STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385229	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Junction City	530 Birch Street Junction City, OR 97448

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 34324 Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation of financial resources for 1 of 1 sampled resident (#4) reviewed for misappropriation. This placed residents at risk for financial loss. Findings include: Resident 4 admitted to the facility in 2022 with diagnoses including congestive heart failure. A 4/29/24 FRI indicated Staff 5 (LPN) informed Staff 2 (DNS) and Staff 1 (Administrator) of Resident 4 giving $1200 to Staff 3 (CNA). Resident 4 indicated $1000 was a loan and $200 was a gift. Interviews indicated the following: - Staff 5 indicated she was in Resident 4's room providing a treatment and the resident talked about helping others over the years and felt obligated to help others in time of need. Resident 4 told Staff 5 that two weeks ago she/he heard about a CNA at the facility who was struggling to pay rent and she/he gave the CNA $1200 to help pay the rent. Resident 4 indicated the CNA she/he gave the money to was Staff 3. - Resident 4 stated she/he was speaking with Staff 3 about finances and Staff 3 indicated she was unable to pay her rent. Resident 4 indicated she/he offered her $1200; $200 as a gift and $1000 as a loan. - Staff 3 admitted to speaking with Resident 4 about her financial situation and admitted to accepting a $1200 check. Staff 3 was suspended pending the investigation. The facility's investigation indicated the taking, borrowing, or accepting of funds from a person residing at the facility by a staff person was considered financial exploitation. The money was refunded to Resident 4 and Staff 3 was terminated on 5/3/24. Resident 4's Care Plan was updated to include trauma (abuse) with a history of giving money to those who are in need. The Oregon Board of Nursing was notified of Staff 3's misconduct; law enforcement was also notified. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 10:56 PM Resident 4 stated Staff 3 told her/him that she helped someone out and did not have the money to pay her rent that was due the following week. Staff 3 informed Resident 4 she had three small children. Resident 4 stated she/he thought about it and felt bad, so she gave Staff 3 a check for $1200. Resident 4 stated she/he told Staff 3 that $200 was a gift and $1000 was a loan to pay back when she could. Resident 4 stated she/he was talking to Staff 5 and told her about it. Resident 4 stated administrative staff spoke to her/him about it and Staff 3 was fired. Resident 4 stated Staff 3 never refused the money or indicated she was unable to accept money from residents. On 6/5/24 at 10:32 AM Staff 2 stated he and Staff 1 spoke with Staff 3. Staff 2 stated Staff 3 indicated she spoke with Resident 4 about her financial issues and that she was not able to pay her rent. Staff 2 stated Staff 3 indicated Resident 4 offered her money and Staff 3 accepted the money. Staff 2 stated Staff 3 indicated she was aware it was wrong, but felt she had no other option. Staff 2 stated a plan of correction was immediately started which included training with all staff and audits related to misappropriation. On 6/5/24 at 11:25 AM Staff 5 stated she was in Resident 4's room completing a treatment and the resident started telling her about giving Staff 3 money. Staff 5 stated she immediately informed the DNS and Administrator. On 6/5/24 at 12:26 PM Staff 3 stated she returned from vacation and was having family issues. Staff 3 stated somehow Resident 4 found about her financial issues and offered to help. Staff 3 stated she told Resident 4 no, but the resident kept offering to help. Staff 3 stated she accepted the $1200, cashed the check and paid her rent. Staff 3 stated a month later she received a call from Staff 1; she was suspended, and then terminated due to accepting money from Resident 4. Staff 3 stated she did not steal anything. Resident 4 was coherent and offered the money to her. Staff 3 stated she told the resident it was against the rules of the facility to accept money from a resident, but the resident was crying, so she, just did it. On 6/5/24 at 12:41 PM Staff 1 stated after it was reported to her, she and Staff 2 contacted Staff 3. Staff 1 stated Staff 3 admitted to accepting money from Resident 4 and asked if she was going to terminated. Staff 1 stated Staff 3 immediately knew she was wrong and indicated she was in a tight spot and needed to send money to her family. Staff 1 stated Staff 3 indicated she thought she was going to be get away with it. Staff 1 stated Staff 3 was terminated, and the allegation of misappropriation was substantiated. On 6/4/24 at 10:20 AM the facility provided information to indicate education and an in-service was provided to nursing staff related to the identified incident. The deficient practice was determined to be past non-compliance, corrected on 4/29/24.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 2 of 3 sampled residents (#s 1 and 5) reviewed for medication. This failure resulted in Resident 1 sustaining a gastrointestinal (GI) bleed which required hospitalization , and placed residents at risk for adverse medication side effects. Findings include: 1. Resident 1 readmitted to the facility on [DATE] with diagnoses including pulmonary embolism (blood clot in the lungs). The 3/4/24 physician orders indicated Resident 1 was to receive apixaban (anticoagulant medication) 10 mg BID for six days, then 5 mg BID. The 3/2024 MARS indicated Resident 1 received the following: -apixaban 10 mg one dose on the evening of 3/4/24. -apixaban 10 mg BID from 3/5/24 through 3/26/24. -apixaban 10 mg one dose on the morning of 3/27/24. The 3/27/24 medication incident report indicated Resident 1 readmitted to the facility with an order for apixaban and it was incorrectly entered into the facility's electronic record system without the correct stop dates and dose adjustment. The medication error was caught by the nurse practitioner on 3/27/24. The medication double and triple checks were not completed correctly. The resident was not aware of the medication error until she/he was notified by staff when collecting blood tests. The 4/3/24 Summary indicated: Actions taken: the nurse practitioner notified Staff 2 (DNS) and resident care manager of the error. Staff 2 and resident care manager pulled the charge nurse to discuss the orders and the error on admission. The administrator was notified. Stat labs were ordered. Resident 1 was sent to the hospital due to low hemoglobin counts. The 4/2/24 hospital records indicated Resident 1 presented to the hospital with melena (black tarry stools and a symptom of internal bleeding); GI bleed; acute blood loss and anemia. The nursing facility failed to decrease apixaban from 10 mg to 5 mg. The resident had a lab result for Hemoglobin of 6.5, which deviated from a baseline of 9-10. Resident 1 received a blood transfusion and was admitted to the hospital. On 6/5/24 at 1:30 PM Staff 2 (DNS) acknowledged Resident 1 received apixaban 10 mg BID from 3/4/24 through 3/26/24. Staff 2 stated Resident 1's physician order indicated she/he was to start taking the lower dose of apixaban 5 mg BID on 3/11/24 and she/he continued to receive apixaban 10 mg BID until the error was discovered by the nurse practitioner on 3/27/24. Staff 2 acknowledged stat labs were ordered and it was determined Resident 1 had a GI bleed, was sent to the hospital, and received a blood transfusion as a result of receiving increased apixaban. 2. Resident 5 was admitted to the facility in 5/2024 with diagnoses including diabetes. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The 6/1/24 Medication Error Report indicated Resident 5 received Resident 7's medications in error on 6/1/24 at 7:25 PM. The medications included the following: -tamsulosin 0.4 mg (medication for benign prostatic hyperplasia) -buspirone 20 mg (antianxiety medication) -loxapine 50 mg (antipsychotic medication) -metoprolol extended release 50 mg (blood pressure medication) -seroquel 100 mg (antipsychotic medication) -terazosin 4 mg (blood pressure medication) The 6/1/2024 8:07 PM Progress Note by Staff 4 (LPN) indicated she was notified by the CMA that Resident 5 received a fell ow resident's medication. The resident was evaluated for neurological and cognition changes immediately and none were found. Vitals were checked immediately, with instructions for neurological vitals protocol - vitals stable, though blood pressure observed to be slightly hypotensive at 103/60. The resident stated she/he felt fine, smiled and interacted pleasantly with staff. The nurse notified the hospice nurse who relayed the information to the physician. Currently awaiting further instruction from the hospice physician. The 6/1/24 10:10 PM Progress Note by Staff 4 indicated hospice followed up and requested to hold lisinopril (blood pressure medication) and finasteride (medication for benign prostatic hyperplasia) for the next 24 hours, and to notify hospice before administering comfort medications. Notified poison control per hospice request, and poison control staff confirmed the resident could continue to be monitored at the facility and confirmed the administered medications would not hit peak times simultaneously. Neurological checks remained within normal limits for the remainder of shift. On 6/5/24 at 12:04 PM Staff 4 stated she was notified by Staff 6 (CMA) on the evening of 6/1/24 that a medication error occurred when Staff 6 administered Resident 7's medications to Resident 5. Staff 4 stated Resident 5 did not usually take medications at night as she/he was on PRN comfort medications only. Staff 4 stated she immediately initiated neurological checks, contacted the physician, hospice and poison control and it was determined the resident would remain in the facility and continue to be monitored for medication side effects. Staff 4 further stated the resident was hypotensive and tired, but had no other side effects from the medications. On 6/7/24 at 1:05 PM Staff 6 (CMA) stated on 6/1/24 she prepared evening shift medications for Resident 7. Staff 6 stated a CNA asked her for assistance in Resident 5's room. Staff 6 stated after she assisted the CNA she gave Resident 5 the medications she prepared for Resident 7. She stated she realized her error when she went to leave the room and called Resident 5 by the incorrect name and the CNA corrected her. Staff 6 stated she reported the error to Staff 4. Staff 6 further stated Resident 5 was monitored and had no adverse side effects due to the medication error. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 6/7/24 at 2:07 PM Staff 2 (DNS) acknowledged Resident 7's medications were administered to Resident 5 by Staff 6 on the evening of 6/1/24 in error. Staff 2 acknowledged the medications included tamsulosin 0.4 mg; buspirone 20 mg; loxapine 50 mg; metoprolol extended release 50 mg; seroquel 100 mg and terazosin 4 mg.