STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385195	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Beaverton	11850 SW Allen Blvd. Beaverton, OR 97008

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to provide equipment to maintain ROM to a resident with limited mobility for 1 of 3 sampled residents (#63) reviewed for mobility. This placed residents at risk for decrease in ROM. Findings include:Resident 63 was admitted to the facility in 2024 with diagnoses including cerebral infarction (disrupted blood flow to the brain)The 6/2/25 Quarterly MDS indicated Resident 63 was cognitively intact, utilized a wheelchair and walker, and was impaired on side.The 6/6/25 Care Plan indicated Resident 63 was non-ambulatory and was wheelchair bound.A 2/18/25 progress note indicated an AFO (Ankle Foot Orthesis) was ordered for Resident 63 in January. The note indicated staff reached out to orthotics and prosthetics and the referral did not include a provider signature and chart notes to support necessity of the AFO.A 3/5/25 Progress Note indicated Resident 63 was still waiting for the AFO to be delivered to start an ambulation restorative program. Resident 63 attended group therapy with the wheelchair.A 4/7/25 physician note clarified Resident 63 required a custom AFO permanently.On 8/4/25 at 2:55 PM, Resident 63 was observed without an AFO. The resident stated she/he participated with the physical therapist individually and was able to walk with assistance. Resident 63 stated she/he stopped walking, and used the wheelchair to participate in group therapy. Resident 63 stated her/his right leg was weaker and ROM decreased when physical therapy services ended.On 8/7/25 at 9:50AM, Staff 13 (CNA) stated staff did not ambulate Resident 63. Staff 13 stated Resident 63 had a stroke and was unable to ambulate due to right sided weakness. Staff 13 stated Resident 63 worked with PT and used a walker to ambulate. On 8/7/25 at 9:25 AM, Staff 14 (Restorative Aide) stated Resident 63 ambulated with PT. She stated restorative orders indicated Resident 63 participated in group therapy until the AFO arrived. Resident 63 was waiting for the AFO to be delivered to start an ambulating restorative program. On 8/7/25 at 12:23PM, Staff 15 (Physical Therapist) stated Resident 63 received physical therapy from 12/18/24 to 12/24/24. Staff 15 stated Resident 63 was required to use an AFO to ambulate. A referral was sent to prosthetics and orthotics. Resident 63 was measured and was waiting for the AFO to be delivered. Staff 15 stated he thought insurance approval was delayed. Staff 15 stated Resident 63's gait was unsafe, and she/he was waiting for the AFO to be delivered to start an ambulating restorative program. Staff 15 stated Resident 63 did participate in group therapy. Staff 15 stated staff agreed to notify the therapy team when the AFO arrived.On 8/7/25 at 2:13PM, Staff 16 (LPN- Resident Care Coordinator) stated restorative orders indicated Resident 63 participated in group therapy. Staff 16 stated Resident 63 used a wheelchair and walker at baseline. Staff 16 stated the prosthetics and orthotics clinic denied the referral and requested additional documentation. Staff 16 stated additional documentation was sent and she was waiting for the AFO to be delivered. Staff 16 stated she reached out to prosthetics and orthotics clinic on 7/22/25.On 8/8/25 at 9:47 AM, Staff 2 (Director of Nursing Services) acknowledged the arrival of the AFO was not timely. She stated referral requests were not processed in a timely manner. Staff 2 stated she expected staff to follow up with outpatient providers in a timely manner.

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review it was determined the facility failed to ensure residents received trauma informed care for 1 of 3 sampled residents (#8) reviewed for dignity. This placed residents at risk for re-traumatization. Findings include: The facility's 8/2022 Trauma Informed Care and Culturally Competent Care Policy indicated to provide trauma-informed care in accordance with professional standards of practice and to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. It directed staff to identify and decrease exposure to triggers that may retraumatize the resident.Resident 8 was admitted to the facility in 6/2025 with diagnoses including PTSD (Post-Traumatic Stress Disorder, mental condition with intense emotional and/or physical reaction after a traumatic event or experience).Resident 8's 6/19/25 admission MDS revealed the resident was cognitively intact, able to make herself/himself understood and understood others without difficulty, and had a PTSD diagnosis.Resident 8's 6/16/25 Trauma Informed Care Evaluation was marked as The resident does not want to complete this assessment and/or states they have not experienced trauma (end assessment here). No evidence was found in Resident 8's 6/16/25 to indicate a care plan was developed to address the resident's trauma history or involved family members were interviewed to provide information about the resident's trauma history and potential triggers.A 7/1/25 FRI Resident 8 reported Staff 9 (LPN) while alone in the hallway, Staff 9 smelled her/his hair, then pushed her/his wheelchair into their room and smelled her/his hair again. While in the room, Staff 9 hugged Resident 8 from behind seated in the wheelchair and rubbed the resident's arms several times. Resident 8 stated these actions triggered her/his PTSD.On 8/5/25 at 4:38 PM Resident 8 stated the facility should have been aware of her/his PTSD from the hospital notes. Resident 8 stated she/he spoke to several staff of her/his experience with PTSD and triggers and the staff should have been aware.On 8/7/25 at 9:27 AM Staff 9 confirmed he smelled Resident 8's hair and rubbed her/his arms in the hallway and in the room. Staff 9 stated he was aware of Resident 8's PTSD diagnoses from her/his medical history and conversations with the resident.On 8/7/25 at 2:41 PM Staff 2 (DNS) stated all residents with PTSD diagnoses had an initial care plan developed by the admission nurse at the time of admission. She expected Social Services to develop a resident-centered care plan within 72-hours from admission.On 8/8/25 at 9:16 AM Staff 1 (Administrator) acknowledged Resident 8's a history of trauma and nothing was implemented related to her/his trauma triggers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure medication storage was free of expired biologicals for 1 of 3 sampled medication rooms reviewed for medication storage. This placed residents at risk for diminished treatment efficacy. Findings include: The 2014 Oregon Health Authority HIV, STD, TB, Viral Hepatitis Program specified the following:- Vials in use more than 30 days should be discarded due to oxidation and degradation which may affect potency.The facility's 11/2020 Storage of Medications Policy specified the following:- Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.On [DATE] at 10:09 AM, two open, undated vials of tuberculin (used for the testing in the diagnosis of Tuberculosis) and two open, undated insulin pens were observed inside the refrigerator located in the north hall medication storage room.On [DATE] at 10:35 AM, Staff 2 (Director of Nursing) acknowledged the vials of tuberculin and insulin pens were undated and expected staff to discard tuberculin vial and insulin pens within 30 days of opening.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview and record review it was determined the facility failed to provide speech therapy services in a timely manner for 1 of 3 sampled residents (#63) reviewed for mobility. This placed resident at risk for communication barriers. Findings include:Resident 63 admitted to the facility in 2024 with diagnoses including hearing loss.The 4/14/25 Audiologic report AVS (after visit summary) indicated Resident 63 was to start an aural rehabilitation program and to obtain a referral to speech pathology.The 6/24/25 Care Conference indicated Resident 63 did not hear with her/his hearing aids and requested staff to communicate in written form.A review of Resident 63's orders indicated a speech evaluation and treatment orders was entered on 8/7/25. No evidence was found in the resident's medical record to indicate she/he saw a speech pathologist. On 8/4/25 at 2:55 PM, Resident 63 stated she/he preferred to communicate via written form. Resident 63 proceeded to point at her/his ears and said she/he was not able to hear.On 8/8/25 at 9:07 AM, Staff 5 (Director of Rehab) stated Staff 16 (LPN-Resident Care Coordinator) discussed aural rehabilitation services for Resident 63 early in the week. Staff 5 stated Resident 63 was referred to speech therapy a couple days ago. Staff 5 was unaware Resident 63 was seen at the ear clinic in April 2025. Staff 5 expected a referral to speech therapy to be entered the following day after Resident 63's ear clinic appointment.On 8/8/25 at 9:47 AM, Staff 2 stated it was expected for staff to request an AVS after each visit to outpatient appointments. Staff acknowledged the referral to speech therapy was not entered within a timely manner.