

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Junction City		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to protect the resident's right to be free from verbal abuse by Resident 14 for 2 of 5 residents (#s 12 and 13) reviewed for abuse. This placed residents at risk for abuse. Findings include:1 Resident 12 was admitted to the facility in 7/2025 with diagnoses including chronic pain and muscle weakness.A 7/29/25 admission MDS indicated Resident 12's BIMS score was 14 (cognitively intact).A Verbal Aggression Received investigation revealed on 9/2/25 at 7:50 PM Resident 14 entered Resident 12's room and used profanity toward the resident. Staff 9 (CNA) reported Resident 12 called her to the room and said Resident 14 entered her/his room and called Resident 12 names.On 11/18/25 at 1:40 PM, Resident 12 stated on 9/2/25, Resident 14 was yelling at Resident 13 and Staff 8 (CMA). Resident 12 told Resident 14 to stop, and Resident 14 responded by saying he/she would come over there and would take care of it, attempting to start a fight. Resident 12 also reported Resident 14 once asked, while she/he was going to the shower, Is there enough water to wash a [NAME] like you? Resident 12 stated she/he felt verbally abused by Resident 14.On 11/19/25 at 10:15 AM, Staff 9 stated Resident 14 verbally attacked Resident 12 and made fat jokes.On 11/19/25 at 12:07 PM Staff 2 (DNS) confirmed Resident 14's behavior on 9/2/25 was inappropriate.2. Resident 13 was admitted to the facility in 7/2025 with diagnoses including Alzheimer's disease and cognitive communication deficit (difficulty understanding or expressing thoughts due to brain-related conditions).A Verbal Aggression Received investigation dated 9/2/25 at 7:50 PM revealed Staff 8 (CMA) heard a conversation and asked Resident 14 to refrain from speaking to Resident 13. Staff 8 reported she was attempting to redirect Resident 13 as she/he wanted to go to bed and was yelling. Resident 14 started saying You people need to go to fucking jail, you people let these fucking crazies run this place. Abuse was not ruled out.On 11/19/25 at 10:05 AM Staff 8 stated Resident 14 was so rude to Resident 13, and there was a lot of verbal abuse in there.On 11/19/25 at 12:07 PM Staff 2 (DNS) confirmed Resident 14's behavior on 9/2/25 was inappropriate.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 385229
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NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Junction City		STREET ADDRESS, CITY, STATE, ZIP CODE 530 Birch Street Junction City, OR 97448	

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review it was determined the facility failed to thoroughly investigate a treatment-related injury for 1 of 3 sampled residents (#15) reviewed for catheter use. This placed residents at risk for abuse and neglect. Findings include: Resident 15 was admitted to the facility in 9/2024 with diagnoses including quadriplegia (paralysis of all four limbs) and neuropathic bladder (bladder dysfunction caused by nerve damage). A 12/18/24 Quarterly MDS indicated Resident 15's BIMS score was 15 (cognitively intact). A Significant Concern investigation dated 3/18/25 revealed Resident 15 became nonresponsive on 3/15/25 and was sent to the hospital. Care notes documented septic shock (a life-threatening infection) and traumatic Foley catheter placement. The catheter was changed during the night shift on 3/14/25. At 9:30 AM on 3/15/25, Resident 15 complained of nausea and had an elevated temperature. By 6:30 PM, Resident 15 was nonresponsive, and 911 was called. The investigation did not include documentation identifying the staff member who completed the Foley catheter placement or a witness statement from that staff member. On 11/19/25 at 11:27 AM, Resident 15 stated she/he had experienced multiple incorrect catheter placements and infections. Resident 15 reported urology had since assisted, and she/he no longer has any issues with her/his catheter placement. Resident 15 recalled the nurse who placed the catheter on 3/18/25 was a female but could not remember her name. On 11/19/24 at 11:49 AM and 11:55 AM, Staff 14 (RN RCM) stated she did not know who completed the catheter placement on Resident 15. Staff 14 stated Staff 17 (LPN) was working the night Resident 15's catheter was placed. Attempts to reach Staff 17 were unsuccessful. On 11/19/25 at 12:10 PM Staff 2 (DNS) stated he would expect the investigation to have a witness statement from the staff who completed the treatment on Resident 15.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review it was determined the facility failed to provide care and treatment as care planned for 1 of 5 residents (#10) reviewed for abuse. This placed residents at risk for delayed or unmet needs. Findings include: Resident 10 was admitted to the facility in 6/2025 with diagnoses including dementia and dysphagia (difficulty swallowing). A care plan dated 6/11/25 revealed Resident 10 was to eat in the [NAME] dining room, required total assistance to eat, and needed supervision for meals. A 6/19/25 Cognitive Loss and Dementia Care Area Assessment revealed Resident 10 had dementia with agitation. Resident 10 yelled to express her/his needs and redirection was effective. A Verbal Aggression Received investigation dated 8/20/25 revealed at 12:30 PM, Resident 10 and Resident 11 threatened to kick each other's asses. The residents were separated. Resident 10 was care planned to eat under supervision in the [NAME] dining room due to being on an easy-chew diet. Resident 10 had a history of behavioral issues and was on a behavior monitor for verbal aggression. On 11/19/25 at 8:21 AM, Witness 1 (Staff) stated staff were to remain in the [NAME] dining room during meals to supervise residents. Witness 1 reported on three to four occasions; no CNA was present during meals she observed. On 8/20/25, Witness 1 did not observe any CNAs in the [NAME] dining room when Resident 10 and Resident 11 had a verbal altercation. Witness 1 stated since 8/20/25, there were quite a few times CNAs were not present to supervise residents during meals. On 11/19/25 at 8:36 AM, Staff 6 (CNA) stated both Resident 10 and Resident 11 were in the [NAME] dining room on 8/20/25. Staff 6 confirmed she was not present during the entire verbal altercation. Staff 6 acknowledged a CNA was required to supervise residents during meals and believed Staff 7 was present at the time. Staff 6 explained CNAs alternate supervision during meals due to other responsibilities. On 11/19/25 at 9:10 AM Staff 7 (CNA) stated on 8/20/25 she was not in the [NAME] dining room when the altercation occurred between Resident 10 and Resident 11. Staff 7 confirmed Resident 10 was care planned for supervision during meals for safety. On 11/19/25 at 12:05 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed staff should have been present in the [NAME] dining room on 8/20/25 supervising Resident 10 as outlined in the care plan.</p>		