STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385251	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Hillsboro	650 SE Oak Street Hillsboro, OR 97123

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide necessary treatment to promote healing of pressure ulcers for 1 of 1 sampled resident (#92) reviewed for pressure ulcers. This failure resulted in worsening of Resident 92's pressure ulcers and subsequent hospitalization. Findings include: The facility's Pressure Injuries Overview and Wound Staging Skin Management policy dated 3/2020 included the following:Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device.Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed:- Definition or implementation of interventions that are not consistent with resident needs, resident goals, and processional standards of practice.- Monitoring or evaluation of the impact of the interventions.CMS Guidance and Staging:Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions).Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Resident 92 was admitted to the facility on [DATE] with diagnosis including Stage 2 pressure ulcers and was sent to the hospital on 2/27/26.The Admissions MDS with an ARD of 2/19/26 revealed Resident 92 had severe cognitive impairment. The resident had Stage 2 pressure ulcers present upon admission and required extensive assistance with ADLs. Resident 92's 2/13/26 Physician Orders included: Cleanse left buttock and coccyx (tailbone) with NS (normal saline), pat dry, apply foam dressing. Change daily on day shift and PRN for soilage. The order was discontinued on 2/23/26. Resident 92's 2/2026 TAR revealed the order was entered erroneously as PRN only. No wound care was provided on 2/14/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/20/26, 2/21/26, 2/22/26 and 2/23/26, for a total of 10 days. Resident 92's 2/23/26 Physician Orders included: Cleanse buttock and coccyx with wound cleanser, pat dry, apply skin prep to surrounding intact skin, cover wound with vashe (a professional-grade, hypochlorous acid wound cleanser) moistened gauze and cover with foam dressing, complete daily and PRN. The order was discontinued on 2/26/26. Resident 92's 2/2026 TAR revealed the resident received treatment on 2/24/26 and 2/25/26 but no evidence was found wound treatment was provided on 2/26/26. Resident 92's 2/26/26 Physician Orders included: Cleanse buttock and coccyx with wound cleanser, or NS and pat dry, apply vashe soaked to the wound bed and allow to sit for 15 minutes, dry the area and apply medi-honey (medical grade honey product) to the wound bed only, apply skin prep to surround intact skin and cover wound with adhesive bordered foam dressing (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	complete daily and PRN. Everyday shift and every two days. This order was discontinued on 3/2/26. Resident 92's 2/26/26 TAR through 3/2/26 revealed no wound care was completed on 2/26/26 or 2/27/26. A review of Resident 92's Wound Evaluations from 2/13/26 through 2/23/26 revealed the following information:- 2/13/26: the resident admitted with a Stage 2 pressure ulcer to the left buttock with partial thickness. The wound measured 3 cm by 2.5 cm. The wound had light amount of sanguineous (blood drainage), was red in color, no odor present, the wound bed was 100 percent epithelial (skin is healing and regenerating) and wound edges were attached. No pain was reported. - 2/13/26: the resident admitted with a Stage 2 pressure ulcer to the right side of coccyx with partial thickness. The wound measured 3 cm by 2.3 cm. The wound had light amount of sanguineous, was red in color, no odor present, the wound bed was 100 percent epithelial and wound edges were attached. No pain was reported. - 2/18/26: the left buttock wound measured 3.1 cm by 3.4 cm with partial thickness. The wound had light amount of sanguineous, was red in color, no odor present, the wound bed had granulation (new, highly vascular connective tissue that fills the base of an open wound) and slough (impediment, dead tissue), wound edges were attached, with the wound noted to have worsened and pain present. - 2/18/26: the right side of coccyx wound measured 0.3 cm by 0.4 cm with partial thickness. The wound had light amount of sanguineous, was red in color, no odor present, the wound bed had 90 percent granulation with 10 percent slough, wound edges were attached with the wound noted to be improved and pain present. - 2/23/26: the resident's two wounds had merged into one. The wound measured 5.5 cm by 6.5 cm with partial thickness. The wound had light serosanguineous (thin, watery, pale, red/pink drainage), was pink in color, no odor present, the wound bed had 60% granulation and 40% slough, wound edges were attached, with the wound noted to have worsen and pain present. A review of Resident 92's progress notes revealed the following:- From 2/13/26 through 2/21/26 and on 2/25/26 Resident 92's skin was documented as intact and no wounds present. - Physician Notes from Staff 41 (Physician's Assistant) indicated on 2/13/26 and 2/20/26 Resident 92 had a Left buttock stage 2 pressure ulcer measuring 3.1 by 3.3 cm with no depth. Small stage 2 pressure ulcer in right medial gluteal cleft. Coccyx (tailbone) area with blanchable discoloration, patient denies pain at this site.-Physician Note on 2/25/26 revealed wounds were not evaluated. - On 2/26/26, Staff 17 (LPN) expressed concerns for Resident 92's wound being a lot worse since it was last assessed. A review of Resident 92's provider notes on 2/27/26 revealed Staff 2 (DNS) and Staff 41 (Physician's Assistant) went to see Resident 92's wounds due to two nurse's notes expressing concern with her/his worsening wound. Staff 41's physical exam revealed the pressure ulcers had merged to a Stage 4 pressure ulcer approximately 5 cm round with depth at approximately 4 cm. There was a significant amount of stool present and packed into the ulcer with a foul odor and slough present. Staff 41 noted it was difficult to tell if there was active bleeding or purulent drainage given how dirty the wound was found and the bone was exposed. Given the severity of the ulcer, Resident 92 was sent to the hospital. On 5/11/26 at 10:47 AM, Staff 17 (LPN) stated she inputted Resident 92's orders from the provider on 2/13/26 and confirmed there were scheduled daily wound care orders and PRN. Staff 17 stated she was unsure why the scheduled daily orders were discontinued the same day they were inputted. Staff 17 stated she was directed to perform wound care based on orders reflected on the TAR and if the orders were not on the TAR, then she would not be alerted to provide wound care treatment. Staff 17 stated she recalled doing wound care, but confirmed she did not document the information. Staff 17 stated if there was no documentation of wound care being performed on the TAR, then there was no other way to confirm it was done. Staff 17 stated she did not know what made the resident's wound worsen so quick. On 5/11/26 at 11:07 AM, Witness 1 (Family Member) stated family were frequently with Resident 92 from the morning until evening each day. Witness 1 stated Resident 92 expressed pain, but was unsure if wound care was being provided. Witness 1 stated she/he trusted the facility to provide appropriate wound care to Resident 92. On 5/11/26 at 11:54 AM, Staff 20 (RN) stated he knew Resident 92 had a big wound, but could not recall performing wound care on her/him. He stated he would perform wound care based on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	orders, which were located on a Resident 92's TAR. Staff 20 stated if he provided wound care for Resident 92, he would notate it was completed on the TAR. On 5/11/26 at 11:56 AM, Staff 19 (RN) stated she could not recall Resident 92 had wound care orders and confirmed she did not perform wound care on Resident 92. She stated a resident's TAR would dictate whether or not she would need to perform wound care for Resident 92. She stated if she provided wound care to a resident, she would document on the TAR it was completed. On 5/11/26 at 12:06 PM, Staff 6 (LPN Care Manager) stated staff were directed to perform wound care based on the orders reflected on a resident's TAR. Staff 6 stated on 2/13/26, Resident 92's wound care orders for scheduled daily and PRN were deleted, and reentered incorrectly as only the PRN orders which were reflected on Resident 92's TAR. Staff 6 stated she expected staff to document on TAR when wound care was performed. Staff 6 stated if wound care was not documented on the TAR, then it was not clear it was done. Staff 6 stated when she saw Resident 92's wound on 2/23/26, she stated she was concerned because it did not look like it was getting better. On 5/11/26 at 12:24 PM, Staff 38 (Assistant DNS) stated staff were directed to perform wound care based on orders reflected on a resident's TAR. She stated staff were expected to document on the TAR any wound care completed for a resident, because if it was not documented then it was unclear if the wound care was completed. On 5/11/26 at 12:43 PM, Staff 41 (Physician's Assistant) stated she saw Resident 92's wounds on 2/13/26 and they were pretty small and not significant, and both wounds were a Stage 2. Staff 41 stated she ordered daily wound care and PRN. Staff 41 indicated on 2/23/26 she changed the orders based on staff noting in the clinical record the wound had worsened and she was not asked to come in to assess the wound. Staff 41 stated on 2/26/26, she received more concerns regarding Resident 92's wound worsening and on 2/27/26 when she entered Resident 92's room, there was a foul odor. Staff 41 stated when she saw Resident 92's wound, she was shocked. Staff 41 stated the left buttock and coccyx wound had merged into one wound, was bigger than when she last evaluated the wound on 2/13/26. Staff 41 stated the wound was a Stage 4 pressure ulcer, because she could see structures (the visible tissue types within a wound bed) and bone, and the wound had a significant amount of feces impacted inside of it. Staff 41 stated due to the severity of the wound, she had Resident 92 sent out to the hospital on 2/27/26. On 5/11/26 at 1:36 PM, Staff 2 (DNS) stated she expected staff to enter physician's orders correctly into their system. Staff 2 acknowledged Resident 92's wound worsened, acknowledged scheduled wound care effective 2/13/26 were discontinued erroneously and confirmed there were minimal entries on Resident 92's TAR indicating wound care was performed. Staff 2 stated she expected staff to document on the TAR when orders were performed for a resident. Staff 2 confirmed the wound worsened. The deficient practice was identified as Past Noncompliance based on the following:On 2/27/26, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a failure to follow physician's orders for wound care:a. On 2/27/26, the facility identified all residents with wounds and verified each were appropriately staged and wound care was accurate according to physician's orders.b. 3/2/26, education was provided to staff on order entry verification and the importance of repositioning.c. 3/9/26, education was provided to staff on proper wound staging and following provider's orders.d. 3/15/26, all care managers, Assistant DNS and DNS completed online comprehensive wound care certification course to enhance wound care knowledge. e. Implementation of a verification system to ensure orders are entered correctly.f. Ongoing audits with wound care, order entry and repositioning.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were adequately supervised and protected from avoidable accidents. Specifically, the facility failed to:(1) Ensure adequate supervision to prevent accidents for 1 of 4 sampled residents (#44), a severely cognitively impaired resident, who was left unsupervised in the community in a high-traffic, [NAME] area for an unknown period of time and was subsequently located and returned to the facility by law enforcement. This failure was determined to constitute an Immediate Jeopardy (IJ) situation, placing Resident #44 at risk of being struck by a motor vehicle, resulting in serious injury, serious harm, impairment, or death; and(2) Ensure accurate and updated care plans for 2 of 4 sampled residents (#s 3 and 47). Specifically, the facility failed to revise Resident 47's care plan following two elopement incidents and failed to implement care plan interventions related to multiple falls for Resident 3, placing both residents at risk for avoidable accidents. Findings Include: The facility's Wandering and Elopements policy, dated 11/2025, indicated the following: -If a resident went missing, the facility was to initiate the elopement/missing resident emergency procedure. The facility's, undated, Missing Resident Action Plan per the emergency preparedness plan, indicated when a resident went missing and was found, the facility would: -Arrange transportation for the resident back to the facility if needed. (1). Resident 44 was admitted to the facility in 10/2024 with diagnoses including cognitive impairment, right leg above the knee amputation, diabetes, dementia and epilepsy (a seizure disorder). Resident 44's 10/2024 Care Plan indicated the following: -The resident had a right leg above the knee amputation, was at moderate risk for falling and used a wheelchair for mobility. -The resident spoke primarily Spanish with limited English and required the use of an interpreter to communicate. -The resident had altered cognition. -The resident was hard-of-hearing. -The resident required one person assistance with transfers. -The resident was allowed to be outside, on the facility property only, independently. Resident 44's 1/17/26 Quarterly MDS revealed the resident had severely impaired cognition and used a wheelchair. The facility's 4/20/26 Significant Noncompliance Investigation revealed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-On 4/17/26, Resident 44 experienced a potential for major injury or death due to the resident leaving the facility unsupervised and being unable to find her/his way back. -On 4/17/26 at approximately 3:30 PM, Staff 33 (CMA) was driving back to the facility after completing a personal errand and saw Resident 44 on a busy arterial/commuter highway. Staff 33 parked her car and approached the resident. Resident 44 expressed that she/he had difficulty getting back to the facility due to the poor condition of the sidewalks, and had fallen. -Staff 33 contacted Staff 34 (Former Administrator) and spoke with her multiple times, with the aid of Staff 12 (Staffing Coordinator) who spoke fluent Spanish and provided interpretation assistance. Staff 34 instructed Staff 33 to leave Resident 44 and return to the facility. Staff 33 informed Staff 34 that Resident 44 requested help back to the facility and the resident reported she/he had fallen. Staff 33 was told under no circumstances was she allowed to push the resident back to the facility or take Resident 44 back to the facility in her car. Staff 33 confirmed with Staff 34 that she was to leave Resident 44 and was told the resident was allowed to be out, and since the resident chose to leave, she/he had to find her/his way back. -Staff 33 had Resident 44 turn her/his wheelchair in the direction of the facility, encouraged the resident to return to the facility and left Resident 44 on the busy street. -Staff 33 returned to the facility at approximately 3:40 PM. At approximately 3:45 PM, Staff 2 (DNS) and Staff 12 left the faciity on foot to look for Resident 44 and were unable to locate her/him and returned to the facility at approximately 5:00 PM. Upon return, Staff 34 informed Staff 2 and Staff 12 that Resident 44 was able to be independently outside and if the resident was not back by 8:00 PM, they were to contact the police. -At approximately 5:15 PM, the facility received a call from the police stating Resident 44 was at the police station and was lost. -Resident 44 was brought back to the facility by her/his daughter around 5:40 PM, uninjured. -Resident 44 was last seen at approximately 2:15 PM, inside the facility. -The investigation substantiated neglect due to Staff 34 instructing Staff 33 to not assist Resident 44 to return to the facility. -Staff 34 was terminated. A review of Resident 44's health record found no documented evidence the resident was assessed to be safe to leave the facility premises or be in the community in a high traffic area, without supervision. On 5/5/26 at 11:45 AM, Staff 40 (CNA) stated Resident 44 spoke primarily Spanish and was very confused and thought her/his meal tickets were money and tried to pay staff using her/his meal tickets. On 5/5/26 at 2:18 PM, Staff 3 (Regional Director of Operations) stated Resident 44 was care planned to go outside, independently, but was not allowed to leave the facility premises because she/he had a BIMS of four which indicated severe cognitive impairment. On 4/17/26, Resident 44 was found by (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Staff 33, far from the facility, on her/his way to the store. Resident 44 asked Staff 33 to help her/him get back to the facility because the resident had difficulty navigating the sidewalk due to the poor condition of the sidewalks. Staff 33 contacted Staff 34 and was instructed to return to the facility and it was ok for Resident 44 to be off facility premises and to leave the resident where she/he was at. Staff 33 returned to the facility. Staff 3 stated Staff 2 and Staff 12 decided to walk to where Staff 33 had last seen Resident 44, but the resident was no longer there. Staff 2 and Staff 12 walked and walked and finally returned to the facility, unable to locate Resident 44. Other staff also looked for Resident 44 but were unable to locate her/him. Staff 3 further stated Staff 2 and Staff 12 were then instructed by Staff 34 to contact the police if Resident 44 did not return to the facility by 8:00 PM (three hours later). Not long after that, the police contacted the facility and reported they had Resident 44 at the police station because she/he was lost. Staff 34 was later terminated. On 5/6/26 at 9:38 AM, Staff 34 stated on 4/17/26, she received a phone call from Staff 33 who reported she had run into Resident 44 at a nearby store. Resident 44 told Staff 33 the sidewalks were difficult to navigate and asked Staff 33 to push her/him back to the facility. Staff 34 stated it was her understanding that Resident 44 was not asking for help but wanted to be pushed back to the facility so she told Staff 33 it was not best practice, due to safety concerns for both Staff 33 and Resident 44. Staff 34 stated if the resident needed assistance, Staff 33 should call 911. Staff 34 stated about one hour later, Staff 2 and Staff 12 told her Resident 44 was not back and they were going to go look for her/him. Staff 34 stated she told Staff 2 and Staff 12; it was the resident's right to be off the premises since she/he was care planned to leave the facility and they were making assumptions that something was wrong. Staff 2 and Staff 12 returned about an hour later; unable to locate the resident. Staff 2 and Staff 12 asked what the next steps were and Staff 34 instructed them to wait an hour and a half and if Resident 44 did not return by then, staff were to initiate the elopement protocol. Staff 34 reported about 20 minutes later, she was informed the facility received a call from the police department and Resident 44 was at the police station and was lost. On 5/6/26 at 10:18 AM, Staff 33 stated on 4/17/26, she was doing a double and had to pick up her daughter from school. At about 3:30 PM, she was returning to the facility and saw Resident 44 on a busy street, away from the facility. Staff 33 stated she was not sure if Resident 44 should be there because she/he was confused at baseline, so she parked her car and approached Resident 44. Staff 33 called Staff 12 and was told as far as she knew, Resident 44 could be out there. Staff 33 stated Resident 44 told her she/he was going to the store, which was at least another half mile away, so she encouraged Resident 44 to turn around and go back to the facility. Staff 33 stated while on the phone with Staff 12, Staff 12 went to ask, and was told it was ok for Resident 44 to be out there. Staff 33 stated she hung up with Staff 12 but then Resident 44 asked her to walk beside her/him and told her she/he had fallen, pointing to where the sidewalk went down. Staff 33 called back Staff 12 and reported to her that it was not safe for Resident 44 to be out there. Staff 12 stated it was Resident 44's right to be out here so Staff 33 asked to speak to Staff 34, again. Staff 33 told Staff 34 that Resident 44 was on a very busy street and Staff 33 was told under no circumstances was she allowed to touch Resident 44 because it was her/his right to leave the facility and if she/he wanted to leave the facility, she/he had to get herself/himself back. Staff 33 told Staff 34 that Resident 44 reported she/he fell and asked if she could bring Resident 44 back and was, again, told no by Staff 34. Staff 33 stated she did not think Resident 44 was safe to be out in the community, alone, which is why she contacted Staff 34 for direction. Staff 33 stated when she returned to the facility she was really upset because she did not want Resident 44 to get hurt and the resident was left on a very busy street. Staff 33 then spoke to Staff 2 and Staff 12 who went looking for the resident but were unable to locate her/him. Staff 33 stated she was not instructed by Staff 34, at any time, to contact 911 and she was told to leave Resident 44 where she/he was and return to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/6/26 at 10:40 AM, Staff 7 (LPN-Resident Care Manager) stated on 4/17/26, she was contacted by Staff 2 to come to the facility to help interpret and complete an assessment on Resident 44 after she/he returned from being lost in the community. Staff 7 completed a full head-to-toe assessment and Resident 44 had no injuries. Staff 7 stated Resident 44 was unable to remember any details regarding being lost. On 5/6/26 at 11:37 AM, Staff 12 stated on 4/17/26 around three something she received a phone call from Staff 33 who found Resident 44 out in the community. Staff 12 reported she went to find Staff 2 and Staff 34. Staff 12 handed the phone to Staff 34 and walked away while Staff 34 and Staff 33 spoke. Staff 34 handed the phone back to Staff 12 once the phone call ended. A few minutes later, Staff 33 called back asking what she should do about Resident 44 because Staff 34 told her to leave the resident where she/he was and she did not feel it was safe. Staff 33 spoke with Staff 34, again, and was told Resident 44 could not get into Staff 33's car so Staff 12 conveyed the information in Spanish to Resident 44 and asked the resident if she/he felt safe getting back to the facility which Resident 44 responded, yes. Around 3:35 PM, Staff 33 returned to the facility. According to Staff 12, around 3:40 PM to 3:45 PM, Staff 2 and Staff 12 decided to look for Resident 44 but were unable to find her/him and returned back to the facility around 5:00 PM. Staff 2 and Staff 12 asked Staff 34 what they should do next and were instructed to contact the police if Resident 44 did not return to the facility by 8:00 PM. On 5/6/26 at 1:20 PM, Staff 4 (Regional Director of Quality Assurance) stated she was contacted by Staff 34 around 5:00 PM on 4/17/26 and was told Staff 34 was initiating an elopement protocol and risk management for Resident 44 who was found lost in the community. Staff 4 stated over the weekend (4/18/26 or 4/19/26) an anonymous caller reported the whole scene to the company's fraud and abuse hotline. Staff 4 stated her and Staff 3 went to the facility on 4/20/26 and suspended Staff 2 and Staff 34 until an investigation was completed. Staff 4 stated as soon as she realized Resident 44 had a BIMS score of four, she knew the resident was not supposed to be out in the community by herself/himself, unsupervised. Staff 4 reported this was a huge safety concern for Resident 44 and a liability for the facility. Staff 4 stated Staff 34 was terminated. On 5/8/26 at 9:20 AM, 9:26 AM and 10:09 AM, Staff 29 (CNA), Staff 47 (CNA) and Staff 14 (Social Services Coordinator) stated Resident 44 spoke mainly Spanish, was hard of hearing, was confused and her/his thoughts did not always make sense. Staff reported the resident required an interpreter, and even with an interpreter, had difficulties holding a conversation and remembering information. On 5/11/26 at 9:55 AM, Staff 1 (Administrator), Staff 2 and Staff 4 stated Resident 44 should have been brought back to the facility and not left alone when found off the facility premises. Staff 4 stated Staff 34 had a duty to instruct Staff 33 to assist Resident 44 back to the facility and Resident 44 should not have been left unsupervised in the community. On 5/7/26 at 2:19 PM the facility was notified that the deficient practice constituted an IJ. An IJ removal plan was requested. On 5/7/26 at 5:10 PM the IJ removal plan was approved and the facility provided documentation which indicated the facility previously identified and corrected the deficient practice. The corrective measures included: On 4/22/26, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined there was deficiency in leaving cognitively impaired residents out in the community, unsupervised. The Plan of Correction included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	a. Resident 44 received a complete head to toe assessment, was placed on alert monitoring, was added to the Code Pink binder, a Wander Guard (a specialized, electronic wander management system) was placed on the resident's wheelchair, and her/his care plan was updated with her/his elopement risk. b. An updated BIMS and Elopement Risk Assessment was completed on all residents and care plans were updated. c. The Code Pink binder was updated. d. Staff 34 was terminated on 4/22/26. e. Staff were in-serviced on ensuring adequate supervision for residents with cognitive impairments for community outings.f. Monitoring and audits of the implemented system were performed to ensure correction. (2). Resident 47 was admitted to the facility in 5/2025 with diagnoses including lower extremity amputation, traumatic brain injury and mild cognitive impairments. The 5/8/25 Care Plan revised on 6/6/25 Indicated Resident 47 was at risk for elopement related to a known attempt to leave the facility to withdraw money and had mild cognitive impairment. Interventions included completion of elopement evaluation upon admit, with a significant change of condition and as needed. Determine reasons for wanting to leave and develop activity plan and interventions. Evaluate for acute condition: infection, alteration in blood sugar and implement CODE Pink Protocol. A 6/6/25 Alert Chart Note at 11:15 AM revealed Resident 47 was found outside by Staff 46 (Occupational Therapist) under the car port out front. Brought back inside and was educated on letting the staff know when she/he was going to go outside. The resident stated she/he wanted to go to the bank and get money. A 6/6/25 Nursing Note at 7:39 PM revealed the resident Feels like [she/he] was being held against [her/his] will. Staff discussed with the resident and asked why she/he felt that way. The resident wished to go to the bank and get money. Staff discussed the importance of her/him going with someone due to not wanting the resident to get lost or be alone outside of the facility. The DNS and Administrator were notified. A 6/6/25 Elopement Risk Evaluation and Code Pink document were completed and revealed the following: -Resident 47 was considered low risk for wandering. -Know trends was front door. -Resident 47 stated I am escaping, I want to go home, and I am not staying here forever. -Resident 47 indicated she/he wanted to go to the bank or ATM for money. No evidence was found in the resident's clinical record indicating that the care plan interventions had been revised or updated to address or mitigate the resident's urge to leave the facility. A 9/10/25 Significant Noncompliance Investigation regarding Resident 47's elopement revealed the following: -Resident 47 was last seen in the facility on 9/10/25 between 4:00 PM and 4:30 PM by Staff 44 (CMA). Resident 47 was unable to be found by Staff 42 (LPN) on two attempts for blood sugar (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385251	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of Hillsboro	650 SE Oak Street Hillsboro, OR 97123

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	checks. -On 9/10/25 at 5:00 PM a call was received from a hospital reporting Resident 47 was found at the bank and had fallen out of her/his wheelchair. Was in the emergency room for further evaluation due to the fall. -A 9/10/25 Emergency Department Provider Record reported Resident 47 was found after a fall out of her/his wheelchair on the way to a bank. As a result of the fall, Resident 47 experienced a 3 cm in length by 3 mm deep laceration on her/his amputated left lower extremity at an amputation site. Four sutures were used to close Resident 47's laceration as result of the fall. -On 9/11/25 an Elopement Risk Evaluation was completed and determined Resident 47 to be a moderate risk for elopement related to known attempts to leave the facility to withdraw money at the bank. Staff were to complete Elopement evaluation upon admit, quarterly, with a significant change of condition and as needed. Determine reasons for wanting to leave and develop activity plan/interventions, implement CODE Pink Protocol. No evidence was found in the resident's clinical record indicating that the care plan interventions had been revised or updated to address or mitigate the resident's urge to leave the facility. Attempts to interview Staff 42 regarding Resident 47's 9/10/26 elopement were made on 5/6/26 and 5/7/26 but were unsuccessful. On 5/6/26 at 10:06 AM Staff 13 (Social Services Director) stated Resident 47 was confused and experienced anxiety about wanting to go to the bank to pay her/his rent. Staff 13 stated was aware of the two elopements, and the resident was at risk for wandering with the focus on going to the bank. On 5/6/26 at 10:32 AM Resident 47 stated My memory is shot. The resident stated she/he remembered wanting to go to the bank and was concerned she/he would be kicked out of the facility for not paying her/his bills. On 5/6/26 at 12:58 PM Staff 19 (RN) stated Resident 47 had short-term memory loss and forgot things easily. Staff 19 stated It's an everyday conversation about the bank. Staff 19 stated the resident spent most of her/his time in the facility and to her knowledge, had never asked to go outside but was at risk for wandering with the focus on going to the bank. On 5/6/26 at 3:28 PM Staff 45 (CNA) stated Resident 47 was verbally aggressive, tired of being at the facility and wandered throughout the facility but did not go outside often. Staff 45 stated she recalled her/him wanting to go to the bank and the resident was not present during dinner time. Staff 45 stated she believed the resident was not supposed leave the facility without a staff person present. On 5/7/25 at 11:05 AM Staff 6 (LPN-Resident Care Manager) stated on 6/6/25 Resident 47 was found by Staff 46 outside of the facility attempting to go to the bank and required redirection from Staff 46 to return to the facility. Staff 6 stated an elopement risk assessment was completed on Resident 47 on 6/6/25 after the elopement and was incorrectly scored. Staff 6 stated the section regarding a history of elopements should have been marked which would have resulted in Resident 47's elopement risk to be moderate instead of low. Staff 6 stated care plans were to be updated to reflect Resident 47 elopement risks. Staff 6 confirmed Resident 47 eloped from the facility on 9/10/25 with an attempt to go to the bank alone and fell out of her/his wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/8/26 at 2:30 PM, Staff 44 (CMA) stated she was aware Resident 47 was at risk for wandering and elopement. She reported on 9/10/25, while she was working, Resident 47 could not be located. Staff 44 stated during the facility's search for the resident, she received a call from a hospital informing her Resident 47 had fallen, sustained an injury, and required emergency care. On 5/11/26 at 1:46 PM Staff 1 (Administrator) and Staff 2 (DNS) confirmed Resident 47 was at risk for elopement upon admission, exited the facility unsupervised on 6/6/25, and again on 9/10/25 which resulted in a fall. On 9/30/25, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined there was deficiency in monitoring residents for elopement. The Plan of Correction included: a. Staff were educated on how to identify residents at risk for elopement which included pink tape on the back of resident wheelchairs, b. Elopement risk assessments were completed on all residents and that information was available in a binder, c. A Wander Guard system was installed to alert staff of an attempted elopement which included setting off an alarm and doors becoming closed and locked, d. Monitoring and audits of the implemented system were performed to ensure correction. (3). Resident 3 was admitted to facility in 2/2026 with a diagnosis of facial weakness following cerebral infarction. The Admissions MDS with an ARD of 2/19/26 revealed Resident 3 had a BIMS score of 5, which indicated the resident had severe cognitive impairment. The resident had multiple falls in the last six months. A review of Resident 3's clinical record revealed the resident had a fall with injury on 2/12/26 and two non-injury falls on 2/12/26 and 2/16/26. A review of Resident 3's care plan effective 2/13/26 identified the resident as a fall risk and interventions included to not leave the resident unsupervised in her/his bathroom. The care plan was revised on 2/16/26 which included interventions to not leave the resident alone in her/his room while up in wheelchair. A review of Resident 3's Fall Investigation from 2/27/26 revealed the resident was left alone in her/his room with the door closed during a fire drill. The resident attempted to transfer, which resulted in a non-injury fall. Observations on 5/5/26 at 12:46 PM and 5/6/26 at 8:35 AM revealed Resident 3 out in the common area near the 300 Hall nurse's station. On 5/8/26 at 11:52 AM, Staff 39 (CNA) stated Resident 3 was known to get up on her/his own and attempt to walk. She stated the resident stayed in the common areas in order for staff to have eyes on her/him, due to the resident's history of falling and impulse to get up. Staff 39 stated Resident 3 was a fall risk, required supervision and was not to be left alone in her/his room during a fire drill. On 5/8/26 at 12:19 PM, Staff 40 (CNA) and at 12:25 PM, Staff 27 (CNA) stated during a fire drill, residents who were identified as fall risks were to be kept in a common area for staff to supervise them and should not be left alone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/8/26 at 12:38 PM, Staff 17 (LPN) stated Resident 3 was left in her/his room with the door closed on 2/27/26 during a fire drill and confirmed the resident had a non-injury fall. She stated during a fire drill, Resident 3 was not to be left alone in her/his room and required supervision. On 5/8/26 at 12:48 PM, Staff 18 (LPN) stated during a fire drill the protocol was to direct residents back to their rooms with the door closed. Staff 18 stated the residents who required supervision or were at risk for falls were to be kept close to staff. She stated if the residents wanted to stay in their rooms, staff were to be in the room with them. On 5/11/26 at 9:08 AM, Staff 2 (DNS) stated during the fire drill on 2/27/26, Staff 34 (Former Administrator) was the person who kept Resident 3 in her/his room with the door closed. Staff 2 acknowledged Resident 3's care plan interventions included not to leave her/him alone in a room, the resident had a non-injury fall while she/he was in the room and stated it was inappropriate to have the resident in the room by her/himself. On 5/11/26 at 9:59 AM, Staff 20 (RN) stated during the fire drill on 2/27/26, Staff 34 (Former Administrator) instructed him to place Resident 3 in her/his room and to shut the door. Staff 20 stated he did not agree with Staff 34 and asked if the resident could stay with him, but after a short conversation of disagreement Staff 20 followed Staff 34's order and placed Resident 3 in her/his room and shut the door. The deficient practice was identified as Past Noncompliance based on the following:On 3/2/26, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and determined there was a deficiency in leaving residents identified as a fall risk alone in a room during safety drills:a. Staff 34 was educated on 2/28/26.b. The resident's care plan was updated on 3/2/26 to include a staff member to remain with resident during safety drills.c. Staff interviewed had a good understanding of how to keep residents identified as fall risks safe during fire drills.