STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385203	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Clackamas	220 E. Hereford Gladstone, OR 97027

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review it was determined the facility failed to provide a clean and comfortable homelike environment for 1 of 2 halls reviewed for environment. This placed residents at risk for lessened quality of life. Findings include: On 9/29/25 through 10/1/25 from 8:00 AM to 4:00 PM, resident rooms one, two and four in the [NAME] Hall were observed to be used for storage of new furniture and past resident belongings. Observations of the three rooms included:-Five mattresses stacked on top of an unoccupied bed. The right side of the room was used for storage of a metal rack, two floor mats, a knee wedge, hangers, bath basin, gown, a bag of tortillas and four side tables. On the floor, a drawer from unknown origin was left on the floor and a yellow bath basin was placed on top.-Six mattresses stacked on top of an unoccupied bed. On top of the mattress, several blue blankets were placed on top of the mattresses. A sign above an unoccupied bed stated, emergency overflow bed only.-Three floor mats on top of an empty bed. A blue blanket was placed on top of the floor mats. Two bed frames and two side tables were placed in random places on the left side of the room. On 9/29/25 at 1:32 PM, Resident 48 stated her/his room was an overflow room for staff to store furniture. On 9/29/25 at 1:44 PM, Resident 17 stated the extra furniture in her/his room was there since admission. On 10/1/25 at 8:59 AM, Resident 10 stated the furniture in her/his room bugged her/him but the facility didn't have enough storage. Staff told her/him they tried to move the furniture, but they were short staffed. Resident 10 stated she/he kept the curtain closed to avoid seeing the mess. On 10/1/25 at 9:23 AM, Staff 9 (CNA) stated the resident rooms were used for extra furniture.On 10/1/25 at 11:08 AM, Staff 8 (CNA) stated unoccupied areas in resident rooms were used for extra furniture. Staff 8 stated the facility stored extra equipment including furniture in a trailer next to the facility. On 10/1/25 at 12:58 PM, Staff 1 (Administrator) stated unoccupied resident rooms were used for temporary storage of new furniture. Staff 1 stated he was unaware new furniture was stored in occupied resident rooms. Staff 1 stated one of the rooms was previously unoccupied, but they had a last-minute admission, and he was unaware the resident wanted the furniture removed. Staff 1 stated the shed was not ready for storage. Staff 1 acknowledged storing furniture in occupied resident rooms was not a homelike environment.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. **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 dependent residents received required assistance with ADLs for 1 of 3 sampled residents (#5) reviewed for ADLs. This placed residents at risk for lack of personal hygiene. Findings include:Resident 5 was admitted to the facility in 8/2025 with diagnoses including stroke and dysphagia (difficulty swallowing).Resident 5's Quarterly MDS dated [DATE] indicated the resident was dependent on staff for personal hygiene and grooming.Resident 5's care plan dated 8/28/25 indicated the resident required total assistance with personal hygiene. Resident 5 was observed on 9/29/25 at 1:11 PM, 9/30/25 at 12:59 PM and on 12/4/25 at 11:53 AM with a significant amount of visible facial hair.On 9/30/25 at 1:10 PM Resident 5 stated she/he did not want to have facial hair and wanted staff to take care of her/his facial hair. Resident 5 stated she/he relied on staff to shave unwanted facial hair.On 10/1/25 at 12:07, Staff 10 (CNA) stated she noticed Resident 5's facial hair, which was very visible. Staff 10 indicated Resident 5 was dependent on staff to shave her/him.On 10/1/25 at 12:20 PM, Staff 11 (CNA) stated she obtained information to care for resident 5 from the care plan and acknowledged Resident 5 had a noticeable amount of facial hair.On 10/1/25 at 12:26 PM, Staff 2 (DNS) stated it was her expectation for Resident 5 to have her/his shaving preferences followed and confirmed the resident was dependent on staff for ADL care.

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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. Based on interview and record review it was determined the facility failed to implement care plan interventions to prevent an injury during toileting for 1 of 1 sampled resident (#60) reviewed for falls. This placed residents at risk for injury during transfers and inadequate ADL assistance. Findings include:Resident 60 admitted to the facility in 5/2025 with diagnoses including stroke with left sided weakness.A review of Resident 60's care plan dated 4/29/25 revealed she/he required assistance from two staff members for all transfers and toileting due to high fall risk and multiple falls since admission.A facility investigation created and signed by Staff 2 (DNS) on 5/13/25 indicated Staff 7 (Former NA) transferred Resident 60 to the toilet. Staff 7 attempted to change Resident 60's brief while the resident was seated on the toilet and the resident jerked suddenly which caused the resident to hit her/his head on the mobility bar along the wall, resulting in a large bump on the side of the resident's head.On 12/4/25 at 11:47 AM Staff 2 confirmed Staff 7 did not follow Resident 60's care plan to have two staff assist with toileting Resident 60.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to implement appropriate contact precautions and properly store wound care supplies for 1 of 1 resident (#24) reviewed for hospice. This placed residents at risk for the spread of infection. Findings include:The Center for Disease Control's (CDC) 4/3/24 website, section titled, Transmission Based Precautions, specified Contact Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.The facility's Transmission-Based Precautions policy dated 8/2019 stated:3. When Transmission-Based Precautions are implemented, the Infection Preventionist: -Clearly identifies the type of precautions, the anticipated duration and the personal equipment (PPE) that must be used;-Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and the type of precautions;-The signage informs staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room.Resident 24 was admitted to the facility in 6/2025 with diagnoses including type 2 diabetes and MRSA (a bacterial infection resistant to several antibiotics).a. On 9/29/25 at 9:57 AM, 12/2/25 at 12:40 PM and on 12/3/25 at 9:22 AM room [ROOM NUMBER] was observed to have a full trash bag laying on the floor behind the door, an open bag of incontinence briefs laying on the floor and multiple sterile treatments supplies were opened and in a box on the floor. No staff were present in the room or hallway at the time of the observations.On 12/3/25 at 9:30 AM, Staff 8 (CNA) confirmed the trash bag was on the floor and verified opened sterile wound treatment supplies were being stored on the floor.On 12/3/25 at 9:58 AM, Staff 16 (RN) verified sterile treatment supplies were stored in a box on the floor in room [ROOM NUMBER].On 12/3/25 at 11:20 AM, Staff 5 (IP) and Staff 4 (RNCM) stated it was their expectation for sterile wound care supplies be stored appropriately and off the floor.On 12/3/25 at 11:31 AM, Staff 2 (DNS) stated the storage of sterile supplies on the floor was not consistent with facility practice and should have been addressed immediately by staff.b. On 9/29/25 at 9:57 AM, 12/2/25 at 12:40 PM and on 12/3/25 at 9:22 AM Resident 24 was observed to have scabs and wound dressings on her/his feet and bilateral ankles. Resident 24's room was not identified to require contact precautions.On 12/3/25 at 9:30 AM Staff 8 (CNA) stated Resident 24 was not on contact precautions and she did not wear PPE while providing care for the resident.On 12/3/25 at 9:58 AM Staff 16 (RN) stated Resident 24 was previously on contact precautions but was not any longer, and she wore gloves only when performing dressing changes.On 12/3/25 at 11:20 AM Staff 5 and Staff 4 observed Resident 24's feet and identified an open wound. Both stated the open wound was not reported to them and the resident should have been on contact precautions based on the presence of the wound.On 12/3/25 at 11:31 AM Staff 2 stated it was her expectation open wounds were reported promptly and contact precautions implemented as required. Staff 2 confirmed Resident 24 should have been on contact precautions once the open wound was identified.