

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Valley West Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 Warren Street Eugene, OR 97405	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by staff for 1 of 1 sampled resident (# 101) reviewed for abuse and neglect. This placed residents at risk for abuse. Findings include:</p> <p>Resident 101 was admitted to the facility in 2022, with diagnoses including a below the knee amputation, mood disturbance, and anxiety.</p> <p>An Incident Report dated 5/26/25 indicated there was a physical altercation involving Staff 2 (CNA) against Resident 101. Resident 101 yelled profanities at and flailed her/his arms at Staff 2 during personal cares. Staff 2 grabbed the resident's wrists to calm her/him down then hit the residents left wrist area three times. Staff 2 ran out of the room and self-reported striking the resident to the nurse. Staff 2 was suspended pending an investigation, the Executive Director, the Police, and the State Agency were notified, and an investigation was started.</p> <p>A 5/26/25 Progress Note indicated Staff 2 came out of the resident's room crying and stated she had punched the resident on the left wrist because the resident was being verbally abusive to her. Staff 2 wrote a statement and was sent home. An initial skin assessment yielded nothing, but five minutes later a small bruise was noted to the resident's left wrist and the resident complained of pain with movement of the area.</p> <p>The facility's 5/26/25 Investigation Report concluded Staff 2 hit Resident 101 with her fist on the resident's left wrist after attempting to calm the resident by holding her/his wrists down. Staff 2 acknowledged the abuse, and the potential impact of her actions on the resident's well-being. Staff 2 was terminated from employment with the facility.</p> <p>On 6/25/25 at 11:45 AM, Resident 101 revealed she/he remembered the incident. Resident 101 stated while Staff 2 was providing personal care, she flipped out, hit her/him three times on the wrist, then took off running. Resident 101 stated Staff 2 had never taken care of her/him previously and she/he did not want her taking care of her/him again.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 2:40 PM, Staff 2 (CNA) stated on 5/26/25 she provided personal care for Resident 101. Staff 2 stated she was trying to hurry because the resident was agitated. She attempted to calm the resident but she/he was getting increasingly aggressive. Staff 2 stated at one point she used her arms to hold the resident's wrists down to help calm her/him, which did not work, and she hit the resident's forearm, wrist area three times. Staff 2 stated she felt the resident was going to hit her. Staff 2 also stated the resident did not actually take a swing at her, but she had been scared and understood she had over-reacted.</p> <p>On 6/25/25 at 3:05 PM, Staff 1 (Administrator) acknowledged they had determined there was physical abuse by Staff 2 against Resident 101.</p> <p>On 6/2/25, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined abuse was substantiated. The Plan of Correction included:</p> <ul style="list-style-type: none"> -An Ad Hoc QAPI meeting was held on 5/30/25 to review the incident. -Facility employees were re-educated regarding Abuse and Burnout. -A new plan for abuse training was to be held monthly at All-Staff meetings. -All facility residents were either interviewed or had a new skin evaluation completed. -Regular monitoring observations of CNA staff in various areas of the facility such as resident rooms, shower rooms, hallways, dining rooms, and during activities were conducted. -Audits by DON or Designee of nurses' notes and reviews of Risk Management reports for any signs of abuse or neglect for three months. Any evidence found, if not already reported, would be brought to the Executive Director and the Abuse Policy would be followed. 		