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	08/25/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview and record review it was determined the facility failed to ensure a resident had correct sized incontinence products for 1 of 3 sampled residents (#3) reviewed for environment. This placed residents at risk for skin breakdown. Findings include: Resident 3 was admitted to the facility in 9/2023 with a diagnosis of diabetes. Resident 3's Care Plan initiated on 6/12/24 revealed she/he was incontinent of bowel and bladder and wore a three X brief for dignity. Resident 3's 6/18/25 Annual MDS revealed she/he was cognitively intact. On 8/18/25 at 1:39 PM Resident 3 stated the facility often ran out of the incontinence briefs she/he wore, she/he had to wear a smaller size, and it was uncomfortable. On 8/20/25 at 1:19 PM Staff 15 (Central Supplies) stated he ordered residents' incontinence supplies. Resident 3 required a special order. He ordered two boxes every two weeks; however, the shipment did not always arrive because it was back ordered. Staff 15 stated the back order happened regularly. If Resident 3's size did not come in, staff had to use the smaller sized brief. On 8/20/25 at 2:23 PM Staff 16 (CNA) stated approximately every two weeks Resident 3 did not have her/his sized brief for approximately two to three days. On 8/20/25 at 2:39 PM Staff 12 (Social Services) stated Resident 3 reported concerns related to not having the correct sized brief. When she looked into the issue, the supplies were back ordered. On 8/20/25 at 3:01 PM Staff 1 (Administrator) stated if Resident 3 was care planned to have a specific sized brief, the facility needed to ensure there were enough supplies in the facility at all times.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review it was determined the facility failed to notify a resident's family of a hospitalization for 1 of 2 sampled residents (#3) reviewed for hospitalization. This placed residents at risk for lack of family involvement. Findings include:Resident 3 was admitted to the facility in 9/2023 with a diagnosis of diabetes. Resident 3's clinical record indicated Witness 1 (Family) was listed as her/his first emergency contact. Resident 3's 4/25/25 Progress Note revealed her/his oxygen saturation levels dropped multiple times, a rapid pulse, and five episodes of diarrhea. Despite interventions, Resident 3's oxygen level did not increase, and she/he was transferred to the hospital for evaluation. Resident 3's clinical record did not indicate Witness 1 was notified. Resident 3's 6/18/25 Annual MDS revealed she/he was cognitively intact. On 8/21/25 at 3:05 PM Resident 3 stated she/he had family, including Witness 1, who should be contacted when she/he was hospitalized . On 8/25/25 at 8:38 AM Witness 1 stated she was to be notified when Resident 3 had a change in condition. Witness 1 stated she was not notified in 4/2025 when Resident 3 was hospitalized . Witness 1 stated Resident 3 called her after she/he returned to the facility from the hospital and told Witness 1 she/he had been sick for many days. On 8/21/25 at 2:34 PM Staff 2 (DNS) stated Resident 3 was her/his own responsible party and staff did not have to notify family of hospitalizations.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to report a bruise of unknown origin for 1 of 3 sampled residents (#41) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 41 admitted to the facility on [DATE] with diagnoses including heart failure and pain. A 6/14/25 physician order instructed staff to complete weekly skin checks on the resident's shower days and document on the Weekly Skin Audit. A 7/14/25 physician order instructed staff to administer apixaban 5 mg (anticoagulant) two times a day for blood clots. Resident 41's Annual MDS completed on 8/7/25 revealed a BIMS score of 9, which indicated the resident had moderate cognitive impairment. The 8/15/25 Alert Note indicated the nurse was notified Resident 41 had a long, dark bruise on the underside of her/his right breast. Resident 41 was unable to explain how the bruising occurred and did not complain of pain. No documentation was found to indicate staff notified the State Agency.On 8/19/25 at 10:53 AM, Resident 41 was unable to recall if she/he had any bruises.On 8/20/25 at 4:04 PM, Staff 17 (LPN) confirmed on 8/14/25 he was notified Resident 41 had a large bruise on her/his right breast. The resident did not recall how the bruise occurred. Staff 17 noted the resident was on anticoagulant medication and bruised easily. Staff 17 initiated a risk management report but did not report the incident to the State agency.On 8/21/25 at 4:42 PM, Staff 2 (DNS) was asked to provide copies of all internal and facility reported incidents (FRIs) that involved alleged abuse. Staff 2 confirmed on 8/14/25 staff identified a bruise on Resident 41, the resident was unable to state how the bruise was acquired, and the incident was not reported to the State agency.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure therapy was ordered for a discharged resident for 1 of 2 sampled residents (#22) reviewed for discharge. This placed residents at risk for lack of timely services after discharge. Findings include: Resident 22 was admitted to the facility in 7/2022 with a diagnosis of a stroke. Resident 3's 7/31/25 Discharge Summary and Plan revealed she/he was discharged on 7/31/25 and a Home Health Agency referral was submitted. The expected start of care was 8/4/25. On 8/18/25 at 4:56 PM Witness 4 (Complainant) stated Resident 22 just received orders for therapy on 8/18/25. On 8/20/25 at 2:46 PM Staff 12 (Social Services) stated Resident 22's discharge was resident driven. The facility therapy department recommended two additional weeks of therapy, but Resident 22's family wanted her/him to discharge on [DATE]. Home Health physical therapy and occupational therapy orders were recommended but the orders were not signed before the resident was discharged because the physician was not in the facility. On 8/21/25 at 9:43 AM Witness 2 (Assisted Living Executive Director) stated Resident 22's home health services were delayed. On 8/21/25 at 4:52 PM Witness 3 (Home Health Manager) stated they did not receive therapy orders until Resident 22 went to her/his Primary Care Physician, and that physician's office sent the orders. Witness 3 stated on 8/18/25 Resident 22 was accepted into home health therapy services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure the state Long Term Care Ombudsman's office was notified of facility discharges for 3 of 4 sampled residents (#s 3, 22, and 56) reviewed for discharges and hospitalization. This placed residents at risk for lack of advocacy. Findings include: 1. Resident 3 was admitted to the facility in 9/2023 with a diagnosis of diabetes. Resident 3's Progress Notes revealed she/he was admitted to the hospital on [DATE]. A review of Resident 3's clinical record revealed the state long term care ombudsman (LTCO) was not notified of the resident's facility discharge. On [DATE] at 12:25 PM Staff 11 (Regional Director of Quality Assurance) verified there was no documentation the LTCO was notified of Resident 3's discharge. 2. Resident 22 was admitted to the facility in 7/2022 with a diagnosis of a stroke. Resident 22's Discharge Summary and Plan of Care revealed she/he was discharged on [DATE]. Review of Resident 22's clinical record revealed the state long term care ombudsman (LTCO) was not notified of the resident's facility discharge. The 7/2025 Ombudsman Notice of Residents Discharge form did not include Resident 22. On [DATE] at 12:25 PM Staff 11 (Regional Director of Quality Assurance) verified there was no documentation the LTCO was notified of Resident 22's discharge. 3. Resident 56 was admitted to the facility in 8/2023 with diagnoses including acute respiratory failure with hypercapnia (excess carbon dioxide in the blood) and chronic systolic heart failure (long-term condition where the heart has difficulty pumping blood). Progress Notes indicated Resident 56 was admitted to the hospital on [DATE]. A review of Ombudsman Notice of Residents Discharge forms for 6/2025 and 7/2025 did not include Resident 56's name. On [DATE] at 10:47 AM, Staff 12 (Social Services) stated she sent a monthly fax to the Long-Term Care Ombudsman's (LTCO) office listing all resident discharges. No additional information was provided. On [DATE] at 11:25 AM, an attempt to contact the LTCO office was not successful. On [DATE] at 11:49 AM, Staff 2 (DNS) stated the LTCO office would be expected to be notified monthly if a resident went to the hospital and returned. If a resident died, the LTCO office would be expected to be notified as soon as the facility became aware of the death.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, interview, and record review it was determined the facility failed to ensure the resident's care plan was comprehensive for 1 of 3 sampled residents (#41) reviewed for abuse. This placed residents at risk for increased complications related to anticoagulant medication use. Findings include: Resident 41 admitted to the facility on 8/2024 with diagnoses including heart failure and pain. A 6/14/25 physician order instructed staff to complete weekly skin checks on the resident's shower days and document any skin irregularities on the Weekly Skin Audit. A 7/14/25 physician order instructed staff to administer apixaban 5 mg (anticoagulant) two times a day for blood clots. Resident 41's 8/7/25 Annual MDS revealed a BIMS score of 9, which indicated the resident had moderate cognitive impairment. The 8/15/25 Alert Note indicated the nurse was notified Resident 41 had a long, dark bruise on the underside of her/his right breast. Resident 41 was unable to explain how the bruising occurred and did not complain of pain. Resident 41's 8/21/25 care plan indicated the resident was on anticoagulant therapy for blood clots. The goal was for the resident to remain free from adverse reactions related to anticoagulant use. Staff were directed to report abnormalities to the nurse, document, and report bruising.On 8/20/25 at 3:56 PM, Staff 33 (CNA) stated on 8/14/25 she identified a large bruise on Resident 41's right breast and reported the findings to the charge nurse.On 8/20/25 at 4:04 PM, Staff 17 (LPN) confirmed he was notified Resident 41 had a bruise on her/his right breast, the resident did not recall how she/he got the bruise, she/he was on anticoagulant medication, and bruised very easily. Staff 17 initiated a risk management and notified management but did not update the care plan.On 8/21/25 at 4:42 PM, Staff 2 (DNS) confirmed Resident 41 had a physician order for anticoagulant medication and it was not on the care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview and record review it was determined the facility failed to ensure physician orders were followed for 4 of 15 sampled residents (#s 3, 5, 21, and 59) reviewed for medications, insulin, medication administration, and tube feedings. This placed residents at risk for adverse medication effects. Findings include:1. Resident 3 was re-admitted to the facility in 4/2025 with a diagnosis of heart failure. Resident 3's 6/19/25 clinic physician summary indicated she/he was on a fluid restriction and was seen for a follow-up visit from a recent hospitalization for heart failure. The clinic visit summary revealed a handwritten order which instructed staff to discontinue Resident 3's fluid restriction. If Resident 3 experienced a five pound or greater weight gain in 24 hours, increased swelling in her/his legs, or difficulty breathing with exertion, the fluid restriction was to be reinstated. Resident 3's 6/2025 MAR revealed her/his fluid restriction was discontinued on 6/19/25. Resident 3's 7/2025 and 8/2025 TAR revealed her/his weights were monitored daily unless refused. The daily weights were discontinued on 8/11/25. The TARs did not indicate Resident 3's legs were monitored for edema. Resident 3's Progress Notes dated 6/19/25 through 8/19/25 revealed one note on 6/22/25 which addressed her/his lower extremity edema. On 8/22/25 at 9:35 AM Staff 10 (Regional Reimbursement Resource Nurse) acknowledged Resident 3 was on a fluid restriction which was discontinued on 6/19/25 with instructions to reinstate if she/he had symptoms of fluid retention. Staff 10 stated Resident 3 did not have weight gain and was stable. Staff 2 (DNS) stated Resident 3 had a desired weight loss, her/his daily weights were discontinued, and she/he often refused to be weighed. Staff 2 acknowledged the facility did not clarify with Resident 3's physician if the fluid restriction parameters were still required. On 8/22/25 at 9:48 AM Staff 26 (RNCM) stated Resident 3 refused weights, but the facility did not monitor Resident 3 for symptoms of fluid overload including her/his breathing status, lung assessment, or leg swelling. 2. Resident 5 admitted to the facility in 4/25 with diagnoses including end stage kidney disease and Type I diabetes. The facility’s 2024 Standing Physician Orders for diabetic management instructed staff to inject 1 gram glucagon when diabetic residents became unresponsive, or capillary blood glucose (CBG) was below 70 mg/dL. The 4/30/25 admission MDS revealed Resident 5 had a BIMS of 13, which indicated the resident was cognitively intact. Resident 5’s 6/2025 Diabetic Administration Record (DAR) did not include standing orders for glucagon injections. No documentation was found to indicate staff administered glucagon on 6/5/25 or 6/29/25 when the resident’s CBGs were below 70 mg/dL. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress notes from 6/5/25, 6/29/25, 7/6/25, and 7/24/25 revealed severe hypoglycemia (blood glucose ranging 31-51mg/dL) and hospital transfers. On 7/6/25 and 7/24/25, staff were unable to locate glucagon injections in the facility, requiring emergency transport to the hospital. A 7/31/25 Physician order instructed staff to maintain glucagon injections in the emergency kit. Staff were to inject 1 mg glucagon every 12 hours PRN for low CBG related to hypoglycemia. On 8/21/25 at 9:06 AM, Staff 18 (LPN) confirmed the emergency kit did not include any glucagon injections. Staff 18 stated all diabetic residents should have standing orders for glucagon injections and gel, available on the medication cart. On 8/21/25 at 9:20 AM, Staff 17 (LPN) stated within the past few months, the facility ran out of glucagon injections on several occasions. During this time, Resident 5 frequently experienced low CBG levels, and required hospitalization due to hypoglycemia. Staff 17 further stated nurses were responsible for ordering additional doses however, there were sometimes delays in the pharmacy delivering the injections. On 8/21/25 at 4:36 PM, Resident 5 reported having multiple hospitalizations in recent months due to hypoglycemia. Resident 5 stated she/he was afraid to go to sleep at night due to frequent drops in her/his CBGs. On 8/22/25 at 12:40 PM, Staff 2 (DNS) and Staff 11 (Regional Director of Quality Assurance) confirmed the facility failed to follow standing orders and maintain sufficient glucagon supplies, contributing to multiple hospitalizations for Resident 5. b. The 6/9/25 Hospital After Visit Summary revealed Resident 5 was seen from 6/5/25 through 6/9/25 for hypoglycemia. A follow-up appointment was scheduled for 6/12/25. The physician referral orders indicated Resident 5 was to be enrolled in a continuous glucose monitoring (CGM) program. A 7/6/25 nephrology referral revealed due to Resident 5’s multiple hospitalizations related to either hyperglycemia or hypoglycemia, the resident was determined to have brittle diabetes (highly unpredictable blood glucose levels). The nephrologist recommended enrollment in a CGM program. The 7/31/25 Hospital After Visit Summary revealed a physician prescribed CGM. Medication changes included Dexcom G7 (blood-glucose) Receiver and Dexcom G7 (blood-glucose) Sensor. No documentation was found to indicate the facility followed through with the physicians’ orders. On 8/22/25 at 9:45 AM, Staff 32 (RCM) stated when residents are admitted or re-admitted with new orders, the facility used its triple check system to ensure orders were accurately entered. Staff 32 was unable to provide documentation Resident 5’s physician orders from 6/12/25, 7/6/25, and 7/31/25 were followed up on. On 8/22/25 at 12:40 PM, Staff 2 and Staff 11 confirmed the facility failed to follow up with physician orders related to Resident 5’s diabetic management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 21 was admitted to the facility in 6/2025 with diagnoses including diabetes and visual loss. An 8/2025 BIMS assessment indicated Resident 21 was cognitively intact. An 8/13/25 Progress Note indicated a provider order was received for Bactrim DS 800-160 mg (an antibiotic medication) to be taken twice a day for seven days. An 8/13/25 Progress Note indicated a provider order to decrease Resident 21’s Lantus insulin (diabetic medication) from ten units twice a day to five units twice a day. A provider order for Lantus insulin five units twice a day was entered into Resident 21’s chart on 8/13/25. An 8/14/25 Progress Note indicated Resident 21 received ten units of Lantus insulin during the morning 7:00 – 10:00 AM administration window. A provider order for Bactrim DS 800-160 mg twice a day for seven days was entered into Resident 21’s chart on 8/14/25. A review of Resident 21’s 8/2025 Diabetic Administration Record revealed the following: On 8/14/25 in the 7:00 - 10:00AM administration window ten units of Lantus insulin were administered, and then the order was discontinued. On 8/20/25 at 12:30 PM, Resident 21 stated she/he was aware of mistakes made with her/his insulin and antibiotic medications earlier in the month. On 8/25/2025 at 10:23 AM, Staff 2 (DNS) acknowledged the medication errors and stated her expectation was for provider orders to be double checked for accuracy by two nurses on different shifts for any new medication, any changes to medications, and prior to any medications being discontinued. 4. Resident 59 was admitted to the facility in 12/2024 with diagnoses including left sided Hemiplegia (paralysis of the left side) and intracerebral hemorrhage (a type of stroke). Review of a 2/12/25 Facility Reported Incident (FRI) indicated Resident 59 missed multiple administrations of Isosource Enteral Feed 1.5 (liquid food given though a tube) 300 ml via G-Tube (a flexible tube inserted into the stomach through the abdomen) from 2/1/25 through 2/5/25. A provider order for Isosource 1.5 300 ml via G-Tube at HS was started on 1/31/25 and was incorrectly discontinued on 2/1/25. A 2/1/25 Progress Note indicated Resident 59 was eating food by mouth and was no longer receiving the Isosource 1.5 300 ml via G-Tube. Another provider order for Isosource 1.5 300 ml via G-Tube at HS was started on 2/6/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 59’s 2/2025 MAR indicated she/he did not receive the HS administration of Isosource 1.5 300 ml via G-Tube from 2/1/25 through 2/5/25. Alert notes from 2/7/25 through 2/10/25 indicate Resident 59 had no adverse effects from the missed administrations of Isosource 1.5 300 ml via G-Tube at HS. On 8/25/2025 at 10:23 AM, Staff 2 (DNS) acknowledged the medication error and stated her expectation was for provider orders to be double checked for accuracy by two nurses on different shifts for any new medication, any changes to medications, and prior to any medications being discontinued.

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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. Based on observation, interview and record review it was determined the facility failed to ensure a resident's environment remained free from accident hazards for 1 of 9 sampled residents (#52) reviewed for staffing. This placed residents at risk for accidents. Findings include:Resident 52 was admitted to the facility in 7/2025 with diagnoses including fracture of left leg, anxiety, and difficulty in walking. The care plan dated 7/12/25 identified Resident 52 as high risk for falls. Staff were instructed to keep her/his call light within reach at all times and DO NOT leave the resident unsupervised in the bathroom or on the bedside commode. A 7/16/25 admission MDS BIMS assessment indicated a score of 13 (cognitively intact). On 8/20/25 at 8:05 AM, the call light time log showed Resident 52 activated her/his call light at 7:45 AM. Staff 17 (LPN Charge Nurse) entered the room the room at 8:06 AM-21 minutes later. On 8/20/25 at 8:30 AM Staff 17 stated he entered Resident 52's room because the call light had been on for a while. At 8:36 AM Resident 52 stated she had been waiting on the bedside commode, and her/his buttocks were getting sore. Resident 52 reported self-transferring back to bed. Resident 52 was observed in bed with a gait belt around her/his upper waist. Resident 52 stated Staff 17 entered the room after she/he had already self-transferred. On 8/21/25 at 10:58 AM, Staff 14 (CNA) stated she assisted Resident 52 onto the bedside commode on 8/20/25. She then informed other staff by radio she needed to complete a shower for another resident. After finishing the shower, she saw Resident 52's call light was on and again informed staff by radio. Staff 14 stated she did not know Resident 52 was not to be left alone on the bedside commode. On 8/22/25 at 11:57 AM, Staff 2 (DNS) confirmed Resident 52 was care planned to be supervised while on the bedside commode.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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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 0690 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 interview and record review it was determined the facility failed to ensure residents received timely incontinence care for 2 of 10 residents (#6 and 15) reviewed for staffing. This placed residents at increased risk for skin breakdown and loss of dignity. Findings include:1. Resident 6 was admitted in 7/2025 with diagnoses including kidney failure and muscle weakness. The admission MDS dated [DATE] identified the resident as frequently incontinent of urine and she/he required assistance with toileting. Resident 6 was cognitively intact and did not have any behaviors of rejection of care. The 7/15/25 Urinary Incontinence CAA identified frequent incontinence and dependance on staff for safe completion of toileting hygiene and needs. Resident 6's care plan dated 7/23/25 directed staff to encourage the use of the call light for assistance, offer frequent toileting opportunities, provide frequent check and change throughout each shift, and perform peri care after each incontinent episode.A Documentation Survey Report for bladder from 8/1/25 through 8/18/25 revealed the following for Resident 6:-Day shift: incontinent 11 times, both continent and incontinent five times, continent two times, no documentation one time. No documentation of refusals.-Evening shift: incontinent nine times, both continent and incontinent four times, continent seven times, and no documentation of refusals. On 8/21/25 at 6:08 AM and 8/22/25 at 7:05 AM, Resident 6 stated it was easier to wear a brief than to wait for staff for assistance. Resident 6 confirmed having soaked through her/his wheelchair, leaving urine on the floor on 8/17/25. Resident 6 reported difficulty receiving timely assistance from staff to transfer into bed for incontinence care. On 8/22/25 at 6:45 AM Staff 8 (CNA) stated she was so pissed staff assisted Resident 6 up for lunch, on 8/17/25 and she later assisted with dinner. Between lunch and dinner, Resident 6 remained in her/his wheelchair without receiving incontinence care. Resident 6 urinated all over herself/himself. Staff 8 stated Resident 6 urinated on herself/himself during dinner, leaving a large puddle on the floor. On 8/22/25 at 9:03 AM Staff 4 (CNA) stated she assisted Resident 6 up for lunch and provided incontinence care on 8/17/25. Staff 4 stated she did not provide any incontinence care after lunch. On 8/22/25 at 10:58 AM Staff 5 (CNA) stated he worked the evening shift on 8/17/25 and was assigned to the same hall as Resident 6. He could not recall if he was specifically assigned to Resident 6 but remembered assisting with incontinence care. Staff 5 recalled the evening being very busy and stated Resident 6's urine maybe was on the floor and he helped clean the urine up. On 8/22/25 at 11:44 AM Staff 2 (DNS) stated staff were expected to check on residents every two hours and offer to lay them down in bed. If a resident refused assistance, staff are to notify the nurse. 2. Resident 15 was admitted in 5/2025 with diagnoses including benign prostatic hyperplasia (non-cancerous enlargement of the prostate) with lower urinary symptoms. The admission MDS dated [DATE] identified Resident 15 as cognitively intact and frequently incontinent of both bladder and bowel. Resident 15 also required the assistance of staff for incontinence care. The care plan dated 5/15/24 directed staff to encourage the use of the call light for assistance and to offer frequent toileting opportunities. A Resident Family Grievance Communication Form dated 8/11/25 documented on 8/10/25, Resident 15 requested a brief change at 1:10 PM. At 2:10 PM, Staff 5 entered the room and was informed assistance was still needed. Staff 5 stated he was told Resident 15 had already received incontinence care. A Documentation Survey Report for bladder from 8/1/25 through 8/12/25 revealed the following for Resident 15:-Day shift: incontinence two times, both continent and incontinent 12 times, and continent four times with no documentation of refusals.-Evening shift: incontinent six times, both continent and incontinent four times, and continent two times with no documentation of refusals. On 8/21/25 at 10:49 AM, Staff 5 stated on 8/10/25, Resident 15 reported being soaked through her/his brief and did not receive staff assistance, there was urine on the floor under her/his wheelchair, and Resident 15 requested to file a grievance. On 8/22/25 at 10:27 AM, Resident 15 confirmed timely incontinence care was not provided on 8/10/25. On 8/22/25 at 12:01 PM, Staff 2 (DNS) stated staff were expected to provide timely incontinence care, check on residents every two hours, and offer to lay them down in bed. If a resident refused assistance, staff were to notify the nurse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide respiratory care and services for 1 of 1 sampled resident (#6) reviewed for medications and respiratory services. This placed residents at risk for unmet respiratory needs. Findings include:Resident 6 was admitted in 7/2025 with diagnoses including sleep apnea and edema (swelling caused by fluid retention).Per the facility's Oxygen Administration policy and procedure, documentation must include:-Date and time of oxygen setup or adjustment-Oxygen flow rate, route, and rationale-Frequency and duration of treatment-Reason for PRN administration-Assessment data before, during, and after the procedure-Resident's tolerance of the procedure The admission MDS dated [DATE] identified Resident 6 was cognitively intact and exhibited no behaviors. Resident 6 was not on oxygen therapy.A physician order dated 8/7/25 instructed staff to administer oxygen at two liters per minute via nasal cannula PRN for shortness of breath. No start date was listed. There was no documentation of oxygen tubing changes or cleaning of the oxygen concentrator filter. An 8/9/25 Physician's Progress Note stated Resident 6 frequently complained of dyspnea (difficulty breathing), although oxygen saturation was good. Oxygen was provided to relieve the sensation.The O2 Saturation Summary Report from 8/7/25 through 8/21/25 revealed oxygen use via nasal cannula on the following dates and times:-8/8/25 at 6:52 AM-8/11/25 at 8:12 AM and 4:07 PM-8/12/25 at 6:34 AM and 2:34 PM-8/13/25 at 6:36 AM-8/14/25 at 6:52 AM-8/20/25 at 10:09 AM, 3:06 PM, and 10:33 PM-8/21/25 at 7:13 AM, 8:44 AM, 2:58 PM, and 6:36 PMReview of Resident 6's 8/2025 MAR and TAR from 8/1/25 through 8/20/25 contained no documentation of Resident 6's PRN oxygen therapy. The care plan dated 8/12/25 identified a risk for ineffective breathing pattern due to edema and positioning. Interventions included:-Administer oxygen as prescribed or per standing order-Encourage coughing, deep breathing, and forced expiratory techniques as ordered-Evaluate pulse oximetry (measurement of oxygen saturation)On 8/21/25 at 6:08 AM, Resident 6 stated she/he used oxygen while sleeping and wore the nasal cannula most of the time. Resident 6 was observed wearing a nasal cannula with oxygen in use.On 8/21/25 at 7:37 AM, Witness 5 stated Resident 6 used oxygen part of the time. On 8/21/25 at 9:20 AM, Staff 7 (CNA) stated Resident 6 always used oxygen during her shifts. On 8/21/25 at 9:37 AM, Staff 9 (Physical Therapist Assistant) stated Resident 6 relied on oxygen. On 8/22/25 Staff 2 (DNS) confirmed there was no documentation on the MAR or TAR of Resident 6's use of oxygen and she would also expect an oxygen tubing and filter cleaning schedule.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide sufficient nursing staff to ensure residents attained or maintained their highest practicable mental, physical, and psychosocial well-being for 5 of 10 sampled residents (#s 1, 7, 24, 52, and 61) reviewed for staffing. This placed residents at risk for unmet needs. Findings include:1. Resident 1 was admitted to the facility in 7/2025 with a diagnosis of UTI. Resident 1's 8/4/25 admission MDS revealed she/he had memory loss. On 8/18/25 at 11:53 AM Resident 1 stated, at times, it took approximately 30 minutes for staff to answer her/his call light, and it occurred on all shifts. Resident 1's Past Calls log from 8/14/25 through 8/17/25 revealed her/his call light was activated without a response for more than 30 minutes on 8/15/25 at 7:16 AM, 8/15/25 at 12:22 PM, and 8/16/25 at 7:19 AM. On 8/20/25 at 1:27 PM Staff 14 (CNA) stated Resident 1 often activated her/his call light and was not sure why she was not able to answer it in less than 30 minutes. On 8/20/25 at 2:20 PM Staff 16 (CNA) stated 7:00 AM was a busy time of day when she assisted residents up for breakfast, to bathe, and to get ready for the day. Some days after assisting a resident, there would be eight additional call lights on. Staff 16 stated she had to assist one resident at a time. On 8/21/25 at 2:44 PM and 8/22/25 at 11:57 AM Staff 2 (DNS) stated it was the expectation for resident call lights to be answered within five to ten minutes, and no more than15 minutes during the busy times of the day, such as mealtimes. 2. Resident 7 was admitted to the facility in 6/2024 with diagnoses including fracture of left femur. The care plan dated 3/12/25 identified Resident 7 required assistance with ADLs including repositioning and toilet use. An Annual MDS BIMS assessment dated [DATE] indicated a score of 15 (cognitively intact). A Resident Family Grievance Communication Form dated 8/10/25 revealed Resident 7 activated her/his call light to request assistance with a bedpan. The resident waited one hour before staff entered the room. A few minutes before shift change, Resident 7 was assisted onto the bedpan. After completing use, the resident activated the call light again. No staff responded until shift change was completed. The facility response indicated the call light was activated at 1:31 PM and remained on for 35 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/25 at 1:35 PM, Resident 7 stated on 8/10/25 she/he activated her/his call light and was on the bed pan for 20 to 30 minutes. Resident 7 had to wait until the evening shift came on before being assisted off the bed pan. Resident 7 stated she/he completed a grievance. On 8/21/25 at 10:49 AM, Staff 5 (CNA) stated Resident 7 was upset on 8/10/25 and reported she/he waited for assistance for an hour without a response from staff. Staff 5 assisted the resident to complete a grievance form. On 8/22/25 at 12:01 PM, Staff 2 (DNS) stated staff were expected to respond to call lights within five to 10 minutes, and no more than 15 minutes. 3. Resident 24 was admitted to the facility in 7/2024 with diagnoses including respiratory failure and kidney disease The care plan dated 10/4/24 identified Resident 24 as incontinent of bowel and bladder. The resident was encouraged to use the call light for assistance. A Quarterly MDS BIMS assessment dated [DATE] indicated a score of 14 (cognitively intact). A Resident Family Grievance Communication Form dated 8/7/25 revealed Resident 24's call light remained on for one hour and 20 minutes without response. The Past Calls report for call light log 8/12/25 through 8/14/25 and 8/16/25 showed the following: -8/13/25 at 12:45 PM, the call light was on for over 25 minutes without response. -8/16/25 at 9:34 AM the call light was on for over 26 minutes without response. On 8/18/25 at 12:14 PM, Resident 24 stated call light response times were too long. The resident reported one instance took 45 minutes for staff to respond. Resident 24 stated long call light wait times frequently occurred in the afternoons and resulted in multiple episodes of incontinence. On 8/22/25 at 12:01 PM Staff 2 (DNS) stated staff were expected to respond to call lights within five to 10 minutes, and no more than 15 minutes. 4. Resident 52 was admitted to the facility in 7/2025 with diagnoses including fracture of left leg, anxiety, and difficulty in walking. A 7/16/25 admission MDS BIMS assessment indicated a score of 13 (cognitively intact). On 8/20/25 at 8:05 AM, Call light computer time log at the nurses station showed Resident 52 activated the call light at 7:45 AM. Staff 17 (LPN Charge Nurse) entered the room at 8:06 AM-21 minutes later. At 8:30 AM Staff 17 stated he entered Resident 52's room because the call light had been on for a while. At 8:36 AM Resident 52 stated she had been waiting on the bedside commode, and her/his buttocks were getting sore. Resident 52 reported self-transferring back to bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/25 at 10:58 AM, Staff 14 (CNA) stated she assisted Resident 52 onto the bedside commode on 8/20/25. She then informed other staff by radio she needed to complete a shower for another resident. After finishing the shower, she saw Resident 52's call light was on and again informed staff by radio. On 8/22/25 at 12:01 PM, Staff 2 (DNS) stated staff were expected to respond to call lights within five to 10 minutes, and no more than 15 minutes. 5. Resident 61 was admitted to the facility in 8/2025 with diagnoses including diabetes and traumatic subdural hemorrhage (bleeding in the brain caused by trauma). On 8/18/2025 at 4:16 PM, Resident 61 stated she/he had to wait “quite a long time” on 8/17/25 and 8/18/25 to get help from staff. A review of the Call Light Audits for 8/17/25 and 8/18/25 revealed the following call light durations: 8/18/25 at 12:22 AM - 1 hour 7 minutes, 8/18/25 at 6:11 AM - 39 minutes, 8/18/25 at 10:35 AM - 31 minutes, 8/18/25 at 1:23 PM - 28 minutes, and 8/18/25 at 10:51 PM - 25 minutes. On 8/25/2025 at 10:18 AM, Staff 2 (DNS) acknowledged the call light durations and stated her expectation was all staff were responsible for responding to call lights in five to fifteen minutes, no matter what shift, or what was going on in the building.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review it was determined the facility failed to ensure a resident's pain medication was available for 1 of 5 sampled residents (#3) reviewed for medications. This placed residents at risk for uncontrolled pain. Findings include: Resident 3 was admitted to the facility in 9/2023 with a diagnosis of chronic pain. Resident 3's 6/18/25 Annual MDS revealed she/he was cognitively intact. Resident 3's 6/2025 MAR revealed on 6/12/25 she/he was administered one dose of oxycodone (narcotic pain medication). Resident 3's 4/2025 Order Summary Report revealed she/he was to be administered oxycodone every eight hours PRN for pain. Progress Notes revealed the following:6/12/25 follow up with Resident 3's clinic for an oxycodone refill. Staff were notified they were no longer able to use the emergency supply of oxycodone. 6/13/25 The pharmacy reported Resident 3's oxycodone was on hold pending clarification of which physician was allowed to prescribe refills. Resident 3's 8/2025 Orders Summary Report revealed she/he was to be administered oxycodone every eight hours PRN for pain. Resident 3's 8/2025 MAR revealed she/he was to be administered oxycodone every eight hours PRN for pain. The MAR also indicated oxycodone was to be refilled by one specific physician. As a result, Resident 3 was not administered oxycodone on 8/3/25, 8/4/25, 8/16/25 or 8/17/25. Progress Notes revealed the following:-8/16/25 Resident 3 refused showers and stated she/he would continue to refuse showers until her/his pain medication was re-ordered. -8/17/25 Resident 3's oxycodone was not delivered, the pharmacy reported they needed a new prescription, and Resident 3 did not exhibit signs of pain. -8/18/25 Resident 3's clinic was called for her/his oxycodone refill. -8/19/25 Resident 3's provider was unable to be reached, and a message was left. Resident 3 was administered PRN Tylenol (non-narcotic pain medication) and she/he attended an appointment to have her/his oxycodone prescription refilled. On 8/20/25 at 8:01 AM and 8/21/25 at 7:58 AM Resident 3 stated her/his oxycodone was originally ordered to be administered every eight hours PRN and she/he liked to take the medications three times a day. Resident 3 stated if she/he did not take her/his pain medication, it was difficult to get out of bed in the morning and participate in activities. Resident 3 stated she/he had another appointment with her/his physician in 30 days, and they needed to figure out a system for the facility not to run out of pain medications. On 8/21/25 at 12:24 PM Staff 17 (LPN) stated staff tried to refill Resident 3's prescription at least one week prior to the oxycodone running out. On 8/21/25 at 2:53 PM Staff 2 (DNS) stated the nurses faxed resident 3's oxycodone refill request to the clinic and they were to follow up to ensure they received a response. Staff 2 acknowledged there needed to be a system in place to ensure Resident 3's oxycodone prescriptions were filled timely.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review it was determined the facility failed to have an on-hand supply of emergency hypoglycemic medication and administer anti-seizure medications according to provider orders for 2 of 13 residents (#s 5, and 30) reviewed for insulin and medication errors. This placed residents at risk for serious adverse health outcomes and death. Findings include: 1. Resident 5 admitted to the facility in 4/2025 with diagnoses including end stage kidney disease and Type I diabetes. The facility’s 2024 Standing Physician Orders for diabetic management instructed staff to inject 1 gram glucagon when diabetic residents became unresponsive, or capillary blood glucose (CBG) was below 70 mg/dL. The 4/2025 Diabetic Administration Record (DAR) did not include standing orders for glucagon injections. The 4/30/25 admission MDS revealed Resident 5 had a BIMS of 13, which indicated the resident was cognitively intact. A 6/5/25 Summary for Providers Note revealed Resident 5 had a change in mental status, was unresponsive, and was difficult to arouse. Resident 5’s CBG was 34 mg/dL. Resident 5 was sent to the hospital. A 6/5/25 Hospital Provider Note revealed Resident 5 admitted with hypoglycemia and altered mental status. The resident's CBG was 34 mg/dL, and she/he required repeated administrations of intravenous dextrose (D50). A 6/29/25 Progress Note indicated Resident 5 was sent to hospital for low blood glucose of 34 mg/dL. The 6/2025 DAR revealed no standing orders or documentation on 6/5/25 or 6/29/25 staff administered glucagon injections. A 7/6/25 Progress Note revealed Resident 5 was found leaning to the left side, moaning, grinding teeth, and with clammy and sweaty skin. Resident 5’s CBG was 51 mg/dL. The nurse was unable to locate a glucagon injection and called 911. A repeat CBG was 46 mg/dL. About 20 minutes later, paramedics arrived and found the resident’s CBG at 31 mg/dL. The resident was given intravenous glucose, became responsive about 15 minutes later and was transported to the hospital. A 7/6/25 Progress Note revealed Resident 5 was admitted to the hospital for hypoglycemia and hyperkalemia (dangerous level of potassium in the blood which affects the heart and muscles). A 7/24/25 Progress Note revealed Resident 5 was sweaty, lethargic, weak, and had slurred speech. Resident 5’s CBG was 36 mg/dL. Staff notified the physician and reported a glucagon injection or glucagon gel was not available in the facility. The physician instructed staff to send Resident 5 to the hospital if her/his condition did not improve. Resident 5 was transferred to the hospital. A 7/31/25 Physician order instructed staff to maintain glucagon injections in the emergency kit. Staff were to inject 1 mg glucagon every 12 hours PRN for low CBGs related to hypoglycemia. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 8/21/25 at 4:36 PM, Resident 5 reported having multiple hospitalizations due to hypoglycemia. Resident 5 stated she/he was afraid to go to sleep at night because her/his blood sugars dropped and she/he often woke up in the hospital. Resident 5 further stated it was frightening to wake up in the hospital surrounded by unfamiliar people with no memory of the events leading to the hospitalization. On 8/21/25 at 9:06 AM, Staff 18 (LPN) confirmed the facility did not have any glucagon injections available in the emergency kit. On 8/21/25 at 9:10 AM, Staff 11 (Regional Director of Quality Assurance) confirmed the facility did not have any glucagon injections available in the emergency kit. Staff 11 stated the facility had standing orders for all diabetic residents, which should include their own glucagon injections and glucagon gel available on the medication carts. On 8/21/25 at 9:20 AM, Staff 17 (LPN) stated within the past few months, Resident 5 frequently experienced low CBGs, and required hospitalization due to hypoglycemia. Staff 17 further stated nurses were responsible for ordering additional doses however, there were sometimes delays in the pharmacy delivering the injections. On 8/21/25 at 6:56 PM, Staff 22 (LPN) stated Resident 5’s CBGs often went very low. On 8/22/25 at 12:40 PM, Staff 2 (DNS) and Staff 11 (Regional Director of Quality Assurance) confirmed the facility failed to follow standing orders and maintain sufficient supplies of glucagon injections for diabetic residents. Staff 2 confirmed Resident 5 was hospitalized multiple times as a result of the facility not having glucagon injections. 2. Resident 30 admitted to the facility in 8/2023 with diagnoses including quadriplegia (paralysis in all four limbs) and traumatic brain injury. During an observation of medication administration on 8/21/25 at 12:25, the Electronic Medication Administration Record (EMAR) used by Staff 20 (CMA) indicated multiple residents were receiving medications later than ordered. On 8/21/2025 at 12:45 PM, Staff 19 (LPN) stated he noticed medications were running later than ordered, and he was not sure what the policy was for late medications, or when he was supposed to ask for help. A review of Resident 30’s 8/21/25 Medication Administration Audit Report revealed the following: Baclofen 10mg (muscle relaxant) ordered four times a day for muscle spasms: - ordered to be given at 7:00 AM and was administered at 12:24 PM by Staff 19 (LPN). - ordered to be given at 12:00 PM and was administered at 1:26 PM by Staff 19 (LPN). - ordered to be given at 4:00 PM and was administered at 3:07 PM by Staff 20 (CMA). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Levetiracetam 500mg (anti-seizure medication) ordered three times a day for Epilepsy (a seizure disorder): - ordered to be given at 7:00 AM and was administered at 12:24 PM by Staff 19 (LPN). - ordered to be given at 12:00 PM and was administered at 1:26 PM by Staff 19 (LPN). - ordered to be given at 4:00 PM and was administered at 3:07 by Staff 20 (CMA). Klonopin 0.5mg (anti-seizure medication) ordered three times a day for Epilepsy: - ordered to be given at 7:00 AM and was administered at 12:24 PM by Staff 19 (LPN). - ordered to be given at 12:00 PM and was administered at 1:26 PM by Staff 19 (LPN). - ordered to be given at 4:00 PM and was administered at 3:07 PM by Staff 20 (CMA). Progress Notes from 8/21/25 through 8/25/25 revealed no documentation the provider was contacted regarding the med errors, and no alert charting was in the resident’s medical chart. On 8/25/2025 at 9:53 AM, Staff 21 (Pharmacist) stated the Baclofen 10mg, Levetiracetam 500mg, and the Klonopin 0.5mg were not advised to be given so close together. She stated the medications are generally spread out over the waking hours for Resident 30, and the provider should be contacted for orders. She stated these medications administered in close proximity could cause increased lethargy and sedation. On 8/25/2025 at 10:21 AM Staff 2 (DNS) stated Staff 19 (LPN) was a new nurse and should not have been administering all the medications by himself. She stated the expectation for staff is to ask for assistance when they need help. On 8/25/2025 at 6:07 PM, Staff 25 (Medical Director/Doctor) stated he was aware of the medication errors on 8/21/25. He stated Resident 30 has had violent shaking episodes in the past when her/his medications were not administered on time, and the current medication administration schedule was currently managing her/his seizures. He stated the expectation was for staff to call him for orders when they were late with medication or if a medication dosage was missed.

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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** Based on observation, interview, and record review it was determined the facility failed to ensure resident medications were not expired for 1 of 1 medication storage room, 1 of 2 medication carts, and 1 of 1 treatment carts reviewed for medication storage. This placed residents at risk for lack of medication efficacy and adverse reactions from expired medications. Findings include:The facility Medication Labeling and Storage policy, with unknown publication date, stated multi dose vials were to be dated when opened and discarded within 28 days. During an observation of the medication storage room on 8/19/25 at 1:18 PM, the following were found: - Two bottles of Metamucil (a laxative medication) with an expiration date of 4/2025. On 8/19/25 at 1:34 PM, Staff 22 (LPN) stated the expectation for expired medication was for it to be destroyed and replaced. During an observation of the [NAME] Fir Drive medication cart on 8/19/2025 at 2:04 PM, the following was found: - One bottle of acid reducer 20mg (medication used to reduce stomach acid) with an expiration date of 5/2025. On 8/19/2025 at 2:14 PM, Staff 23 (CMA) stated the expectation for expired medication was for it to be removed from the medication cart, destroyed, and replaced. During an observation of the [NAME] Fir Drive treatment cart on 8/19/2025 at 2:17 PM, the following were found: - One vial of Insulin Asparte (medication used for diabetes) with an open date of 7/17/25. - One vial of Insulin Glargine (medication used for diabetes) with an open date of 7/17/25. On 8/19/2025 at 2:22 PM, Staff 22 (LPN) stated the expectation for insulin was for it to be destroyed 28 days after it was opened and replaced with a new vial. On 8/25/2025 at 10:17 AM, Staff 2 (DNS) acknowledged expired medications were found in the medication storage room, on the [NAME] Fir Drive medication cart, and on the [NAME] Fir Drive treatment cart. She stated the expectation for expired medications was for them to be destroyed and replaced. She stated insulin was to be destroyed 28 days after being opened and replaced with a new vial.

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	08/25/2025

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

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review it was determined the facility failed to ensure a resident's denture was replaced timely for 1 of 1 sampled resident (#3) reviewed for dental. This placed residents at risk for weight loss. Findings include: Resident 3 was admitted to the facility in 9/2023 with a diagnosis of diabetes. Resident 3's ADL report revealed at times she/he required assistance with oral care. Resident 3's 1/14/15 Care Conference Information form revealed Resident 3 reported the facility lost her/his lower denture. Resident 3 stated she/he set the lower denture on the bedside table and did not place the denture in her/his denture cup. Resident 3 also stated at bedtime she/he requested a snack and at that time she/he could not find her/his lower denture. Resident 3 stated a CNA looked for the denture in the linens, laundry, and dietary department but the denture was not located. Resident 3's 7/9/25 Progress Note revealed Staff 1 (Administrator) notified Staff 12 the facility was to replace Resident 3's lost denture. On 8/20/25 at 8:01 AM Resident 3 stated in 1/2025 she/he was in bed and took her/his dentures out to clean them, put the upper denture in the denture cup, and put the lower denture on the bedside table. Resident 3 stated she/he may have put it in a napkin because she/he was putting adhesive on it. Resident 3 stated later in the evening she/he was going to eat a snack, and she/he could not find the lower denture. The CNAs tried to find the dentures in the bedding, laundry, and garbage and could not find it. Staff 2 (DNS) informed her/him she/he was responsible for the care of her/his dentures. Therefore, she/he would have to pay for the replacement of the dentures. On 8/20/25 at 3:01 PM Staff 1 (Administrator) stated he was not notified of the missing denture in 1/2025. If he would have been aware of Resident 3's missing denture, the replacement process would have been started soon after it was lost.

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	08/25/2025

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined the facility failed to ensure an ice machine drain had an airgap to prevent back flow for 1 of 1 kitchen. This placed residents at risk for foodborne illness. Findings include: On 8/20/25 at 11:04 AM and 8/20/25 at 11:20 AM with Staff 29 (Dietary Manager) the ice machine drainpipe was observed to be in a drain hole with no air gap. Staff 29 stated there was no flooding in the kitchen for years. On 8/21/25 at 12:31 PM Staff 30 (Maintenance) stated in 7/2025 the airgap was identified on a work order to be fixed but was not. On 8/25/25 at 10:33 AM Staff 1 (Administrator) stated he was not aware of the lack of airgap for the ice machine prior to survey.

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	08/25/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined the facility failed to provide clean and sanitary smoking equipment for 1 of 4 sampled residents (#21) reviewed for smoking. This placed residents at risk for respiratory issues and cross-contamination. Findings include: Resident 21 admitted to the facility in 6/2025 with diagnoses including nicotine dependency and visual loss. The 6/9/25 Smoking Safety Evaluation revealed Resident 21 was alert and oriented, had visual impairment, and required staff supervision while smoking, including the use of a smoking apron.The 8/6/25 Quarterly MDS revealed Resident 21 had a BIMS of 14, which indicated the resident was cognitively intact.On 8/18/2025 at 1:17 PM, Staff 20 (CMA) assisted Resident 21 to the supervised smoking area. Staff 20 and Staff 33 (CNA) stated no clean smoking aprons were available, as the only remaining apron was moldy. Staff 20 stated he would not want to put a moldy apron on himself, nor would he want to put it on any resident.On 8/18/2025 at 1:19 PM, Staff 33 was told by Staff 2 (DNS) they did not have any more smoking aprons in the facility. The remaining smoking apron was covered in black mold stains. Staff 33 attempted to wipe down the moldy smoking apron with an alcohol-based wipe before placing it on Resident 21. After Staff 33 put the smoking apron on Resident 21 she/he stated, yep that smells like mold and alcohol. On 8/18/2025 at 1:22 PM, Staff 33 stated residents should not be wearing moldy smoking aprons. On 8/20/25 at 1:10 PM, Staff 30 (Maintenance Director) stated once he became aware, he replaced all of the smoking aprons. Staff 30 confirmed this was an infection control concern.