstructive pulmonary disease), and respiratory failure. A review of Resident 18's clinical record revealed she/he was transferred to the hospital on 5/27/25. No evidence was found in Resident 18's clinical record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital. On 6/6/25 at 8:55 AM, Staff 2 (DNS) stated a written bed hold notification was not provided to Resident 18 or her/his representative at the time of transfer to the hospital because her/his payer source was Medicaid. On 6/6/25 at 10:33 AM, Staff 17 (Regional Nurse Consultant) confirmed a written bed hold policy, including reserved payment, needed to be provided to Resident 18 or her/his representative at the time she/he was transferred to the hospital.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. Based on interview and record review, it was determined the facility failed to ensure qualified staff administered medications for one of one facility reviewed for medication administration. This placed residents at risk for receiving medication errors. Findings included: The Oregon State Board of Nursing indicated the title abbreviation CMA is protected by Oregon law and means Certified Medication Aide, not Certified Medical Assistant. The abbreviation CMA could not be used by medical assistants in Oregon. Medical assistants are unregulated personnel and work in outpatient settings under the direction of a physician. The facility's Administering Medications policy, dated 4/2019, indicated only persons licensed or permitted by the state could prepare, administer, and document the administration of medications. A public complaint was received on 3/15/25, which alleged the facility failed to ensure staff were qualified to administer medications to residents. On 6/3/25 at 11:36 AM, Staff 20 (Staffing Coordinator) stated she posted on an agency website the facility needed CMAs to pass medications on day shift. Staff 19 (Agency Medical Assistant) signed up for the shift and passed medications on the first and second floors of the facility. It was not until the end of the day shift the facility realized Staff 19 was a Medical Assistant, not a CMA, and could not administer medications to residents in a nursing facility. On 6/4/25 at 11:51 AM, Staff 2 (DNS) stated Staff 19 told Staff 2 she was a medication aide. Staff 19 passed medications on 3/15/25, on day shift. Staff 2 stated Staff 19 did not pass the medications per established protocols and the nurses questioned her ability, so they looked up her license to find out she was a Medical Assistant not a CMA. On 6/5/25 at 11:06 AM, Staff 19 stated she was told she could administer medications at the nursing facility if she was working under a nurse or physician. Staff 19 stated she had worked eight hours in the facility on 3/15/25. On 6/6/25 at 1:15 PM, Staff 1 (Administrator), Staff 2, and Staff 3 (Regional Clinical Nurse) acknowledged Staff 19 administered medications to residents in the facility. Staff 2 stated the staffing agency was called, and the facility no longer used the staffing agency's services. Staff 2 stated her expectation was for nursing staff to be licensed or certified to work in the facility

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined the facility failed to provide respiratory care and services under physician orders for 1 of 2 sampled residents (#47) reviewed for respiratory services. This placed residents at risk for unmet respiratory needs. Findings include: Resident 47 was admitted to the facility in 8/2024 with diagnoses including COPD (Chronic Obstructive Pulmonary Disease an airway disease which restricts breathing) and diabetes. The undated facility Oxygen Administration policy and procedures revealed: 1. Verify a physician's order for the procedure. Review the physicians' orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. The 12/24/24 care plan indicated Resident 47 experienced shortness of breath with decreased energy and fatigue. Interventions included learning signs of respiratory compromise, encouraging sustained deep breaths, and monitoring and documenting changes in orientation, increased restlessness, anxiety, and air hunger. Resident 47 was to have oxygen via nasal cannula PRN. O2 Sat Summary (Oxygen Saturation Summary) printed on 6/4/25 revealed from 5/1/25 through 6/3/25, Resident 47's oxygen vitals were checked 45 times, and the resident was documented as being on oxygen via nasal cannula 32 times. Resident 47's 5/16/25 Quarterly MDS indicated the resident was cognitively intact. On 6/2/25 at 12:50 PM, and 6/4/25 at 8:53 AM, Resident 47 was observed in bed with oxygen administered through a nasal cannula. On 6/3/25 at 8:08 AM, Resident 47 was observed in bed with oxygen administered through a nasal cannula. On 6/5/25 at 7:28 AM, Staff 3 (CNA) stated Resident 47 used oxygen while she/he was in bed but did not use it when she/he was up in her/his wheelchair. On 6/5/25 at 9:01 AM, Resident 47 was observed with oxygen administered through a nasal cannula. A review of the Resident 47's clinical record found no documentation of physician orders for oxygen administration, how often the oxygen filter was to be cleaned, checked, or how often the oxygen tubing was to be changed. On 6/5/25 at 10:28 AM, Staff 2 stated Resident 47 did not have any current orders for oxygen.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to provide appropriate pain management for 1 of 2 sampled residents (#55) reviewed for pain. This placed residents at risk for uncontrolled pain. Findings include: Resident 55 was admitted to the facility in 2/2025 with diagnoses including osteoarthritis of the hip and knee and chronic pain. A 4/16/25 Physician's Progress Note indicated Resident 55 experienced severe osteoarthritis. The recommendation was to continue pain management with PRN acetaminophen. A revised 4/17/25 care plan revealed Resident 55 experienced chronic pain due to gout, and bilateral severe osteoarthritis of the hip. Interventions included attempting non-pharmaceutical interventions before administering pain medications per physician orders and report to the nurse complaints of pain or requests for pain treatment. Resident 55's 5/21/25 Quarterly MDS indicated the resident was cognitively intact. Resident 55 received scheduled pain medication and no PRN pain medications. Resident 55 was in almost constant pain, which affected sleep, day-to-day activities, and therapy frequently. The resident reported a pain level of seven on a scale from 0-10. A 6/2025 MAR instructed staff to administer gabapentin 300 mg by mouth in the afternoon for pain and gabapentin 300 mg two capsules two times a day for pain at 8:00 AM and 8:00 PM. Resident 55 was also ordered to have acetaminophen 500 mg two tablets every 8 hours for pain. Both orders were administered as physician ordered. On 6/2/25 at 12:48 PM and 6/5/25 at 8:51 AM, Resident 55 stated she/he was asking for something to assist with breakthrough pain, but nothing had happened yet. Resident 55 stated there were days when she/he was very painful and needed additional medication. Resident 55 stated she/he took gabapentin and acetaminophen and did not take anything for breakthrough pain. Resident 55 stated she/he put in a request a couple of weeks ago and nothing was done. Resident 55 stated topical creams did not work. No documentation or communication with the provider about pain management was found in Resident 55's clinical record. On 6/5/25 at 11:21 AM, Staff 2 (DNS) stated she could not find any information to indicate the physician was contacted for clarification for the PRN acetaminophen. Staff 2 stated she expected staff to contact the physician to clarify the information in the physician's progress note.

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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 interview and record review, it was determined the facility failed to ensure narcotic drug records were in order, and an account of all controlled drugs was maintained for 4 of 4 medication carts reviewed for medication administration. This placed residents at risk for drug diversion. Findings included: On 6/4/25 at 11:14 AM, book four on the South hall's 5/2025 medication cart Narcotic log book revealed 57 times out of 186 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 11:30 AM, book four on the South hall's 4/2025 medication cart Narcotic log book revealed 45 times out of 180 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 11:45 AM, book seven on the North hall's 3/2025 medication cart Narcotic log book revealed 92 times out of 186 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 11:50 AM, book seven on the North hall's 4/2025 medication cart Narcotic log book revealed 82 times out of 180 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 11:55 AM, book seven on the North hall's 5/2025 medication cart Narcotic log book revealed 64 times out of 186 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 12:00 PM, book 14 on the South hall's 3/2025 medication cart Narcotic log book revealed 94 times out of 186 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 12:05 PM, book 14 on the North hall's 4/2025 medication cart Narcotic log book revealed 52 times out of 186 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 12:10 PM, book 14 on the North hall's 5/2025 medication cart Narcotic log book revealed 36 times out of 180 counting opportunities the facility staff did not sign verification the narcotic count was accurate. On 6/4/25 at 12:22 PM, Staff 2 (DNS) verified the missing signatures in the Narcotic books. Staff 2 acknowledged the Narcotic book always needed to be signed by two nurses or CMAs to verify the count was accurate.