STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385239	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Coos Bay	2625 Koos Bay Blvd Coos Bay, OR 97420

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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 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. 34324 Based on observation, interview, and record review it was determined the facility failed to ensure resident rooms were cleaned for 1 of 3 sampled residents (#9) reviewed for environment. This placed residents at risk for lack of a homelike environment. Findings include: Resident 9 admitted to the facility in 2024 with diagnoses including respiratory failure and heart failure. Review of Resident Council notes for 2/2024 indicated residents reported a lot of dirt on the floors and the floors needed to be swept more. Observations made from 4/29/24 through 5/1/24 revealed a visible layer of white and gray dust and hairs underneath Resident 9's bed. Review of the Daily Cleaning Check-Off form indicated Resident 9's room was cleaned on 4/27/24. On 5/1/24 at 12:24 PM Staff 19 (Housekeeping Manager) stated housekeeping staff cleaned one of three resident halls per day. Staff 9 stated the daily cleaning of resident rooms consisted of cleaning the bathroom, taking out the trash, wiping down high touch areas, sweeping and mopping. Staff 19 stated it was brought to her attention that Resident 9's floor was dirty with dust. Staff 19 acknowledged there was a layer of dust under Resident 9's bed and stated it was, unacceptable.

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: 385239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42271 Based on interview and record review it was determined the facility failed to protect residents' right to be free from verbal abuse from Staff 24 (RN) for 1 of 1 sampled resident (#20) reviewed for abuse. This placed residents at risk for abuse. Findings include: The facility's Abuse policy, revised 4/2021, stated the facility and staff would protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including facility staff. Resident 20 was admitted to the facility in 2023 with diagnoses including major depressive disorder and anxiety disorder. Resident 20's 2/7/24 Comprehensive MDS indicated the resident was cognitively intact. Resident 20's 2/26/24 Care Plan indicated the resident was independent with bathing and required set up help only. Resident 20 showered one time per week per the resident's request. Resident 20's 4/2024 shower logs revealed the resident frequently refused showers. A 3/31/24 Progress Note indicated Staff 24 (RN) approached Resident 20 in the morning about taking a shower. Resident 20 refused and stated she/he would take a shower after church. After church Staff 24 reapproached Resident 20 about showering and Resident 20 refused again. On 3/31/24 a Resident/Family Grievance Communication Form completed by Staff 28 (CNA), Staff 29 (CNA), Resident 35 and Resident 20 indicated Staff 24 confronted Resident 20 two times. Per the written statements on the form, Staff 24 stated Resident 20 needed to take a shower before going to church because she/he stunk. On 4/29/24 at 12:40 PM Resident 20 stated on 3/31/24, Staff 24 (RN) confronted her/him, in front of Staff 28 (CNA), Staff 29 (CNA) and Resident 35. Staff 24 stated Resident 20 could not go to church unless the resident took a shower first. Resident 20 stated Staff 24 said, You want people at church to smell you? Resident 20 stated she/he was upset and the comments made her/him feel terrible. On 5/1/24 at 12:23 PM Staff 30 (CNA) stated she arrived to work early on 4/29/24 and Staff 24 instructed her to, make Resident 20 take a shower. Staff 30 stated she would try to get Resident 20 to take a shower. Staff 30 stated after church, she and Staff 24 went into Resident 20's room. Staff 30 stated Resident 20 yelled she/he did not want Staff 24 in the room but Staff 24 would not leave. Staff 30 stated, Staff 24 eventually left the room and Staff 30 observed Resident 20 crying and visibly upset. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 4/2/24 investigation indicated on 3/31/24 Staff 2 (DNS) was notified Staff 24 was insisting Resident 20 take a shower that morning. Resident 20 refused to take a shower and stated she/he would shower after church. Staff 24 asked the resident, do you want the church to smell you? When Resident 20 returned from church, Staff 24 confronted the resident again about taking a shower. Resident 20 stated Staff 24 came to her/his room and yelled at the resident about showering. Resident 20 stated she/he felt it was very rude of Staff 24 and hurt Resident 20's feelings. Resident 20 asked Staff 24 to leave the room and she was escorted out by Staff 30. Staff 28, Staff 29, Staff 30, Staff 31 (LPN) and Resident 35 all indicated Staff 24 yelled at Resident 20 and told her/him you stink. Staff 24 was terminated on 4/2/24. On 5/2/24 at 11:40 AM Staff 2 (DNS) stated she spoke with Staff 24 on 3/31/24 about the incident. Staff 2 acknowledged Staff 24 verbally abused Resident 20. Staff 2 stated Staff 24 was terminated after the incident was investigated.

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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. 42271 Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation by Staff 34 (CNA) for 1 of 1 sampled resident (#302) reviewed for misappropriation of personal funds. This placed residents at risk for financial abuse. Findings include: The facility's revised 4/2021 Abuse, Neglect, Exploitation and Misappropriation Prevention Program stated residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Resident 302 admitted to the facility in 3/2022 with diagnoses including multiple sclerosis. The 4/2023 Comprehensive MDS identified Resident 302 to be alert and oriented. On 5/23/23 a Facility Reported Incident was reported indicating Resident 302 bought Staff 34 (CNA) a scrub top (nurse apparel shirt) purchased on-line for $34.00. Resident 302 stated she/he expected Staff 34 to pay her/him back. Staff 34 paid Resident 302 $20.00. On 5/2/24 at 9:13 AM and at 2:10 PM Staff 34 was unable to be reached via phone. On 5/2/24 at 9:53 AM Staff 5 (Social Services Director) observed Staff 34 always wore cartoon scrub tops. Staff 5 interviewed Resident 302 and the resident made a comment she/he liked Staff 34's scrub top. Staff 34 said there was a scrub top he wanted to have online but he did not have an account. Resident 302 stated she/he would order it and he agreed he could pay her/him back. Staff 5 stated Staff 34 wore the new scrub top to work and Resident 302 felt disrespected. Staff 34 did not pay Resident 302 the full amount due for the scrub top. Staff 5 stated the facility paid the resident back for the scrub top and Staff 34 was terminated. On 5/2/24 at 12:16 PM Staff 2 (DNS) and Staff 4 (Corporate RN) stated Resident 302 was reimbursed for the scrub top. On 5/2/24 at 1:41 PM Resident 302 stated Staff 34 showed her/him a picture of a scrub top online and the resident stated she/he would order it for him. Resident 302 stated on 5/4/23 Staff 34 showed her/him a scrub top online. Resident 302 ordered the scrub top and it was delivered the following day on 5/5/23. Resident 302 stated she/he gave the scrub top to Staff 34 and he wore it. Resident 302 stated she/he begged him to pay the money owed and after some time he paid $20. Resident 302 stated Staff 34 did not pay the remaining balance due for the scrub top and continued to wear the scrub top. Resident 302 stated she/he filed a grievance due to Staff 34 not paying her/him back. Resident 302 stated Staff 2 and Staff 5 stated the facility would pay her/him back, but they never did. On 5/2/24 at 2:02 PM Staff 35 (Business Office Manager) stated she did not have a receipt for Resident 302's reimbursement for the scrub top. On 5/2/24 at 2:07 PM Staff 4 acknowledged the misappropriation of the resident's funds and stated there were no receipts for reimbursement to Resident 302. Staff 4 stated staff were not to accept gifts or money from residents.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34324 Based on observation, interview and record review it was determined the facility failed to ensure residents with contractures received ROM services and equipment to prevent further decrease in ROM and skin breakdown for 1 of 1 sampled resident (#4) reviewed for mobility. This placed residents at risk worsening contractures. Findings include: Resident 4 admitted to the facility on [DATE] with diagnoses including quadriplegia and rheumatoid arthritis. The 2/4/24 admission ADL CAA indicated Resident 4 had impaired ROM and the Care Plan would refer to restorative and/or skilled therapy as appropriate. Resident 4's clinical record included a copy of a 11/29/21 Care Plan from Resident 4's previous facility. The Care Plan indicated Resident 4 had contractures to her/his bilateral hands and legs related to rheumatoid arthritis. Interventions included the use of palm protectors to be worn during the day. The 1/31/24 Care Plan revealed no indication of Resident 4's contractures or use of a palm device. Review of a 3/15/24 OT Evaluation indicated Resident 4 transferred from another facility without therapy orders and a referral was made for contracture management. The evaluation indicated no device was found in Resident 4's room and the resident would benefit from positioning the left hand, skin protection of the right hand and the need for a Restorative Aide (RA) program. The evaluation further included the need for a splint and indicated the resident would benefit from ROM to reduce pain, improve skin integrity issues and reduce the risk for further contractures. On 4/29/24 at 1:28 PM Resident 4 was observed in bed and both of her/his hands were observed to be contracted. Resident 4's nails were trimmed but no palm device was observed in place. On 4/30/24 at 3:36 PM Resident 4 stated she/he had palm protectors that were worn at the previous facility. Resident 4 stated she/he did not participate in an RA program since she/he admitted to the facility. Resident 4 stated she/he was interested in wearing palm protectors again and participating in RA. Resident 4's right hand palm protector was observed to be in her/his top nightstand drawer. On 5/2/24 at 10:58 AM Staff 17 (OT) stated she completed the 3/15/24 therapy evaluation for Resident 4. Staff 17 stated RA referrals were completed by filling out the RA form and then discussing it with Staff 15 (Restorative Aide). Staff 17 stated devices such as splints were discussed with the RNCM to determine the device and a schedule for use. Staff 17 stated she saw Resident 4 three times. Staff 17 stated Resident 4 used palm protectors and wore them well. Staff 17 stated Resident 4 went to the hospital on 3/21/24 but was not picked back up after she/he returned to the facility on [DATE]. Staff 17 acknowledged no RA referral was completed for Resident 4 and there was no follow-up regarding the recommended use of a palm device. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 11:18 AM Staff 15 stated Resident 4 was not on the RA list, and he never received a referral for Resident 4 to participate in the RA program. On 5/2/24 at 12:17 PM Staff 3 (RNCM) stated Resident 4 transferred from another facility. Staff 3 stated Resident 4 was compliant with care, but had very fragile skin, and was prone to skin tears and bruising that required extra monitoring. Staff 3 stated Resident 4 also had contractures to both hands. Staff 3 stated Resident 4 had an OT evaluation completed but was, unsure what came of it. Staff 4 acknowledged no follow up was completed regarding the 3/15/24 OT recommendations and acknowledged she was not aware Resident 4 was not being seen by RA.

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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. 34702 Based on interview and record review it was determined the facility failed to assess falls and provide treatment to prevent falls for 1 of 1 sampled resident (#25) reviewed for accidents. This placed residents at risk for falls and injuries. Findings include: Resident 25 admitted to the facility in 2022 with diagnoses including weakness and heart failure. The 1/26/24 Annual MDS indicated Resident 25 was cognitively intact. On 4/29/24 at 1:31 PM Resident 25 stated she/he fell out of the sit-to-stand (a device used to transfer residents between seated to standing positions) several months ago. On 4/30/24 Resident 25's clinical record was reviewed. No fall assessments or incident reports were found. On 4/30/24 a fall assessment was requested from Staff 2 (DNS). On 4/30/24 at 10:31 AM Staff 2 (DNS) stated Resident 25 did not have a fall from the sit-to-stand device, but was assisted to the floor by staff and stated, So it wasn't a fall. Staff 2 stated no assessment was completed. On 5/1/24 at 2:12 PM Staff 2 provided a written statement dated 5/1/24 from Staff 20 (CNA) that indicated, At around 8 PM myself and another CNA [were] laying a resident down with a sit-stand, when [her/his] legs seemed to give out. One of us was in front of [her/him], when [her/his] legs seemed to give out. I was behind [her/him] so was able to guide [her/him] by sliding [her/him] down my right leg. Then we used a [mechanical] lift to put [her/him] on the bed, resident had no claims of pain. The date of the incident was not noted on the witness statement. On 5/1/24 at 3:55 PM Staff 2 provided a statement that Staff 20 noted the incident with Resident 25 happened on the approximate date of 2/19/24 but could not recall the exact date. On 5/1/24 at 2:25 PM Resident 25 stated she/he fell on her/his hip and back but did not remember the date. Resident 25 stated Staff 20 and another staff assisted her/him with the sit-to-stand. Resident 25 stated she/he fell to the floor on her/his left hip, hit the floor, and laid on the floor on her/his side. Resident 25 stated staff had to use a mechanical lift to get her/him off the floor and back into bed. Resident 25 stated Witness 3 (Family Member) was present at the time of the fall. On 5/1/24 at 2:33 PM Witness 3 stated Resident 25 had a fall about a month prior. The resident was on the edge of the bed, slid down the CNA's leg, landed on the floor, and was scared. Witness 3 stated it happened so fast and it also scared him when it happened. Witness 3 stated he did not like the sit-to-stand device that was used because the way staff had to maneuver the resident with the gait belt was difficult, especially if the staff using it were not strong. Witness 3 stated the other CNA who assisted looked like she was confused when using the sit-to-stand device. Witness 3 stated staff used a mechanical lift to assist the resident off the floor and back to bed after the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 2:45 PM training logs were requested from Staff 14 (Director of Rehab) for Resident 25's sit-to-stand device. On 5/1/24 at 3:59 PM and 5/2/24 at 10:06 AM messages were left for Staff 20. A return call was not received. On 5/1/24 at 4:07 PM Staff 14 stated Staff 15 (Restorative Aide) was the only staff who was supposed to use the sit-to-stand device with Resident 25. Staff 14 acknowledged other staff were not trained to use the sit-to-stand device for Resident 25. On 5/2/24 at 2:03 AM Staff 21 (LPN) stated she worked on 3/1/24 when Resident 25 had a fall, but did not witness it. Staff 21 stated Staff 20 and Staff 8 (CNA) reported they assisted the resident with the sit-to-stand when the resident fell to the ground. Staff 21 stated she started an incident report and then reported the incident to Staff 2. Staff 21 stated the expectation was to get witness statements for incident reports and she thought she had the staff's written statements but was unable to locate them in the clinical record. Staff 21 stated the incident report was struck out and did not have information regarding the incident. On 5/2/24 at 12:27 PM Staff 3 (RNCM) stated she was not aware of a fall or incident for Resident 25. Staff 3 reviewed the medical record and stated an incident report was started on 3/1/24 and was blank. Staff 3 stated Staff 2 struck out the incident report on 3/6/24 due to incorrect documentation. On 5/2/24 at 12:38 PM Staff 8 stated she was present for Resident 25's fall on 3/1/24. Staff 8 stated she wrote a statement and provided it to the facility. Staff 8 stated Staff 20 showed her how to use the sit-to-stand transfer device on 3/1/24. Staff 8 stated Resident 25 claimed she/he could use the device, but her/his knees were too weak to use it. Staff 8 stated the resident was sitting in her/his wheelchair and was assisted to get up, but her/his legs got wobbly. Staff 8 stated the resident had a gait belt on and, We brought [her/him] down to the ground onto the floor. Staff 8 stated the resident was anxious after the incident and only wanted bigger staff to use the device with her/him. On 5/2/24 at 1:19 PM and on 5/3/24 at 9:10 AM Staff 2 stated staff did not report Resident 25's fall but she found out about it through an unrelated grievance. The findings were reviewed with Staff 2 regarding the incident report that Staff 21 opened on 3/1/24 at 10:00 PM. Staff 2 stated she struck out the incident report on 3/6/24 because there was no information in the report. Staff 2 acknowledged Resident 25 had a fall on 3/1/24, it was not investigated and interviews were not completed with Staff 21, Staff 20 and Staff 8 who worked with Resident 25 on 3/1/24. Staff 2 further acknowledged Staff 20 and Staff 8 did not receive the appropriate training for using the sit-to-stand device for Resident 25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48830 Based on observation, interview, and record review it was determined the facility failed ensure oxygen was administered as ordered and maintain oxygen concentrators for 2 of 3 sampled residents (#s 36 and 251) reviewed for oxygen therapy. This placed residents at risk for increased risk for respiratory failure. Findings include: 1. Resident 36 was admitted to the facility in 8/2023 with diagnoses including chronic respiratory failure with hypercapnia (buildup of carbon dioxide in the bloodstream). The 1/15/24 Significant Change MDS indicated Resident 36 was moderately cognitively impaired. Multiple observations from 4/29/24 through 5/1/24 revealed Resident 36 used an oxygen concentrator. The external filter on the oxygen concentrator was observed to have a layer of dust when touched with a finger. Resident 36's physicians order dated 4/2/24 indicated: - clean external filter on the oxygen concentrator every Tuesday on night shift. The 4/2024 TAR indicated on 4/23/24 the external filter on the oxygen concentrator was cleaned by Staff 21 (LPN) who worked the night shift. On 4/29/24 at 12:34 PM Resident 36 stated she/he wore oxygen continuously. On 5/1/24 at 12:17 PM Resident 36's oxygen concentrator's external filter was observed to have no change in appearance. On 5/1/24 at 2:23 PM and 2:41 PM Staff 12 (LPN) and Staff 13 (LPN) both stated the night shift nurses were responsible for cleaning Resident 36's oxygen concentrator filter. On 5/1/24 at 2:56 PM a phone call and voicemail were placed to Staff 21 with no return phone call. On 5/1/24 at 3:32 PM Staff 2 (DNS) observed the oxygen concentrator's external filter and acknowledged the filter was not clean. 2. Resident 251 was admitted to the facility in 2/2024 with diagnoses including acute respiratory failure with hypoxia (not enough oxygen in the tissues in your body) and dementia. The 3/1/24 Significant Change MDS indicated Resident 251 was moderately cognitively impaired. Observations from 4/29/24 through 5/1/24 revealed Resident 251 used an oxygen concentrator with a nasal cannula (lightweight tubing with two prongs placed in nostrils) with a flow rate of three liters of oxygen. The external filter on the oxygen concentrator was observed to have a layer of dust when touched with a finger. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 251's physicians order dated 4/2/24 indicated: - oxygen at one to two liters per minute via a nasal cannula as needed for shortness of breath. The 4/2024 TAR did not indicate when the external filter on the oxygen concentrator was to be cleaned. On 4/29/24 at 12:44 PM Resident 251 stated she/he used oxygen but could not state when she/he used it or how many liters were prescribed. On 5/1/24 at 2:23 PM Staff 12 (LPN) stated the resident used oxygen as needed and the physician order stated one to two liters per minute for the flow rate. Staff 12 further stated night shift nurses were responsible for cleaning Resident 251's oxygen concentrator. On 5/1/24 at 3: 21 PM Staff 2 (DNS) stated Resident 251 had a physicians order for oxygen therapy as needed at a flow rate of one to two liters per minute. On 5/1/24 at 3:32 PM Staff 2 observed and acknowledged the physician order was not followed regarding the oxygen flow rate and the external filter of the oxygen concentrator was not clean.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34702 Based on interview and record review it was determined the facility failed to follow pharmacist recommendations in a timely manner for 1 of 5 sampled residents (#30) reviewed for unnecessary medications. This placed residents at risk for unnecessary medication administration. Findings include: Resident 30 admitted to the facility in 2023 with diagnoses including major depressive disorder and psychosis. The 1/16/24 pharmacist recommendation indicated Resident 30 did not display psychotic behavior but had issues with depression, and to consider an order to increase nortriptyline (antidepressant) to 50 mg daily at bedtime for depression and to decrease aripiprazole (antipsychotic) to 2 mg daily for psychosis. The pharmacist recommendation was not signed by the physician until 2/4/24 (19 days after the recommendation was made). The physician recommendation included to discontinue nortriptyline and start Lexapro (antidepressant) 5 mg daily. On 5/1/24 at 2:12 PM Staff 2 (DNS) stated the expectation was for pharmacist recommendations to be reviewed and signed by the physician within 7 days. Staff 2 acknowledged Resident 53's pharmacist recommendations were not completed until 19 days after the recommendation was made, which was not timely.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on observation, interview, and record review it was determined the facility failed to ensure proper labeling of biologicals, and failed to ensure proper storage temperatures were logged and maintained for 2 of 2 treatment carts and 1 of 1 medication room reviewed for medication storage. This placed residents at risk for reduced efficacy of medication and adverse medication side effects. Findings include: 1. On [DATE] at 3:20 PM two vials of tuberculin (used for the testing in the diagnosis of Tuberculosis) were observed to be opened; one was dated October of an illegible year and another was dated [DATE]. The manufacturer's instructions indicated to discard the medication 30 days after opening. On [DATE] at 3:20 PM Staff 12 (LPN) acknowledged the two vials of tuberculin were opened and expired. 2. On [DATE] at 3:20 PM the medication refrigerator temperature logs were observed to be blank on [DATE], [DATE], and [DATE] through [DATE]. On [DATE] at 3:20 PM Staff 12 (LPN) acknowledged the temperature logs were blank on [DATE], [DATE] and [DATE] through [DATE]. 3. On [DATE] at 3:28 PM the treatment cart for the 100 hall was observed to have one Admelog insulin vial with an open date of [DATE]. Per manufacturer instructions Admelog insulin was good for 28 days after opening (expired on [DATE]). On [DATE] at 3:28 PM Staff 8 (LPN) acknowledged the Admelog insulin vial was expired. 4. On [DATE] at 3:28 PM the treatment cart for the 100 hall was observed to have one Novolog insulin vial with an open date of ,d+[DATE] (no year was documented). Per manufacturer instructions Novolog insulin was good for 28 days after opening (expired on [DATE]). On [DATE] at 3:28 PM Staff 8 (LPN) acknowledged the Novolog insulin vial was expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Coos Bay	2625 Koos Bay Blvd Coos Bay, OR 97420

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47005 Based on observation, interview, and record review it was determined the facility failed to handle and prepare food in a sanitary manner for 1 of 1 kitchen reviewed for sanitary practices. This placed residents at risk for food borne illness. Findings include: On 5/2/24 at 11:48 AM Staff 26 (Cook/Dietary Aide) was observed to cut a hamburger patty with gloved hands on the cutting board attached to the steam table. Staff 26 placed the hamburger patty on a plate. Staff 26 then grabbed a rag from the red bleach bucket and wiped the cutting board and knife. The cutting board was observed to still be wet when Staff 26 used the same gloved hands to grab a skinned baked potato and cut it on the wet cutting board with the same knife. On 5/2/24 at 11:50 AM when asked about the drying time after wiping a surface, Staff 26 stated she, had no idea. When asked when it was appropriate to change gloves, Staff 26 stated she changed gloves often and had a box of gloves next to her work surface. When asked why she did not change her gloves after using the rag from the bleach bucket and before touching food, Staff 26 stated, I should have changed my gloves, but I forgot. On 5/3/24 at 9:19 AM Staff 27 (Dietary Manager) stated she expected staff to change their gloves and perform hand hygiene whenever they touched a potentially contaminated surface area to minimize risk of food borne illness, and expected staff to use portable cutting boards and to change out the cutting boards when needed.

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NAME OF PROVIDER OR SUPPLIER: Avamere Rehabilitation of Coos Bay		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Koos Bay Blvd Coos Bay, OR 97420	

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 48830 Based on interview and record review it was determined the facility failed to have a dialysis agreement in place for 1 of 1 sampled resident (#45) reviewed for dialysis. This placed residents at risk for not receiving dialysis services. Findings include: Resident 45 admitted to the facility in 4/2024 with diagnoses including dependence on renal dialysis. On 4/30/24 a copy of the dialysis agreement was requested from Staff 4 (Corporate RN). On 4/30/24 at 1:52 PM Staff 4 stated the facility did not have a dialysis agreement in place for Resident 45.

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NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Coos Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Koos Bay Blvd Coos Bay, OR 97420	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48830 Based on interview and record review it was determined the facility failed to accurately document medication administration for 1 of 4 sampled residents (#33) reviewed for physician orders. This placed residents at risk for inaccurate medical records. Findings include: Resident 33 admitted to the facility in 3/2024 with diagnoses including hypothyroidism (when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs) and septic arthritis (an infection in the joint fluid and tissues). a. A physician order dated 4/1/24 instructed staff to administer one tablet of levothyroxine 50mcg (a thyroid medication) one time a day at 5:00 AM. A review of Resident 33's April 2024 MAR revealed the resident did not receive the scheduled dose on 4/26/24 at 5:00 AM. There were no progress notes in the resident's clinical record to indicate the reason for the missed dose. On 5/2/24 at 1:50 PM Staff 3 (RNCM) stated the documentation for 4/26/24 on the MAR was inaccurate. Staff 3 stated she contacted Staff 32 (LPN) on 5/2/24 and Staff 32 indicated Staff 32 administered levothyroxine 50 mcg to Resident 33 and forgot to document in the clinical record. b. A physican order dated 4/22/24 instructed staff to administer vancomycin solution 250 ml (an antibiotic) intravenously (into the vein) two times a day at 11:00 AM and 11:00 PM. A review of Resident 33's April 2024 TAR revealed the resident did not receive the scheduled dose of vancomycin solution 250 ml on 4/26/24 at 11:00 AM. There were no progress notes in the resident's clinical record to indicate the reason for the missed dose. On 5/2/24 at 1:50 PM Staff 3 (RNCM) stated the documentation for 4/26/24 on the TAR was inaccurate. Staff 3 stated she contacted Staff 33 (LPN) on 5/2/24 and Staff 33 administered vancomycin solution 250 ml intravenously to Resident 33 and forgot to document in the clinical record.

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NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Coos Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Koos Bay Blvd Coos Bay, OR 97420	

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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. 48830 Based on interview and record review it was determined the facility failed to process laundry to produce hygienically clean laundry and prevent the spread of infection for 1 of 1 laundry room reviewed for infection control. This placed residents at risk for contaminated laundry. Findings include: According to the Center for Disease Control and Prevention: Guidelines for Environmental Control in Healthcare Facilities (2003); Laundry and Bedding Section G.II.D, damp laundry was not to be left in machines overnight. On 5/1/24 at 1:17 PM Staff 22 (Housekeeping) stated her shift ended at 2:00 PM and she had the last shift of the day. Staff 22 stated when wet laundry was not completed in the washing machine at the end of her shift, she left the wet laundry in the washing machine overnight. Staff 22 stated the next morning she transferred the wet laundry to the dryer and did not rewash the laundry. On 5/2/24 at 8:52 AM Staff 23 (Housekeeping) stated her shift ended at 2:00 PM and she had the last shift of the day. Staff 23 stated multiple times a week she left wet laundry in the washing machine overnight and transferred the wet laundry to the dryer the next morning. She stated she did not rewash the laundry before it was transferred to the dryer. Staff 23 further stated when the dryer cycle was not completed at the end of her shift, she placed the damp laundry in a basket and covered it. The next morning, she then placed the damp laundry back into the dryer to finish the drying process. On 5/2/24 at 10:15 AM Staff 19 (Housekeeping Manager) was informed of the findings. She acknowledged the staff did not follow standards to produce hygienically clean laundry.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48830 Based on interview and record review it was determined the facility failed to ensure residents were offered a pneumonia vaccine for 1 of 5 sampled residents (#30) reviewed for immunizations. This placed residents at risk for infections. Findings include: The facility's Pneumococcal Vaccine Policy dated 3/2022 indicated, assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission if not conducted prior to admission. Resident 30 admitted to the facility in 8/2023 with diagnoses including depression. A review of Resident 30's clinical record revealed she/he did not receive a pneumonia vaccine and there was no indication the resident was offered a pneumonia vaccine upon admission to the facility. On 5/2/24 at 1:30 PM Staff 18 (IP) stated upon admission a resident was to be offered vaccinations if eligible, including the pneumonia vaccine. Staff 18 confirmed Resident 30 was not offered the pneumonia vaccine upon admission.