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 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. (continued on next page)

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

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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.	-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: -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. (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 5/5/26 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 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 (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.	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. 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 (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.	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: 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. (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.	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 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. (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 5/7/25 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. 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. (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 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. 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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 rooms and bathrooms were free from damages and use of garbage bags as pull cords for 21 out of 55 sampled resident rooms (Room #s 202, 203, 204, 205, 206, 207, 208, 210, 212, 214, 501, 502, 504, 505, 506, 507, 508, 509, 510, 511, and 513) and 2 of 4 sampled residents (#s 8 and 75) reviewed for environment. This placed residents at risk for an unhomelike environment. Findings include:The facility's 12/2009 Maintenance Service policy instructed the facility's maintenance personnel to maintain the building in compliance with current federal, state, and local laws, regulations, and guidelines as well as to maintain the building in good repair and free from hazards. The facility's 2/2021 Homelike Environment policy instructed the facility to ensure a clean, sanitary, and orderly environment for the facility. 1. On [DATE] at 11:34 AM Resident room [ROOM NUMBER] was observed to have multiple areas of damage to the floor: - A crack raised about one quarter of an inch, approximately four feet long running parallel with the door frame. In front of the raised crack was a four-inch by three-inch spot of missing flooring with exposed subfloor. - A three-foot-long scratch crossing perpendicularly to the raised crack had the subfloor visible. - Multiple divots and gouges were observed in the flooring around each of the four legs of the bed, some of which exposed the subfloor and the rest had dark staining and debris visible. - Other scratches observed to have dark staining and debris visible in them. On [DATE] at 10:48 AM three of five Resident Council Members expressed concerns over the state of the floors in resident rooms, stating the floors looked terrible and suggested the facility cut out the damage sections at least until they replaced the whole floors. On [DATE] at 11:34 AM Staff 11 (Maintenance Director) stated room [ROOM NUMBER] was one of the worst rooms of the facility for floor damage and intended to level the floor but had not scheduled the repair yet. He also stated he was told the carpet from the hallways were going to be replaced, but was unsure when this would occur, and acknowledged multiple resident rooms needed to be replaced as well. 2. On [DATE] between 8:12 AM and 9:16 AM a tour of the facility revealed 22 resident rooms had multiple damages to the flooring, which included a combination of the below listed damages: - Circular and square shaped gouges (circular, arched, and square shaped) located around where the four legs of the bed had been pressed into the floor when locking the bed in place. Most of these gouges exposed the subfloor or had a buildup of a dark material in them. - Flooring seams that were separated apart, which exposed one quarter to one half of an inch wide by as much as 36 inches long of subflooring. (continued on next page)

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	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Deep enough scratches that the subfloor was exposed and dark staining had built up in them. Some of the scratches were a few inches long and others were over a foot in length. - One resident room and one shower room were missing transition strips. One resident room had a transition strip that had begun to lift, which was a potential trip hazard. - One or more areas of exposed subfloor due to missing flooring material. One of rooms, the missing portion of flooring was approximately 4 feet by 2 feet jaggedly around the toilet (shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]). - The flooring under the toilet in the shared resident bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] was observed to have a different texture than the rest of the flooring as it was discolored and felt dry, leathery, and porous and the room had a strong urine-like odor with no visible signs of urine present. On [DATE] at 9:40 AM Staff 1 (Administrator) and Staff 11 entered each of the 22 rooms and confirmed the damages and acknowledged the flooring needed to be repaired. Staff 1 stated plans on repairing the floors in resident rooms were paused due to plumbing issues that started in [DATE] which required emergent attention. At 12:39 PM Staff 1 provided copies of bids completed on [DATE] and [DATE] both bids were expired one on [DATE] and the other on [DATE]. Review of the bids revealed multiple rooms were not included in the bids from the 200 hall and none of the rooms in the 500 hall. 3. Resident 8 was admitted to facility in 3/2026 with diagnosis of urinary tract infection. The Admissions MDS with an ARD of [DATE] revealed Resident 8 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Observations on [DATE] at 10:17 AM, [DATE] at 12:17 PM and [DATE] at 8:20 AM revealed Resident 8's light cord was made of a piece of cloth and plastic trash bag. On [DATE] at 11:06 AM, Staff 36 and at 3:29 PM, Staff 32 (CNA) stated if residents couldn't reach a light cord, the protocol was to input the issues into TELS, which was an electronic messaging system where environmental issues could be reported to the Maintenance Director. Staff 36 and Staff 32 stated it took time for maintenance issues to be resolved. On [DATE] at 3:37 PM, Staff 37 (RN) stated if a resident couldn't reach their light cord, she would let maintenance know by leaving a note in the message box by their office. On [DATE] at 3:46 PM, Staff 11 (Maintenance Director) stated work orders for residents took priority when managing his work for the day. Staff 11 stated he received work orders based on staff submitting issues in TELS. Staff 11 stated when a resident discharged from the facility, housekeeping informed him of any issues that needed to be fixed prior to another resident moving into the room. At 3:58 PM, he confirmed Resident 8 had a trash bag and cloth as a pull cord for her/his light and stated it didn't look good and was not homelike. Staff 11 stated he had plenty of pull cords in stock and the issue was easily replaced. On [DATE] at 4:29 PM, Staff 1 (Administrator) and Staff 3 (Regional Director of Operations) acknowledged the plastic bags tied to the light cord and Staff 1 stated it was not homelike for (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. Staff 1 and Staff 3 stated they expected for staff to notify maintenance via TELS when residents have issues with their environment. 4. Resident 75 was admitted to facility in 3/2023 with diagnosis of local infection of the skin and subcutaneous tissue (deepest layer of skin). The Admissions MDS with an ARD of [DATE] revealed Resident 75 had a BIMS score of 15, which indicated the resident was cognitively intact. Observations on [DATE] at 10:37 AM, [DATE] at 11:49 AM and [DATE] at 9:15 AM revealed Resident 75's light cord was made of a plastic trash bag. On [DATE] at 10:37 AM, Resident 75 stated the plastic bag was brought to her/him when she/he could not reach the light cord. Resident 75 stated she/he did not know there were actual light cords to replace it and would rather have the real one. Resident 75 stated staff had just tied a bag to the short light cord so she/he could reach it. On [DATE] at 11:06 AM, Staff 36 and at 3:29 PM, Staff 32 (CNA) stated if residents couldn't reach a light cord, the protocol was to input the issues into TELS, which was an electronic messaging system where environmental issues could be reported to the Maintenance Director. Staff 36 and Staff 32 stated it took time for maintenance issues to be resolved. On [DATE] at 3:37 PM, Staff 37 (RN) stated if a resident couldn't reach their light cord, she would let maintenance know by leaving a note in the message box by their office. On [DATE] at 3:46 PM, Staff 11 (Maintenance Director) stated work orders for residents took priority when managing his work for the day. Staff 11 stated he received work orders based on staff submitting issues in TELS. Staff 11 stated when a resident discharged from the facility, housekeeping informed him of any issues that needed to be fixed prior to another resident moving into the room. At 3:58 PM, he confirmed Resident 75 had a trash bag as a pull cord for her/his light and stated it didn't look good and was not homelike. Staff 11 stated he had plenty of pull cords in stock and the issue was easily replaced. On [DATE] at 4:29 PM, Staff 1 (Administrator) and Staff 3 (Regional Director of Operations) acknowledged the plastic bags tied to the light cord and Staff 1 stated it was not homelike for residents. Staff 1 and Staff 3 stated they expected for staff to notify maintenance via TELS when residents have issues with their environment.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review it was determined the facility failed to ensure resident care was provided in a manner that maintained and promoted dignity for 1 of 1 sampled resident (#10) reviewed for dignity. This placed residents at risk for receiving care that did not promote their dignity. Findings include:Resident 10 admitted to the facility in 7/2025 with diagnoses including diabetes and dementia.Resident 10's 4/20/26 quarterly MDS indicated the resident had a BIMS of 3, which indicated severe cognitive impairment.1. On 5/4/26 at 12:15 PM Staff 35 (LPN) performed a CBG check on Resident 10 in the dining room. Resident 10 required an insulin injection. At 12:19 PM Staff 35 raised the resident's shirt and administered the insulin into her/his abdomen in the dining room. Both incidents were conducted without Resident 10's permission to allow Staff 35 to complete the CBG check and insulin administration in the dining room. There were eleven residents and one family member present in the dining room.On 5/4/26 at 12:25 PM Staff 35 confirmed he did not ask permission from Resident 10 to do the CBG check and insulin injection in the dining room with other individuals present. On 5/4/26 at 2:06 PM Resident 10 stated she/he preferred to have her/his insulin administered in a private space.On 5/6/26 at 10:50 AM Witness 3 (Family Member) stated Resident 10 was very modest all her/his life and would want the CBG testing and insulin injections completed in private.On 5/8/26 at 10:00 AM Staff 2 (DNS) confirmed Staff 35 should have asked Resident 10 to go to a private area for the CBG check and insulin injection and not complete those cares in front of other people.2. On 5/6/26 at 10:08 AM Witness 4 (Phlebotomist [person who draws blood for testing]) was observed drawing blood from Resident 10's left arm while she/he was in the dining room with three other residents. Witness 4 obtained Resident 10's blood without offering to take her/him to a private area. On 5/6/26 at 10:11 AM Witness 4 stated she typically drew blood from residents in the dining room. Witness 4 stated she had asked Resident 10 for permission to draw Resident 10's blood but had not asked the other residents if they were okay with being present. On 5/6/26 at 10:14 AM Staff 25 (CNA) stated he observed Witness 4 completing the blood draw without asking Resident 10's permission to complete the blood draw in the dining room. He stated drawing blood, CBG checks, and injections were supposed to be completed in rooms. Staff 25 stated he did not stop her but had intended to speak with her afterwards.On 5/6/26 at 11:11 AM Resident 10 stated she/he was not comfortable having her/his blood drawn in the dining room.On 5/6/26 at 10:50 AM Witness 3 (Family Member) stated Resident 10 was very modest all her/his life and would want her/his blood drawn in private.On 5/8/26 at 7:35 AM Witness 5 (Lab Supervisor) and Witness 6 (Phlebotomist Supervisor) stated the laboratory's policy was to have their phlebotomists draw blood from residents in resident rooms, not in the dining room with others present, due to sanitary concerns and to protect the resident's privacy. On 5/8/26 at 10:00 AM Staff 2 (DNS) confirmed Witness 3 should not have drawn blood from Resident 10 in the dining room and the resident should have been assisted to her/his room should have been assisted to her/his room.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review it was determined the facility failed to promote self-determination for 1 of 3 sampled residents (#30) reviewed for choices. This placed residents at risk for lack of honoring choices and care preferences. Findings include: The facility's 10/2025 Dignity Policy indicated resident goals, choices, preferences, values and beliefs were respected and honored to the extent possible, which began with the initial admission and continued throughout the resident's facility stay. Resident 30 was admitted to the facility in 5/2025 with diagnoses including depression. The facility's 12/31/25 CNA Assignment Restrictions Form did not indicate Staff 32 (CNA) could not provide assistance to Resident 30. Resident 30's 2/22/26 Quarterly MDS revealed the resident was cognitively intact and required substantial-to-maximal assistance from staff to bathe. Resident 30's 5/2026 ADL Care Plan revealed the resident required physical assistance from one staff with bathing. Resident 30's 5/2026 Shower Task Log revealed Staff 32 assisted the resident with a shower on 5/4/26.On 5/4/26 at 10:53 AM and 5/8/26 at 10:20 AM, Resident 30 was observed in her/his wheelchair in her/his room. Resident 30 stated she/he asked several times to not have Staff 32 assist her/him with showers because Staff 32 did not wash her/his left side thoroughly but continued to receive assistance from Staff 32 with showers. Resident 30 further stated her/his scheduled shower days were the hardest days of the week for her/him because she/he never knew who was going to provide shower assistance and if her/his preferences would be honored. On 5/8/26 at 10:02 AM, Staff 13 (Social Services Director) stated she informed Staff 2 (DNS) of resident care preferences as soon as she was made aware of them, but Staff 2's response was for residents to tough it out. Staff 13 stated care preferences should be prioritized for Resident 30 because routine was really important to her/his overall well-being. Staff 13 stated she was unaware of the resident's preference to not receive assistance from Staff 32 until 5/8/26. On 5/8/26 at 10:41 AM, Staff 27 (CNA) stated she was not aware of Resident 30's care preferences but was aware that showers were stressful for the resident, and new staff or those staff unfamiliar with her/his routine, could cause the resident to have anxiety or be upsetOn 5/8/26 at 10:58 AM, Staff 26 (CNA) stated Resident 30 did not like to receive assistance from Staff 32 with showers, but Staff 32 still got assigned to [her/him] a lot. Staff 26 stated she did not know why Staff 32 continued to be assigned to assist Resident 30 in spite of the resident's known preference. On 5/8/26 at 12:43 PM, Staff 32 stated she was assigned to assist Resident 30 weekly, which included providing assistance with showers. Staff 32 stated she was aware Resident 30 preferred other male CNAs to help instead of me and confirmed she assisted Resident 30 with a shower on 5/4/26. On 5/11/26 at 12:25 PM, Staff 12 (Staffing Coordinator) stated she was aware of Resident 30's preference to not receive care or showers from Staff 32, and Staff 2 was responsible for updating the CNA Assignment Restrictions Form.On 5/8/26 at 12:01 PM, Staff 2 stated the facility maintained a CNA Assignment Restrictions Form in order to accommodate resident care preferences, and she was responsible to keep the form updated. Staff 2 stated she was aware Resident 30 did not like to receive assistance from Staff 32 with showers. Staff 2 confirmed the preference form had not been updated to include the resident's current preferences, the resident continued to receive showers from Staff 32 despite her/his expressed preference not to and there was no reason her/his shower preferences could not be accommodated.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notifications to 2 of 3 sampled residents (#s 67 and 100) reviewed for Beneficiary Notification. This placed residents and their representatives at risk for unknown financial liabilities. Findings include:1. Resident 67 was admitted to the facility on [DATE] with Medicare Part A benefits.A 4/15/26 NOMNC (Notice of Medicare Non-Coverage) indicated the Resident 67's Medicare Part A benefits ended on 4/17/26. A review of Resident 67's health record indicated the resident remained in the facility and was financially responsible for her/his care from 4/18/26 through 4/20/26. There was no documentation indicating the SNF ABN notification was provided to Resident 67 or their representative to inform them of the resident's daily out-of-pocket expenses.On 5/5 26 at 1:14 PM Staff 13 (Social Services Director) stated they did not provide the SNF ABN form to Resident 67 or their representative. On 5/5/26 at 2:20 PM Staff 1 (Administrator) acknowledged Resident 67 was not provided with the SNF ABN form. Staff 1 stated their expectation was residents or their representatives were informed of the resident's daily out-of-pocket costs using an SNF ABN notification form.2. Resident 100 was admitted to the facility on [DATE] with Medicare Part A benefits. A 3/13/26 NOMNC (Notice of Medicare Non-Coverage) indicated Resident 100's Medicare Part A benefits ended on 3/15/26. A review of Resident 100's health record indicated the resident remained in the facility and was financially responsible for her/his care from 3/16/26 through 3/17/26. There was no documentation indicating the SNF ABN notification was provided to Resident 100 or their representative to inform them of the resident's daily out-of-pocket expenses.On 5/5 26 at 1:14 PM Staff 13 (Social Services Director) stated they did not provide the SNF ABN form to Resident 100 or their representative. On 5/5/26 at 2:20 PM Staff 1 (Administrator) acknowledged Resident 100 was not provided with the SNF ABN form. Staff 1 stated their expectation was residents or their representatives were informed of the resident's daily out-of-pocket costs using an SNF ABN notification form.

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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. Based on interview and record review it was determined the facility failed to provide a bed hold policy to 1 of 1 resident (#89) reviewed for hospitalization. This placed residents at risk for miscommunication of the discharge process. Findings include:The facility's Bed Hold and Return Policy dated 10/2022 states all residents/representatives were provided written information regarding the facility and state be hold policies, which address holding or reserving a resident's bed during periods of absence. Residents were to be provided written notice about these policies at least twice. First, was upon admission to the facility. Second, was at the time of transfer or within 24 hours if the transfer was an emergency.A 2/11/26 at 10:14 AM Progress Note indicated Resident 89 was assessed by Staff 17 (LPN) and determined to require transfer to the hospital due to a change of condition. Resident 89 was not provided a physical copy of the facility's bed hold policy on or after 2/11/26. On 5/8/26 at 8:47 AM Staff 17 confirmed she assessed Resident 89 on 2/11/26. She stated the process involved when a resident was transferred to the hospital did not include providing the resident with information about the facility's bed-hold policy. Staff 17 stated she was unaware she needed to provide resident with the bed-hold policy information when a resident was transferred to the hospital.On 5/8/26 at 9:27 AM Staff 6 (LPN-Resident Care Manager) stated residents were provided bed-hold policy information upon admission but not when they were discharged to the hospital and expected to return. She stated she was unaware residents needed to receive the bedˆhold policy at the time of transfer.On 5/8/26 at 9:33 AM Staff 2 (DNS) confirmed Resident 89 was not provided the bed-hold policy when she/he discharged to the hospital on 2/11/26.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review it was determined the facility failed to provide meaningful activities for dependent residents for 1 of 1 sampled resident (#44) reviewed for activities. This placed residents at risk for lack of social interaction, boredom and isolation. Findings include: The facility's Activity Program policy, dated 11/2025, indicated the following: -The activities program was to support the well-being of residents and to encourage both independence and community interaction. -Activities offered were based on the comprehensive resident-centered assessment and the preferences of each resident. -The activities program was ongoing and included facility-organized group activities, independent individual activities and assisted individual activities. -Activity programs were designed to encourage maximum individual participation and were geared to the individual resident's needs. 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 Activity Profile indicated the resident spoke Spanish with minimal English, used to own a dog and enjoyed gardening, watching TV and religious studies. Resident 44's 10/2024 activity care plan indicated Resident 44's interests included gardening, watching TV and religious study. Resident 44 preferred independent or self-directed activities and she/he enjoyed being outside and was safe to do so. Activity staff were to: -Provide the resident with supplies to facilitate independent activities such as reading materials, puzzles, word searches, cards and crafts.Resident 44's 9/26/25 Activities Profile indicated the resident was able to read and enjoyed movies. Resident 44's 10/17/25 Annual MDS indicated the resident had severe cognitive deficits. Resident 44's activity preferences indicated it was very to somewhat important to listen to music, be around animals and go outside when the weather was good. Resident 44 indicated it was not very important to have books, newspapers or magazines or keep up with the news. Resident 44's 12/26/25 psychosocial and well-being care plan related to restriction of social activities and interactions with other residents and staff due to the resident speaking Spanish only included activity staff were to: -Provide one-on-one visitations with a Spanish interpreter to meet Resident 44's needs.-Resident 44 would be encouraged to go outside in the courtyard to view wildlife, flowers and enjoy good weather when applicable.-Resident 44 would be encouraged to participate in hallway activities such as music, audio books, games, snacks and drinks. Resident 44's 4/17/26 at risk for elopement care plan indicated the resident was no longer safe to go outside, unsupervised. Social service staff and the Resident Care Manager was to determine reasons why Resident 44 wanted to leave the facility and develop an activity plan and interventions to address those findings. Resident 44's Activity Participation Logs including group, one-on-one and independent activities from 4/5/26 through 5/5/26 revealed the following: -The resident watched TV on 4/13/26 and 4/16/26.-The resident went outside for fresh air/outdoor activity on 4/18/26.-On 20 out of 25 days reviewed, it was documented that Resident 44 was keeping up with the news which was not a preferred activity for the resident. Multiple random observations from 5/4/26 through 5/8/26 between the hours of 8:21 AM and 4:19 PM revealed Resident 44 was either in bed with no television on or music playing or was wandering the halls in her/his wheelchair. There were no independent activity materials such as reading materials, puzzles, word searches, cards or crafts available in her/his room. When Resident 44 was up in her/his wheelchair, she/he wandered throughout the facility hallways, at times watching the traffic from the rehabilitation gym's large picture window. Resident 44 was not seen outside which was his very important activity. The resident was not seen in any hallway or group activities, and no one-to-one activities were provided to the resident. On 5/5/26 at 11:45 AM, Staff 40 (CNA) stated Resident 44 did not speak English, liked to watch TV, used to enjoy going outside but was no longer allowed to go outside by herself/himself. Staff 40 stated she had not seen Resident 44 engaged in any group, independent or self-directed activities and the resident primarily wandered throughout the facility in her/his wheelchair. On 5/5/26 at 11:00 AM, Resident 44, with an interpreter present, stated (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she/he loved to go outside, go to the park and to the store. Resident 44 stated she/he liked to watch movies but not all day. Resident 44 stated she/he used to be a gardener/landscaper, mowed lawns and at one time, worked on a Christmas tree farm. Resident 44 stated she/he hoped to go to the park today and would enjoy and be able to do small gardening projects.On 5/8/26 at 9:20 AM, Staff 29 (CNA) stated Resident 44 roamed up and down the hallways in her/his wheelchair. Staff 29 stated Resident 44 spoke primarily Spanish. She stated the resident used to be able to go outside, alone but was no longer able to do so. Staff 29 stated she did not see Resident 44 engaged in any group, independent or self-directed activities. On 5/8/26 at 9:26 AM, Staff 47 (CNA) stated Resident 44 spoke Spanish and needed an interpreter when providing care. Staff 47 stated the resident wheeled around the facility or watched TV. Staff 47 stated the resident used to sit outside by the front door but was no longer allowed to do so. Staff 47 reported he did not see Resident 44 ever involved in any activities. On 5/8/26 at 10:09 AM, Staff 13 (Social Service Director) stated Resident 44 spent her/his time going around the facility in her/his wheelchair. She reported Resident 44 loved to be outside and used to sit outside all the time but was no longer allowed to do so without supervision. Staff 13 stated Resident 44 took pride as a gardener. She stated she did not see Resident 44 involved in group, independent or one-on-one activities. Staff 13 stated she was not notified of Resident 44's 4/17/26 care plan intervention for social services to determine reasons for the resident wanting to leave and developing an activity plan and interventions for her/him so she did not develop any activity plans or interventions for the resident. On 5/8/26 at 12:27 PM, Staff 7 (LPN Resident Care Manager) stated Resident 44 loved to go outside but the resident could no longer go outside without a staff member being with her/him and was not sure if that was even possible at this time. Staff 7 stated she did not determine reasons for the resident wanting to leave the facility and had not developed an activity plan or interventions for her/him. On 5/11/26 at 8:45 AM, Staff 15 (Activity Director) stated Resident 44 loved to go outside but was no longer able to do that. Staff 15 stated she did not provide any materials for Resident 44 to complete independent or self-directed activities. Staff 15 stated the resident's primary interests were gardening, being outside and being around animals and the resident had not been provided with activities related to her/his preferences. Staff 15 stated she wished she could do more for Resident 44, especially regarding her/him being outside, but she needed another staff member to accompany her outside with Resident 44 and staff were usually not available. Staff 15 stated she needed to make a point of providing activities of interest to Resident 44. Staff 15 stated the resident had little interest in keeping up with the news so this would not be an activity she/he enjoyed or preferred.On 5/11/26 at 9:55 AM, Staff 1 (Administrator) stated it was his expectation for residents to have activities developed based on their interests and preferences and acknowledged Resident 44's activity program did not meet the resident's needs, especially since Resident 44 was no longer able to sit outside without supervision.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review it was determined the facility failed to follow physician orders and monitor skin conditions for 1 of 2 sampled residents (#10) reviewed for skin conditions. This placed residents at risk for worsening skin conditions. Findings include:The facility's 11/2025 Weekly Skin Audit policy instructed the facility to mark yes or no in the TAR for any new skin conditions observed during the skin assessment and document findings in the resident's clinical record. Resident 10 admitted to the facility in 7/2025 with diagnoses including diabetes and dementia.Resident 10's 4/20/26 quarterly MDS indicated the resident' did not have any skin issues and was severely cognitively impaired.On 5/4/26 Witness 3 (Family Member) stated two to three weeks prior, she had noticed a growth on top of Resident 10's left wrist she had not seen before and requested a CNA notify the nurse to look at it because she thought the growth should be examined for possible removal but no one had followed up with her.On 5/6/26 at 11:36 AM Resident was observed to have raised growth about the size of a pencil eraser on the top of her/his wrist about where a watch would normally rest. The growth looked to have a rough and dry texture. Resident 10 stated the left wrist growth bothered her/him sometimes, so she/he kept her/his watch pulled back away from it. Review of Resident 10's clinical records revealed the following:- The physician order dated 7/14/25 instructed the facility to complete weekly skin audits, mark a ?Y' or a ?N' for new skin conditions, and document the findings of the skin audit in the resident's clinical records.- The TAR revealed nurses had put a check mark for the Weekly Skin Audit order on 4/13/26, 4/20/26, 4/27/26, and 5/4/26 but the nurse did not document what was observed on those days. - There was no documentation about Resident 10's left wrist growth.On 5/6/26 at 9:47 AM Staff 27 (CNA) stated she was aware of Resident 10's left wrist growth for a while. Staff 27 stated she was unsure how long the growth had been there, but thought other staff knew about the growth so she did not notify the nurse.On 5/6/26 at 1:38 PM Staff 18 (LPN) and 5/6/26 at 3:38 PM Staff 42 (LPN) stated they were unaware of Resident 10's left wrist growth and acknowledged nurses were expected to complete Weekly Skin Evaluation forms when completing weekly skin audits. They stated the Weekly Skin Audit was a head-to-toe examination of the resident's skin to identify new or worsening skin conditions and the Weekly Skin Evaluation form was a required form used to document the status of known skin issues and if there were any new skin conditions identified during the skin audit.On 5/7/26 at 12:18 PM Staff 35 (LPN) stated he looked at Resident 10's arms on 5/4/26 during the weekly skin check but did not notice a left wrist growth. He stated he was supposed to fill out a Weekly Skin Evaluation form but did not.On 5/8/26 at 12:22 PM Staff 7 (LPN - Resident Care Manager) stated she was not notified about Resident 10's left wrist growth and no one notified her of Witness 3's request to have the growth examined by a physician.On 5/11/26 at 9:30 AM Staff 2 (DNS) observed Resident 10's left wrist growth and stated she was unaware of the growth. Staff 2 confirmed Staff 35 should have seen it when he completed the skin audit, documented his findings, and notified the provider.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to ensure residents with limited range of motion received necessary services to prevent a further decrease in range of motion for 1 of 1 sampled resident (#64) reviewed for position and mobility. This placed residents at risk for the development of contractures. Findings include:The facility's 10/2025 Restorative Nursing Services Policy directed the following:-Residents will receive restorative nursing care as needed to help promote optimal safety and independence.-Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care.-Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. -The resident or representative will be included in determining goals and the plan of care. -Restorative goals may include but are not limited to supporting and assisting the resident in participating in the development and implementation of their plan of care. Resident 64 was admitted to the facility in 11/2022 with diagnoses including hemiplegia (severe or complete paralysis on one side of the body) and hemiparesis (partial, one-sided muscle weakness) following a stroke, affecting the left side. An 8/21/23 Physical Therapy (PT) Evaluation & Plan of Treatment revealed the following:-Resident 64 was evaluated to determine her/his ability to use her/his power wheelchair independently. -No deficits were noted related to the resident's right upper extremity. -The resident experienced left sided weakness.-The resident demonstrated good safety using her/his power wheelchair. Resident 64's 12/1/25 Annual MDS revealed the resident was cognitively intact, experienced upper and lower extremity impairment on one side and was dependent on staff assistance for all ADLs outside of eating and oral hygiene. The Functional Abilities CAA revealed the resident had left-sided weakness and impaired mobility. The CAA indicated the current care plan would be continued with the goals of avoiding complications and maintaining the resident's current level of functioning. Resident 64's 1/24/26 ADL Care Plan revealed the following:-The resident required assistance from one-to-two staff to reposition and to turn in bed. -Staff were to turn and reposition the resident every two hours. -The resident required a mechanical lift for transfers. -A therapy evaluation was to be completed as indicated for decline. A review of Resident 64's Rehabilitation Task Form from 4/7/26 to 5/6/26 revealed the resident received left and right lower extremity passive range of motion (the movement of a joint through its full range by an external force) three times weekly. No evidence was found in Resident 64's clinical record to indicate the resident received any assistance with upper body range of motion or on-going assessments and monitoring related to the functioning of her/his upper body. On 5/6/26 at 10:11 AM, Resident 64 was observed in her/his room in bed. Resident 64 used her/his right hand to pull back the blankets that covered her/his left arm. The resident's left arm was bent at the elbow and her/his left thumb bent into the palm of her/his left hand. The resident stated she/he needed to use her/his right hand to move the fingers on her/his left hand because her/his left side was paralyzed. The resident stated Staff 23 (Restorative Aide) provided range of motion for her/his lower body, she/he did not receive any range of motion to her/his upper body, and she/he wanted it. The resident stated her/his left arm was often sore and any therapy was welcome. On 5/6/26 at 9:11 AM, Staff 48 (CNA) stated Staff 23 was responsible for providing range of motion to residents, and CNAs only assisted residents with range of motion if it was in their care plan. Staff 48 stated Resident 64 could not move her/his left side, and her/his left hand was contracted. Staff 48 stated the resident cooperated with range of motion exercises with Staff 23. On 5/6/26 at 9:16 AM, Staff 25 (CNA) stated Staff 23 provided range of motion to residents and range of motion was not a CNA responsibility. Staff 25 stated the resident always cooperated with Staff 23 when he provided range of motion exercises. On 5/6/26 at 12:52 PM, Staff 23 stated Resident 64 was pretty much bedridden, he assisted her/him with restorative exercises to her/his lower body three times weekly, and she/he was always cooperative. Staff 23 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he did not know why the resident did not have a range of motion program for her/his upper body, but the process to add range of motion program to her/his upper body was easy to do. On 5/6/26 at 1:02 PM, Staff 16 (Director of Rehabilitation) stated residents at risk to develop pressure ulcers and contractures included those who were bed bound and/or needed assistance to move, and for these types of residents, we would do something like a restorative program. Staff 16 stated Resident 64 had range of motion limitations and would be appropriate to receive upper extremity restorative exercises. On 5/6/26 at 1:19 PM, Staff 7 (LPN-Resident Care Manager) stated residents who were bed bound were appropriate to receive passive range of motion exercises for both upper and lower body extremities. Staff 7 stated she did not complete any specific assessments or on-going monitoring related to contracture prevention or development, and she relied on CNAs to tell me when [residents] needed something. Staff 7 stated Resident 64 did not get out of bed, confirmed she/he had a range of motion program for her/his lower extremities but did not have one for her/his upper extremities, and she/he should have one in place. On 5/6/26 at 1:36 PM, Staff 2 (DNS) stated residents with limited mobility and need for assistance with ADLs were at risk for contracture development. Staff 2 stated resident mobility was assessed quarterly by way of the MDS Assessment, but this assessment only noted if the resident had an upper or lower body impairment but did not capture specific details about the impairment, including whether or not a previously noted impairment had worsened. Staff 2 stated Resident 64 never got out of bed and was at risk for upper and lower body extremity contractures. At 1:49 PM, Staff 2 observed Resident 64's left arm and stated the resident could use a therapy evaluation and an RA program.

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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. Based on observation, interview and record review it was determined the facility failed to provide adequate catheter care for 1 of 1 sampled resident (#8) reviewed for catheter care. This placed resident at risk for unmet catheter needs and infection. Findings include: The facility's Catheter Care, Urinary Disease Management policy dated 8/2022 included the following:- Infection Control: Be sure the catheter tubing and drainage bag are kept off the floor. 1. Resident 8 was admitted to facility in 3/2026 with diagnoses of urinary tract infection, inflammatory reaction due to indwelling urethral catheter (bacteria entering urinary tract along catheter, causing inflammation) and chronic kidney disease. The Admissions MDS with an ARD of 4/18/26 revealed Resident 8 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. A review of Resident 8's clinical record revealed she/he had an indwelling catheter and interventions included being provided with catheter care.Observations on 5/4/26 at 10:17 AM, 5/5/26 at 8:55 AM, 5/5/26 at 3:09 PM, 5/6/26 at 8:20 AM, and 5/6/26 at 12:26 PM revealed Resident's catheter drainage bag laying flat on the floor of her/his room. On 5/5/26 at 8:55 AM, Staff 36 (CNA) entered Resident 8's room and assisted the resident into her/his wheelchair. At 8:57 AM, Staff 36 exited the room and the resident was observed sitting in her/his wheelchair brushing her/his teeth at the sink with the catheter drainage bag laying flat on the floor beside her/his wheelchair.On 5/6/26 at 9:03 AM, Staff 36 and another CNA entered Resident 8's room to answer her/his call light. At 9:04 AM, Staff 36 and another CNA exited Resident 8's room and Resident 8's catheter drainage bag was observed to be laying flat on the ground beside her/his bed.On 5/6/26 at 11:06 AM, Staff 36 stated Resident 8's catheter drainage bag should not be on the floor.On 5/6/26 at 3:29 PM, Staff 32 (CNA) stated Resident 8's catheter drainage bag was not supposed be lying on the floor.On 5/6/26 at 3:37 PM, Staff 37 (RN) stated Resident 8 was known to take out her/his catheter, move it around, and drop it on the ground. She stated even if staff pick up the catheter bag and placed it in the appropriate place, Resident 8 was known to drop it down on the floor. Staff 37 stated management was fully aware of the resident's behaviors and stated, The catheter issue is not going to be fixed, it's going to end up on the floor again.On 5/6/26 at 4:05 PM, Staff 6 (LPN Resident Care Manager) stated she expected staff to ensure Resident 8's catheter drainage bag was not on the floor, as it was not sanitary and had potential for infection. At 4:18 PM, Staff 6 entered Resident 8's room and confirmed her/his catheter drainage bag was lying flat on the floor beside the bed and stated she had not received reports of the bag being on the floor.On 5/6/26 at 4:20 PM, Staff 2 (DNS) and Staff 4 (Regional Director of Quality Assurance) stated they expected staff to ensure catheter care was followed, which included ensuring the resident's catheter drainage bag was not on the floor. Staff 2 acknowledged Resident 8 was known to have the catheter drainage bag on the floor, as she had recently picked it up off the floor. Staff 2 and Staff 4 stated there was potential for infection with Resident 8's catheter drainage bag on the floor. 2. Observations on 5/6/26 at 1:30 PM revealed Staff 36 (CNA) donning PPE and preparing to empty Resident 8's catheter drainage bag. Staff 36 provided Resident 8 with peri care and a brief change, and was observed not changing gloves or performing hand hygiene before emptying the resident's catheter bag into a graduated container. On 5/7/26 at 8:05 AM, Staff 36 stated he had donned two pairs of gloves before providing peri care and changing Resident 8's brief. Staff 36 stated he doffed one pair of gloves and confirmed he did not perform hand hygiene before touching the spout on the resident's catheter drainage bag. Staff 36 stated he double gloved all the time when he performed catheter care. On 5/7/26 at 8:10 AM, Staff 8 (LPN Infection Preventionist) stated she did not know why a person would double glove when performing catheter care. Staff 8 stated staff should not double glove, peel off a layer, and continue with care as this was not sanitary and was inappropriate when providing care. Staff 8 stated if staff were going to go from a contaminated site to a clean site, she expected them to doff gloves, perform hand hygiene, and don new gloves before touching the clean site.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observation, interview and record review it was determined the facility failed to develop and implement individualized care plans that addressed the emotional and psychosocial needs of the residents for 2 of 3 residents (#s 15 and 30) reviewed for choices. This placed residents at risk for unmet behavioral and emotional needs and a decrease in their quality of life. Findings includeThe facility's 2/2026 Suicide Threats Policy indicated the following:-Staff shall report any resident threats of suicide immediately to the nurse supervisor who shall immediately assess the situation.-After assessing the resident in more detail, the nurse supervisor shall notify the resident's physician and responsible party and seek further direction from the physician. -All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. -Staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. 1. Resident 30 was admitted to the facility in 5/2025 with diagnoses including depression, anxiety and PTSD (Post-Traumatic Stress Disorder). Resident 30's 2/22/26 Quarterly MDS revealed the resident was cognitively intact, and she/he felt down, depressed or hopeless for several days over the last two weeks.A 4/25/26 Progress Note revealed the following: -On 4/24/26, Resident 30 was sent to the emergency department for an evaluation after she/he was found in her/his room with an altered mental status.-An open bottle of over-the-counter pain medicine was found on her/his table and approximately 10 tablets were found scattered on the floor. -The resident returned to the facility on 4/25/26, was placed on frequent checks and the facility implemented further evaluations for safety. Resident 30' 4/25/26 Care Plan revealed the following interventions: -The resident's room door was to be propped open to allow staff to complete a visual check and to hear the call bell.-All hazardous objects were to be removed from the resident's access such as eating utensils.-The resident's call light and bed control cords were to be zip tied to shorten the length of the cord. On 5/4/26 at 10:53 AM, the door to Resident 30's room was observed to be closed. A sign hung on the outside of the door that read, Please close door when leaving. A long plastic bag was observed tied to the outside handle of the door and a long rubber exercise band was tied to the inside handle of the door. Resident 30 was observed in her/his room and sat in her/his wheelchair. The resident's call light cord was zip tied to a bar on her/his bed and the bed control cord appeared shortened; however, various other cords were in reach of the resident such as her/his phone charger. Resident 30 stated she/he recently attempted to end her/his life by taking pills, but she/he did not feel like she was in a space where she/he would do it again. Resident 30 stated the facility shortened the cord to her/his call light after her/his suicide attempt, but they never talked to her/him about other cords and stated, I have a lot of cords in my room. Resident 30 stated the door to her/his room was supposed to be left open a crack for safety, but staff continuously closed it. Resident 30 stated she/he was comfortable with staff knowing about her/his recent suicide attempt and the safety interventions put in place. On 5/5/26 at 12:28 PM, Staff 31 (CNA) was observed at the door of Resident 30's room in the hallway, and the door was open. Staff 31 called into the resident's room and asked the resident if she/he wanted her/his door left open or closed. Resident 30 requested her/his door to be left open. On 5/5/26 at 2:22 PM, the door to Resident 30's room was observed to be closed. Resident 30 was alone inside her/his room and stated staff leave and just shut it behind them. On 5/6/26 at 5:43 AM, the door to Resident 30's room was observed to be closed. Resident 30 was alone inside her/his room. At 5:49 AM, the state surveyor exited the resident's room and left the door cracked open per the resident's request. On 5/6/26 at 5:53 AM, Staff 28 (CNA) stated she was unaware of any safety concerns for Resident 30, and the door to the resident's room was okay to be closed because [she/he] was not a fall risk. On 5/6/26 at 6:08 AM, Staff 21 (RN) stated Resident 30 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was suicidal a couple of weeks ago, and because of that, the door to her/his room was supposed to be left cracked open. Staff 21 stated he was in the resident's room at 5:00 AM this morning and closed the door after he left because he knew dayshift would be there soon. On 5/6/26 at 6:49 AM, the door to the resident's room was observed to be closed and the resident was alone inside. The state surveyor exited the resident's room and left the door cracked open per the resident's request. On 5/6/26 at 7:21 AM, two unidentified staff exited Resident 30's room and closed the door behind them. On 5/8/26 at 8:25 AM, Staff 22 (RN) stated the door to Resident 30's room was to be left open so staff could peak in and check on her/his well-being following her/his recent suicide attempt. On 5/8/26 at 10:02 AM, Staff 13 (Social Services Director) stated she discussed safety interventions with Resident 30 following her/his recent suicide attempt. Staff 13 stated the resident understood her/his door needed to be left open wide enough for staff to see inside, and she/he was in agreement with the intervention. Staff 13 stated the resident's call light cord was zip tied to her/his bed and the cord to her/his bed control was shortened but the resident still had access to other long cords in her/his room which did not make sense. On 5/8/26 at 10:41 AM, Staff 27 (CNA) stated she was not informed of any specific safety interventions in place for Resident 30 and was unsure if the resident's door was supposed to be open or not. On 5/8/26 at 10:58 AM, Staff 26 (CNA) stated she was unaware Resident 30 made any attempts of self-harm or of any safety interventions in place. Staff 26 stated the resident's door was shut at all times because that was the resident's preference. On 5/8/26 at 12:01 PM, Staff 2 (DNS) and Staff 7 (LPN-Resident Care Manager) were present for an interview. Staff 7 stated she discussed safety interventions with Resident 30 following her/his return from the hospital after her/his suicide attempt. Staff 7 stated the resident was in agreement to keep her/his door open, and saw the other long cords, plastic bag and rubber exercise band in the resident's room but did not discuss these safety concerns with the resident. Staff 2 stated the sign on the outside of the resident's door that indicated to keep it shut should have been removed, and the resident's door should be kept open whenever the resident was in the room. Staff 2 further stated the other cords in the resident's room should have been evaluated as safety concerns but were not. 2. Resident 15 was admitted to the facility in 10/2024 with diagnoses including dementia.Resident 15's 9/8/25 Trauma Care Plan revealed the resident was to join in decision-making about her/his care. Resident 15's 4/13/26 Quarterly MDS revealed the resident was cognitively intact, and she/he had no mood symptoms or behaviors. A 4/25/26 Progress Note written by Staff 7 (LPN-Resident Care Manager) indicated the following:-An unidentified resident reported to Staff 7 that Resident 15 stated she/he wished she/he could just take a bunch of pills.-Resident 15 did not recall making this statement, and she/he denied suicidal ideation, intent or plan to harm her/himself. -Resident 15 was placed on alert and frequent checks, and her/his care plan was updated to include suicide risk monitoring interventions, including plastic utensils with meals. Resident 15's 4/25/26 Care Plan revealed the following:-The resident verbalized she/he had a thought to take multiple medications at once.-Frequent checks were initiated for the resident's safety.-All hazardous objects were removed from the resident, including eating utensils. -The resident self-initiated activities, and she/he enjoyed crocheting. A 4/26/26 Social Services Note written by Staff 13 (Social Services Director) revealed Resident 15 made a comment on 4/25/26 about taking pills in a joking way and she/he didn't mean it serious.Resident 15's 4/30/26 Long Term Care Evaluation revealed the resident was alert and oriented, and her/his mood was pleasant. A 4/30/26 Progress Note written by Staff 49 (Physician) revealed Resident 15 had an active diagnosis of an adjustment disorder (a short-term, stress-related mental health condition triggered by a major life change or traumatic event) but her/his insight was intact, she/he had a normal affect (outward expression of a person's internal emotional state) and she/he was generally in a good mood. On 5/4/26 at 12:17 PM, Resident 15 was observed in the facility's dining room. The resident's lunch tray sat on the table along with a plastic fork, spoon and knife. Resident 15 threw the plastic spoon across the table and stated, stupid plastic. At 12:31 PM, an unidentified resident who sat at the same table in the dining room yelled out, How come [Resident (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15] was the only one who got a plastic fork?On 5/4/26 at 3:32 PM, Resident 15 stated she/he made a statement two weekends ago to Staff 2 (DNS) about taking pills that was misunderstood, and as a result, a number of suicide prevention interventions had been implemented. Resident 15 stated she received plastic silverware at mealtimes for a week, and facility staff removed her/his personal scissors but never asked to remove her/his crochet supplies following her/his comment. Resident 15 stated she was informed of the interventions that were to be implemented and was not involved in the decision-making process. Resident 15 stated the interventions were crazy, and she/he had a happy life and would never attempt suicide. Resident 15 stated she/he wanted to receive regular silverware at mealtimes because the plastic silverware broke in her/his food and made it so she/he could not eat. On 5/5/26 at 12:14 PM, Resident 15 was in the facility's dining room, and her/his lunch tray with a set of plastic silverware sat on the table in front of her/him. Resident 15 threw her/his fork across the table. An unidentified resident handed Resident 15 a metal fork, which she/he used to eat. At 12:20 PM, Resident 15 exited the dining room crying and stated, They treat me like a child. On 5/5/26 at 1:22 PM, Staff 10 (Dietary Manager) stated Resident 15 received plastic silverware at mealtimes because it was her/his preference. On 5/5/26 at 1:29 PM, Staff 25 (CNA) stated he was told Resident 15 made a comment about self-harm, but he thought the resident made the comment as a joke. Staff 25 stated he knew the resident very well, and she/he always joked, laughed and was a social person. On 5/5/26 at 1:36 PM, Staff 47 (CNA) stated she was unaware of any statements of self-harm for Resident 15 and stated the resident should receive regular silverware. On 5/5/26 at 1:42 PM, Staff 30 (CMA) stated she was unaware of Resident 15's statement of self-harm until she was notified by Staff 25 on 5/5/26. Staff 30 stated this was why the resident received plastic silverware at mealtimes and the resident needed to be checked on frequently. On 5/5/26 at 1:49 PM, Staff 27 (CNA) stated Resident 15 was really upset about receiving plastic silverware at mealtimes. Staff 27 stated she observed the resident to throw her/his plastic silverware as well as use regular silverware that was given to her/him from other residents. Staff 27 stated she was unaware why the resident received plastic silverware at mealtimes or of any concerns related to self-harm. On 5/5/26 at 2:08 PM, Staff 42 (LPN) stated she was not informed of Resident 15's statement of self-harm that was made on 4/25/26 until 5/4/26. Staff 42 stated she had never heard Resident 15 to make any statements or exhibit behaviors indicative of self-harm.On 5/5/26 at 2:31 PM, Staff 7 (LPN-Resident Care Manager) stated Resident 15's statement about taking pills came off as a joke but the facility's policy was to implement safety interventions regardless of the resident's intent. Staff 7 stated residents who made threats of or attempted self-harm got the same interventions. Staff 7 stated she was not concerned Resident 15 would harm her/himself. Staff 7 stated she asked the resident for her/his scissors, which the resident surrendered, but did not indicate other potentially hazardous items were identified or requested. Staff 7 stated the resident's crochet needles appeared in my box last week, which she still needed to ask [Staff 2] about. Staff 7 stated she informed the resident of the safety interventions that were going to be implemented on 4/25/26 but had not discussed the interventions with the resident after this time.On 5/6/26 at 7:32 AM, Resident 15 was observed in her/his room in her/his recliner chair. A meal tray with a set of plastic silverware was observed on a table next to the resident. Resident 15 stated she/he did not like to use plastic silverware as it made her/him feel like a baby but she/he was not given an opportunity to provide any input related to this intervention. Resident 15 pulled a crochet hook (a handheld tool with a hooked, pointed tip used to pull yarn or thread through loops to create stitches in crochet work and typically made of metal, wood, bamboo or plastic) out of a bag that was next to her/his recliner and stated it was unclear why she/he had to use plastic silverware but was able to retain her/his crochet hook. On 5/6/26 at 9:06 AM, Staff 48 (CNA) stated she was unaware of any safety concerns for Resident 15, and the resident was allowed to receive regular silverware at mealtimes. On 5/6/26 at 9:39 AM, Staff 13 (Social Services Director) stated Resident 15 received standard interventions for safety following her/his statement of self-harm on 4/25/26. Staff 13 stated the resident was very apologetic about making (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this comment as she/he intended it to be a joke. Staff 13 stated she did not talk to the resident about her/his feelings about receiving plastic silverware at mealtimes and did not think to remove any of her/his crochet supplies but that definitely would be a concern. On 5/6/26 at 10:26 AM, Staff 2 stated residents received the same interventions no matter if a comment or an action related to self-harm was made, which included limiting access to harmful materials and plastic silverware at mealtimes. Staff 2 stated she was unaware Resident 15 disliked plastic silverware or other residents were providing the resident with regular silverware. Staff 2 stated she was unaware the resident had crochet hooks and acknowledged the resident's safety interventions were not person-centered and contradictory given she/he maintained her/his crochet supplies. Staff 2 stated she was unaware if the resident was involved in the care planning around her/his safety, but the resident should have been.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review the facility failed to ensure the state survey inspection results were readily accessible for 1 of 1 facility reviewed for resident council. This placed residents and the public at risk of not being informed of the facility's survey history. Findings include:On 5/7/26 at 10:48 AM, five of five members of the resident council answered they were unaware where to access a copy of previous year's survey results or if they were allowed to look at past survey results.On 5/7/26 at 12:00 PM, a tour of the facility found one clear plastic file folder holder attached to the wall near the kitchen entrance labeled Survey Results with a three-ring binder placed in the with survey results included in it. Review of the survey results inserted in the binder revealed the last survey results were dated 8/25/23 for the 7/31/23 recertification survey and 4/19/24 complaint survey result. There was no survey results observed for the 1/2025 recertification survey in the binder. On 5/8/26 at 9:40 AM Staff 43 (Receptionist) identified a second location for survey results. A three-ring binder labeled Survey Results in green highlighter color ink was observed resting against the wall on the corner of her desk. Review of the binder revealed the last survey results were dated 8/25/23 for the 7/31/23 recertification and there were no observed survey results for the 1/2025 recertification survey in the binder. On 5/8/26 at 10:15 AM Staff 1 (Administrator) confirmed the binders had survey results for the 7/31/23 recertification survey and last year's survey results were not available for review.