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	07/28/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to accurately assess 1 of 1 sampled resident (#1) reviewed for skin conditions. This placed residents at risk for unmet needs and delayed treatment. Findings include: Resident 1 admitted to the facility on [DATE] with diagnoses including unstageable pressure ulcer to the buttocks and pain. The 6/24/25 admission MDS indicated Resident 1 was at risk for developing pressure ulcers and had one or more unhealed pressure ulcer injuries. The MDS did not include documentation indicating the number of unstageable pressure ulcers due to non-removable dressings or devices. The section addressing unstageable pressure ulcers present on admission or re-entry was left incomplete. The skin and ulcer treatment section indicated the resident used a pressure reducing device for the bed and received surgical wound care. No documentation reflected the resident was receiving care for a pressure ulcer.On 7/24/25 at 4:08 PM, Staff 2 (DNS) acknowledged Resident 1's MDS was inaccurate.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to notify the physician and act upon a change in condition timely resulting in increased avoidable pain and psychosocial harm for 1 of 1 sampled resident (#1) reviewed for skin conditions and behavioral health. Findings include: a. Resident 1 was admitted to the facility on [DATE] with diagnoses including adjustment disorder with depressed mood, anxiety, intentional poisoning by methamphetamine, self-harm, history of suicide attempts, accidental and intentional substance abuse overdose. Resident 1 was under the care of a neuropsychologist and received outpatient services prior to admission. A 6/3/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed frustration regarding communication about wound care and pain management. The resident reported feeling unheard and unsupported when advocating for her/his needs. The 6/5/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed ongoing distress and frustration with miscommunication, particularly around care preferences the resident described feeling overwhelmed, out of control, and reported declining care as a result. The anxiety care plan initiated on 6/17/25, indicated Resident 1 received anxiety medication. The goal was to reduce signs and symptoms of anxiety. Interventions included staff to administer anti-anxiety medications as ordered and monitor the resident for adverse side effects.On 6/18/25 Resident 1 was admitted to hospice. Staff were to call or fax for the flowing concerns: Immediately, if the patient experiences any change in condition or has unrelieved pain or distress. Facility staff interventions: Address psychosocial/spiritual needs monitor and address patient fears and encourage social interaction.The mood/behavior/psychosocial care plan initiated on 6/18/25, indicated Resident 1 had mood and behavioral issues related to recent amputations, hospice admission, acute and chronic pain, adjustment disorder with depressed mood, and generalized anxiety disorder. The resident's goal was to prevent any decline in mood over the next 30 days. Interventions included administrative medications per physician orders, document the resident's behavior as needed, and notify the social service director of any decline in mood or behavior.No documentation was found in the clinical record to indicate the facility monitored the resident's mood to determine if her/his goal were met.The communication care plan, initiated on 6/20/25, indicated Resident 1 had ineffective coping related to history of substance abuse. The resident's goal was to ensure her/his safety. Interventions included staff to refer the resident for mental health consultation as needed.The trauma care plan, initiated on 6/21/25, indicated resident one had complex traumas. Interventions included assigning consistent care givers to build trust. Staff to notify the nurse when the resident was triggered. Staff to maintain a comfortable distance, respecting personal space, and stop care if the resident was uncomfortable. The 6/19/25 Hospice Order indicated a Master of Social Work (MSW) provided and assisted with emotional behavioral management related to depression, symptom management, signs of worsening depression, guilt, shame, and self-loathing of family systems regarding addiction. Resident and staff were to report improved ability to manage depressive symptoms. A hospice MSW will monitor for signs of worsening depression. No documentation was found in the clinical record to indicate Resident 1 was provided or assisted with emotional behavioral management or monitored for signs of worsening depression. Resident 1's 6/24/25 admission MDS indicated the resident was cognitively intact, had minimal or no depression and exhibited no behaviors. The psychotropic drug use CAA indicated: The resident and family participate in her/his care conference with the facility and hospice. No concerns identified at this time.The 6/24/25 admission MDS CAAs did not trigger concerns for the areas related to communication, psychosocial well-being, mood, behavioral symptoms or nutritional status.On 7/23/25 at 11:20 AM, Staff 2 (DNS) and Staff 14 (Social Services Director) confirmed Resident 1 received behavioral health services prior to admission, and Staff 14 confirmed services continued after admission. However, the facility did not coordinate with the resident before the behavioral health worker met with her/him. Staff 2 acknowledged this approach was not resident centered stated that. Staff 2 also confirmed the resident's behavioral care plan was not individualized or resident centered. Staff 14 stated she attempted to meet with the resident on the day of admission to complete the trauma assessment, but the resident refused. Staff 14 did not reattempt the assessment, seek information from the family, or develop a resident centered care plan for trauma. Staff 14 also reviewed the MDS and confirmed that sections related to mood, psychosocial well-being, communication, and behavior were blank On 7/24/25 at 9:12 AM, Staff 7 (LPN) stated she was aware of Resident 1's complex mental health needs. Staff 7 stated the resident was on

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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. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review it was determined the facility failed to ensure a resident with a history of trauma received trauma-informed care for 1 of 1 sampled resident (#1) reviewed for mood and behavior this placed residents at risk for unmet needs and a decrease in their quality of life. Findings include:On 6/17/25 Resident 1 admitted to the facility with diagnoses including adjustment disorder with depressed mood, anxiety, intentional poisoning by methamphetamine, self-harm, history of suicide attempts, accidental and intentional substance abuse overdose.Prior to admission Resident 1 received care from a neuropsychologist. A 5/29/25 Rehabilitation Neuropsychology Consult Note documented during the interview, the resident expressed mixed emotions, reported hopelessness about achieving sobriety, reconnecting with family, and managing psychosocial stressors. The resident reported feeling overwhelmed, lacked non-substance related coping strategies, and disclosed a long history of depression and suicidal ideation. A 6/3/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed frustration regarding communication about wound care and pain management. The resident reported feeling unheard and unsupported when advocating for her/his needs.The 6/5/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed ongoing distress and frustration with miscommunication, particularly around care preferences the resident described feeling overwhelmed, out of control, and reported declining care as a result.On 6/17/25 Resident 1 admitted to the facility with diagnoses including adjustment disorder with depressed mood, anxiety, intentional poisoning by methamphetamine, self-harm, history of suicide attempts, and both accidental and intentional substance use overdose.The 6/17/25 Trauma Informed Care Evaluation indicated the resident did not want to complete the assessment and/or stated she/he did not experience trauma.A 6/17/25 Physician order instructed staff to administer 0.5 mg Lorazepam (anti-anxiety) one time a day for anxiety. The 6/18/25 mood/behavior/psychosocial care plan indicated the resident had multiple amputations, recently admitted to hospice, had acute pain, adjustment disorder with depressive mood, and generalized anxiety. The resident's goal was to have no decline in mood or increase in behaviors over the next 30 days. Behavior monitor as needed. Behaviors included: 1. Verbal agitation 2. Refusing care 3. Cursing at staff member 4. Isolating or withdrawn 5. Provide positive reassurance 6. Be an active listening 7. Rule out pain. Staff were to notify social service director of any decline in mood or behavior. Triggers: 1. Change in routine 2. Pain 3. Uncertain of future 4. Lack of sleepOn 6/18/25 Resident 1 was admitted to hospice services. The 6/19/25 Hospice Order indicated a Master of Social Work (MSW) was to provide and assist with emotional behavioral management related to depression, symptom management, signs of worsening depression, guilt, shame, and self-loathing of family systems regarding addiction. Resident and staff to report improved ability to manage depressive symptoms. MSW will monitor for signs of worsening depression. No documentation was found in the clinical record to indicate emotional behavioral management was provided, evaluated, or monitored. The clinical record lacked evidence of follow-up assessments, resident responses to interventions, or interdisciplinary team review to determine whether the resident's depressive symptoms were improving.The 6/21/25 Hospice care plan instructed staff to work closely with the hospice team to ensure social needs are met.No documentation was found Resident 1's clinical record to indicate she/he received emotional behavioral support.The 6/21/25 Trauma care plan indicated staff were to assess the effectiveness and appropriateness of the resident's identified triggers and coping strategies on a quarterly or PRN basis. Staff were to update the care plan to reflect any changes. Resident will identify potential triggers and coping strategies. Interventions included identify triggers. Defense mechanisms include screaming, refusing cares, kicking family and staff out of room, and crying. No documentation was found in Resident 1's clinical record to indicate staff assessed or monitored these interventions. There was also no evidence of care plan updates, progress notes, or interdisciplinary review indicating the resident's trauma response or coping strategies had been evaluated or addressed.On 7/21/25 at 2:56 PM, and 7/24/25 at 12:02 PM, Resident 1 stated during a recent hospitalization, she/he requested to be seen by psychiatrist for ongoing mental health needs. After admission to the facility, she/he reported expressing this request multiple times to the hospice social worker. Resident 1 stated she/she was told by the social worker that he was the appropriate person to address her/his needs. Resident 1 stated she/he felt he lacked the clinical qualifications to properly assess or address her/his complex me mental health concerns.On 7/23/25 at 10:23 AM, Staff 15 (Behavioral Health Consultant) confirmed Resident 1 expressed interest in behavioral health services and was identified as an appropriate candidate for behavioral health services. Staff 15 noted the

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review it was determined the facility failed to ensure residents with behavioral health needs, including substance use disorder received appropriate services for 2 of 2 sampled residents (#s 1 and 8) reviewed for behavioral health. This placed residents at risk for unmet behavioral health needs and increased risk of substance misuse or overdose. Findings include:The facility's 11/2022 Substance Use Disorder policy and procedure revealed the following:The behavioral health care needs of residents with a substance use disorder (SUD) or other serious mental health conditions are evaluated as part of the facility assessment. All residents are screened prior to admission for serious mental health disorders, intellectual disabilities, and related conditions to determine if specialized services are required under the Preadmission Screening and Resident Review (PASRR) process. If a resident does not qualify for pass are related specialized services but requires more intensive behavioral health care, the facility will provide or arrange for those services. The specific services needed are identified during the comprehensive assessment, and the resident's care plan will address individualized needs related to mental health or substance use disorder.A resident's history of substance use disorder and potential risk of substance use or overdose while in the facility will be identified to the extent possible and documented in the medical record. 1.On 6/17/25 Resident 1 admitted to the facility with diagnoses including adjustment disorder with depressed mood, anxiety, intentional poisoning by methamphetamine, self-harm, history of suicide attempts, and both accidental and intentional substance use overdose.Prior to admission Resident 1 had been receiving care from a neuropsychologist. A 5/29/25 Rehabilitation Neuropsychology Consult Note documented during the interview, the resident expressed mixed emotions, reported hopelessness about achieving sobriety, reconnecting with family, and managing psychosocial stressors. The resident reported feeling overwhelmed, lacked non-substance related coping strategies, and disclosed a long history of depression and suicidal ideation. A 6/3/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed frustration regarding communication about wound care and pain management. The resident reported feeling unheard and unsupported when advocating for their needs.The 6/5/25 Rehabilitation Neuropsychology Consult Note documented the resident expressed ongoing distress and frustration with miscommunication, particularly around care preferences the resident described feeling overwhelmed, out of control, and reported declining care as a result.The 6/24/25 care plan indicated the resident had ineffective coping skills related to a history of substance use and overdose. The goal was to ensure resident safety. Staff to refer resident to mental health consultation as needed.A 6/25/25 Hospice admission Note indicated prior to admission, Resident 1 was receiving methadone treatment for substance use disorder.On 7/23/25 at 10:23 AM, Staff 15 (Behavioral Health Consultant) confirmed Resident 1 expressed interest in support for substance use and was identified as an appropriate candidate for behavioral health services. Staff 15 noted the resident appeared fatigued, withdrawn, avoidant, and disinterested; behaviors they recognized as signs of trauma. Staff 15 acknowledged they were unable to establish rapport or develop recommendations.On 7/23/25 at 11:20 AM, Staff 14 (Social Services Director) confirmed awareness of the resident's history of substance use. Upon review of the MDS and care plan, Staff 14 acknowledged the documents were not individualized and failed to include any information about the resident's substance use history or prior suicide attempts. Staff 14 also stated they were unaware the resident required substance use treatment.On 7/24/25 at 11:00 AM, Staff 6 (CMA) reported the resident shared her/his past trauma, including long-term substance use, and had expressed feelings of hopelessness. On 7/24/25 at 2:14 PM, Staff 13 (CNA) staff stated approximately one week after admission, the resident disclosed a history of trauma and substance use. Staff 13 stated this information was relayed to the charge nurse, who said they would notify social services. On 7/25/25 at 1:05 PM, Staff 19 (RN/Regional Director of Quality Assurance) and Staff 20 (RCM) confirmed there was no documentation to show the resident's trauma history, substance use, or behavioral health concerns were comprehensively assessed, addressed, or care planned. On 7/25/25 at 2:39 PM, Staff 2 (DNS) acknowledged staff reported concerns related to Resident 1's trauma history, substance abuse, hopelessness, and difficulty coping. Staff 2 also reported the resident requested psychiatric support and he confirmed the facility did not document the resident's request or follow up with behavioral services. Staff 2 further acknowledged the resident had not been comprehensively assessed, the care plan was not individualized, trauma informed, or reflective of the resident's history of suicide attempts.2. On 1/27/25 Resident 8 admitted to the facility with diagnoses including adjustment

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate of less than 5 percent. There were two errors out of 25 medication administration opportunities resulting in an eight percent error rate. This placed residents at risk for an ineffective medication regimen. Findings include:1.Resident 44 was admitted to the facility in 8/2024, with diagnoses including diabetes and obesity.An 8/22/24 physician order indicated Resident 44 received Jardiance (antidiabetic medication) once daily.On 7/23/25 at 9:20 AM, Staff 6 (CMA) stated she was not able to administer Resident 44 her/his scheduled Jardiance because it was not available. Staff 6 stated it had been ordered from the pharmacy but had not arrived. 2. Resident 51 was admitted to the facility in 7/2025 with diagnoses including muscle weakness. A 7/14/25 physician order indicated Resident 51 received Ingrezza (for movement disorder) once daily. On 7/23/25 at 9:32 AM, Staff 6 (CMA) stated she was not able to give Resident 51 her/his scheduled Ingrezza because it was not available. Staff 6 stated it had been ordered from the pharmacy but had not arrived. On 7/25/25 at 1:22 PM Staff 2 (DNS) stated his expectation was for staff to reorder medications before the medications ran out. Staff 2 stated when medications were omitted it was considered a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to ensure infection control standards were implemented for facility laundry services. This placed residents at risk for exposure to and contraction of infectious diseases. Findings include: A 1/2014 facility Departmental (Environmental Services) Laundry and Linen policy indicated staff were to keep soiled and clean linen separated and follow standard precautions, which included the use of clean gowns and hand washing after glove use.A 2023 Rapid Multi Surface Disinfectant Cleaner data sheet revealed viruses and bacteria were killed with proper application as follows:-Influenza viruses after 30 seconds.-Methicillin-resistant Staphylococcus aureus (MRSA) bacteria after three to five minutes.-Soft surfaces were disinfected after 10 minutes.On 7/25/25 at 11:04 AM, a tour of the laundry facility was conducted with Staff 11 (Laundry). Empty laundry bins were observed (soiled area) outside the washer and dryer room (clean area). Staff 11 stated she allowed the Rapid Multi Surface Disinfectant Cleaner to set for 30 seconds for every use in the laundry area. A fabric gown hung on the far wall of the clean area next to the washing machines and a sink was observed in a room accessed by walking through the clean area. Staff 11 stated, after she sorted soiled linen, she hung her gown on the far wall in the clean area and walked through the clean area to wash her hands at the sink. Staff 11 stated she sorted soiled linen a few times a day and the gown was cleaned once daily, Staff 11 stated she was not provided procedures for the use of personal protective equipment in the laundry room and had no information on the dwell time for the Rapid Multi Surface Disinfectant Cleaner. On 7/25/25 at 11:20 AM, Staff 10 (Housekeeping Manager) acknowledged no training was given to staff on how to handle biohazard waste or soiled linens in the laundry area. Staff 10 indicated staff used the disinfectant cleaner to sanitize the fabric gown used by laundry staff and acknowledged increased training for the Rapid Multi Surface Disinfectant Cleaner was needed. On 7/25/25 at 11:35 AM and 1:56 PM, Staff 2 (DNS) acknowledged the flow of the laundry room between clean and soiled areas needed to be addressed. Staff 2 expected the dwell time information of the disinfectant cleaner to be in a binder for staff.