

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 04/05/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to assist residents with formulation of an advance directive for 1 of 1 sampled resident (#10) reviewed for advance directive. This placed residents at risk for lack of individualized healthcare decisions. Findings include:</p> <p>Resident 10 was admitted to the facility in 1/2021 with diagnoses including depression and bipolar disorder.</p> <p>The facility policy, Advance Directives, dated 9/2022 indicated the following:</p> <p>-If the resident or representative indicates that he or she has not established an advance directive, the facility staff will offer assistance in establishing an advance directive.</p> <p>The 11/16/23 Comprehensive Plan of Care Review indicated Resident 10 did not have an advance directive established and requested assistance from facility staff to establish one.</p> <p>A review of Resident 10's clinical record from 11/2023 through 4/2024 revealed no indication facility staff assisted Resident 10 to establish an advance directive.</p> <p>On 4/1/24 at 11:14 AM Resident 10 stated she/he asked for assistance to establish an advance directive in 11/2023 and never received help.</p> <p>On 4/2/24 at 2:31 PM Staff 13 (SSD) acknowledged follow up did not occur after Resident 10 requested assistance on 11/16/23 to establish an advance directive.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>34702</p> <p>Based on observation and interview it was determined the facility failed to ensure resident equipment was clean and in good repair for 2 of 3 sampled residents (#s 14 and 22) reviewed for environment. This placed residents at risk for living in an unhomelike environment. Findings include:</p> <p>1. Resident 22 readmitted to the facility in 10/2023 with diagnoses including dementia and muscle weakness.</p> <p>On 4/2/24 at 9:28 AM Resident 22 was observed to walk with her/his walker and the left front wheel of the walker shook back and forth as she/he pushed it down the hall. The left handle was observed to be worn and missing some foam. Resident 22 stated Staff 19 (Physical Therapist) was aware of the issues with the walker.</p> <p>On 4/3/24 at 11:09 AM Staff 18 (Occupational Therapist) stated Staff 19 was out of the facility for the week. Staff 18 observed Resident 22's walker and stated the bolt that held the wheel was loose and acknowledged it needed repairs.</p> <p>On 4/5/24 at 11:19 AM Resident 22's walker was observed with Staff 1 (Administrator). The left handle of the walker was missing foam and Resident 22 stated the brakes did not work. Staff 1 acknowledged the identified findings for Resident 22's walker.</p> <p>2. Resident 14 admitted to the facility in 12/2021 with diagnoses including multiple sclerosis.</p> <p>On 4/2/24 at 9:45 AM Resident 14's wheelchair was observed to have dried food debris splattered along the sides and it was dirty. The bilateral armrests were torn and the metal underneath was exposed where the resident rested her/his hands.</p> <p>On 4/5/24 at 10:24 AM Staff 8 (CNA) stated she noticed Resident 14's dirty wheelchair a couple of days prior and when she asked staff who cleaned the wheelchairs, she was told night shift was responsible for cleaning the wheelchairs.</p> <p>On 4/5/24 at 11:19 AM Staff 1 (Administrator) observed Resident 14's wheelchair and it was splattered with dried food debris and the bilateral armrests were torn and in disrepair. Staff 1 acknowledged the identified findings.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to update resident care plans related to head lice for 1 of 1 sampled resident (#37) reviewed for head lice. This placed residents at risk for lack of treatment. Findings include:</p> <p>Resident 37 was admitted to the facility in 2/2024 with diagnoses including vascular dementia and bipolar disorder.</p> <p>A 4/2/24 Progress Note indicated the resident was found to have several live head lice on her/his head. The resident's provider was notified on 4/2/24, a treatment was prescribed, and applied the same day. The provider recommended Resident 37 cut her/his hair, however the resident refused.</p> <p>A review of Resident 37's comprehensive care plan from 4/2/24 through 4/3/24 did not reveal any information related to head lice.</p> <p>On 4/4/24 Resident 37's comprehensive care plan was updated to reflect the current diagnosis of head lice.</p> <p>On 4/4/24 at 1:15 PM Staff 2 (DNS) acknowledged Resident 37's care plan was not updated timely.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34702</p> <p>Based on interview and record review it was determined the facility failed to ensure supervision and safety interventions were in place to prevent smoking related accidents for 1 of 2 sampled residents (#22) reviewed for smoking safety. This placed residents at risk for burns and accidents. Findings include:</p> <p>The facility 2/2010 Smoking Policy indicated the following:</p> <ul style="list-style-type: none"> -Residents who smoke were evaluated by a licensed nurse for smoking safety using the Smoking Safety Evaluation prior to being able to smoke at the facility. -Initiate a smoking care plan that identifies dependence status, risk, safety devices needed and other interventions determined by the Smoking Safety Evaluation. <p>Resident 22 readmitted to the facility in 10/2023 with diagnoses including dementia and muscle weakness.</p> <p>The 11/10/23 Smoking Safety Evaluation indicated Resident 22 had a history of smoking in the building, burning her/himself and a history of not following the smoking rules. The resident was to remain supervised for the safety of her/himself, others, and the building.</p> <p>The 2/27/24 Quarterly MDS indicated Resident 22 was moderately cognitively impaired.</p> <p>Resident 22's 3/6/24 Care Plan indicated she/he was to smoke with supervision only and the facility was to store tobacco and fire materials.</p> <p>The 3/28/24 Smoking Injury report indicated Staff 2 (DNS) and Staff 6 (LPN/Infection Preventionist) observed Resident 22 smoking unsupervised with another resident in the courtyard and it was not during the timeframe for supervised smoking. Staff 2 noticed Resident 22's hair was singed on the right side of her/his forehead and the resident had a burn mark above her/his right eye. Resident 22 admitted to smoking a cigarette that was given to her/him by the other resident. Staff 6 and Staff 2 found several cigarette butts and a pack of cigarettes in Resident 22's possession</p> <p>A 3/29/24 progress note indicated Resident 22's forehead burn resolved.</p> <p>On 4/4/24 at 1:50 PM Staff 14 (LPN) stated he worked on 3/28/24 and assessed Resident 22 after she/he burned her/his forehead. Staff 14 stated Resident 22 had a small red mark on her/his forehead where she/he burned her/himself with a cigarette and there was some ash around her/his forehead. Staff 14 stated he applied a bandage over it. Staff 14 further stated the next day the bandage was no longer on her/his forehead and the burn was gone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/5/24 at 12:03 PM Staff 2 (DNS) stated Resident 22 was a supervised smoker and was observed smoking independently on 3/28/24 with another resident. Staff 2 stated he asked Resident 22 what happened, and the resident stated she/he caught her/his hair on fire. Staff 2 acknowledged Resident 22's care plan was not followed for supervised smoking and the resident singed her/his hair and burned her/his forehead.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>48830</p> <p>Based on interview and record review it was determined the facility failed to ensure a RN was available for at least eight consecutive hours, seven days a week for 19 of 60 days reviewed for RN coverage. This placed residents at risk for lack of RN oversight including nursing assessments. Findings include:</p> <p>Review of the facility's Direct Care Daily Staff Reports from 2/1/24 through 3/31/24 indicated there was no RN coverage on the following dates:</p> <p>-2/3/24</p> <p>-2/4/24</p> <p>-2/10/24</p> <p>-2/11/24</p> <p>-2/17/24</p> <p>-2/18/24</p> <p>-2/24/24</p> <p>-2/25/24</p> <p>-3/2/24</p> <p>-3/3/24</p> <p>-3/9/24</p> <p>-3/10/24</p> <p>-3/16/24</p> <p>-3/17/24</p> <p>-3/23/24</p> <p>-3/24/24</p> <p>-3/29/24</p> <p>-3/30/24</p> <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-3/31/24</p> <p>On 4/5/24 at 10:46 AM Staff 7 (Scheduling Coordinator) acknowledged the facility lacked RN coverage on the identified dates.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>42271</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure appropriate medication storage temperatures were maintained within parameters for 1 of 1 medication storage refrigerator reviewed for safe medication storage. This placed residents at risk for receiving medications with reduced efficacy. Findings include:</p> <p>On 4/2/24 at 10:16 AM the medication refrigerator was observed with Staff 6 (LPN/Infection Preventionist). A review of the refrigerator temperature logs indicated temperatures were to be maintained between 36-46 degrees F and the temperature was to be checked twice daily (AM/PM). The temperature logs from 1/1/24 through 4/2/24 revealed 19 instances when the temperature of the refrigerator was below 36 degrees F. The medication refrigerator contained tuberculin (used for testing and diagnosis of Tuberculosis), influenza vaccines (vaccines which require refrigeration), insulin and an emergency medicine kit.</p> <p>A review of the temperature logs from 1/2024 through 4/2024 revealed temperatures out of range for the following dates:</p> <p>January 2024: 1/2; 1/8; 1/10; 1/12; 1/30 and 1/31.</p> <p>February 2024: 2/4; 2/5; 2/6; 2/7; 2/8; 2/14; 2/15; 2/16; 2/23; 2/24; 2/28.</p> <p>March 2024: 3/4 and 3/11.</p> <p>On 4/2/24 at 10:45 AM Staff 2 (DNS) acknowledged the refrigerator temperatures were to be checked and documented twice daily. Staff 2 acknowledged the identified dates when the temperature logs revealed temperatures below 36 degrees F. Staff 2 stated he expected staff to readjust the temperature in the refrigerator, recheck the temperature later and contact management as cold temperatures reduced the efficacy of insulin and vaccines.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677</p> <p>Based on observation and interview it was determined the facility failed to store and handle food in a sanitary manner for 2 of 2 unit refrigerators and freezers reviewed for safe food storage. This placed residents at risk for foodborne illness. Findings include:</p> <p>Observations of the unit refrigerators on [DATE] between 2:34 PM and 4:05 PM revealed the following:</p> <ul style="list-style-type: none"> -The [NAME] unit freezer contained three freezer bags of waffles that were unsealed. -The [NAME] unit refrigerator contained six expired applesauce cups. - The South unit freezer contained two ice cream half gallons with visible freezer burn. -The South unit refrigerator included a bag containing undated mayonnaise and salad dressing, two expired cheese dips with visible spoilage, and six expired yogurts. <p>On [DATE] at 2:58 PM Staff 12 (Dietary Manager) acknowledged the observations and stated the food items were not discarded after the expiration dates.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48830</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure appropriate infection control standards for head lice for 1 of 1 sampled resident (#37) reviewed for head lice. This placed residents at risk for head lice. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) Tip Sheet and Frequently Asked Questions for head lice dated 11/2019 and 9/2020 revealed the following:</p> <ul style="list-style-type: none"> -Patients with head lice should be placed on contact precautions (requires the use of gown and gloves on every entry into a resident's room) until 24 hours following a successful treatment. -Head lice are spread by direct contact with the hair of an infested person and by shared clothing, belongings, lying or sitting on a couch and/or chair without a wipeable surface. -Clothing, linens, and other items that an infested person wore or used during the two days before treatment need to be machine washed with hot water at 130 degrees F and dried on a high heat cycle to destroy lice. -Clothing and items that are not washable can be dry-cleaned or sealed in a plastic bag and stored for two weeks to destroy lice. <p>Resident 37 was admitted to the facility in 2/2024 with diagnoses including vascular dementia and bipolar disorder.</p> <p>The 3/4/24 Re-Admission MDS indicated Resident 37 was mildly cognitively impaired, was ambulatory and wandered at baseline.</p> <p>On 4/1/24 and 4/2/24 random observations of Resident 37 revealed she/he wore a fabric hat and a leather jacket.</p> <p>A Progress Note on 4/2/24 at 11:35 AM indicated Resident 37 was found to have several live head lice on her/his head. The resident's provider was contacted, an order for lice treatment was obtained and Resident 37 received a lice treatment the same day.</p> <p>On 4/2/24 at 1:50 PM the surveyor observed Enhanced Barrier Precautions (the use of gown and gloves only when a resident has an infection and/or uses a medical device such as a catheter) signage next to Resident 37's room.</p> <p>On 4/3/24 at 10:35 AM Staff 16 (Housekeeping) was observed to enter Resident 37's room wearing gloves and she was observed to clean the resident's room and bathroom. In a follow up interview with Staff 16 on 4/3/24 in the afternoon, she stated when a precautions sign was posted outside the resident's room she typically followed the instructions for required PPE prior to entering the resident's room.</p> <p>On 4/3/24 at 10:39 AM Resident 37 was observed wearing the same fabric hat and leather jacket.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/3/24 at 12:11 PM Staff 6 (LPN/ Infection Preventionist) stated Resident 37 was placed on Enhanced Barrier Precautions and she/he received the first treatment for head lice. She stated she thought the resident's laundry and linens were washed with other resident's laundry and linens. Staff 6 stated she did not think Resident 37's jacket could be laundered as it was leather. She also stated Resident 37 was wearing the fabric hat today, so highly unlikely it was laundered.</p> <p>On 4/4/24 at 1:15 PM Staff 2 (DNS) stated the facility was to follow the CDC recommendations for any resident with head lice. He stated the CDC recommended a resident with head lice be placed on contact precautions, not enhanced barrier precautions, until the treatment was applied and 24 hours following the treatment. Staff 2 acknowledged the facility did not follow the CDC recommendations for contact precautions.</p>