STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385120	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley West Health Care Center	2300 Warren Street Eugene, OR 97405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42270 Based on interview and record review it was determined the facility failed to conduct a Significant Change MDS assessment within the required timeframe for 1 of 1 sampled resident (#18) reviewed for hospice. This placed residents at risk for unassessed needs. Findings include: Resident 18 admitted to the facility in 12/2024 with diagnoses including heart failure. A 4/30/25 Progress Note revealed Resident 18 admitted to hospice services on 4/25/25. A Significant Change MDS assessment dated [DATE] was completed on 5/21/25, 27 days after Resident 18 admitted to hospice. On 5/23/25 at 8:36 AM Staff 15 (RN MDS Coordinator) stated Resident 18's Significant Change MDS assessment was not completed within 14 days after Resident 18 was admitted to hospice.

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 42270 Based on interview and record review it was determined the facility failed failed to complete a referral for a Level ll PASARR (Pre-Admission Screening and Resident Review) for 1 of 2 sampled residents (#18) reviewed for PASARR. This placed residents with a mental health disorder at risk for delayed care, emotional distress related to mental illness and lack of services to attain their highest practicable well-being. Findings include: Resident 18 admitted to the facility in 12/2025 with diagnoses including schizophrenia (chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), polydipsia (excessive thirst), hyponatremia (a condition where sodium levels are low often due to excessive water consumption), and panic disorder. A 11/25/24 Level 1 PASARR was completed by the hospital on admission to the facility, no indication of serious mental illness was indicated. A 11/25/24 hospital discharge summary revealed Resident 18 had suicidal ideation on admission to the hospital. A 12/12/24 PASARR Level 1 revealed Resident 18 had serious mental illness indicators and met the conditions for an exempted hospital discharge. A review of Resident 18's physician orders revealed a 12/28/24 order for a 1500 ml/day fluid restriction. A 1/28/25 progress note revealed Resident 18 was heard yelling for five to 10 minutes and stated the voices made me drink water and I'm weak and I let them. A 3/3/25 hospital history and physical revealed Resident 18 admitted to the hospital on 3/3/25. The history and physical revealed Resident 18 admitted to the hospital with an altered mental status which appeared to be caused by consumption of a large amount of water. The history and physical also revealed Resident 18 had a history of hyponatremia due to psychogenic (originating form a psychological rather than a physical cause) polydipsia. A 4/3/25 provider progress note revealed Resident 18 had active suicidal ideation and drank approximately 10 cups of water. The provider instructed the nurse to send Resident 18 to the emergency room for symptomatic chronic hyponatremia (a condition where sodium levels are low often due to excessive water consumption) with associated symptoms of suicidal ideation. A 4/3/25 hospital history and physical revealed Resident 18 admitted to the hospital on 4/3/25 with hyponatremia due to psychogenic polydipsia. The history and physical also revealed Resident 18 reported she/he chronically heard voiced that told her/him to kill her/himself. A 5/7/25 Significant Change MDS revealed Resident 18 had a PHQ-9 score of 14 which indicated moderate depression, and reported feeling down, depressed or hopeless nearly every day. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 18's medical record revealed no evidence of a referral for a PASARR Level II related to a serious mental illness. On 5/21/25 at 9:18 AM Staff 12 (CNA) stated Resident 18 had verbal behaviors and thought everyone was after her/him. On 5/21/25 at 9:25 AM Staff 13 (CNA) stated Resident 18 was on a fluid restriction but would hide cups in her/his room and drank too much fluids. Staff 13 stated Resident 18 would become very upset if she/he saw cups removed from her/his room and would drink water to excess. On 5/21/25 at 10:02 AM Staff 14 (LPN) stated Resident 18 had behaviors related to fluids, was redirectable but would continue to drink excessive fluids and which was detrimental to her/his health. On 5/22/25 at 12:00 PM Staff 11 (Social Services Assistant) stated Resident 18 drank fluids consistently and was diagnosed with polydipsia related to this. Staff 11 stated Resident 18 did not have current mental health involvement and a PASARR Level II was not completed. On 5/23/25 at 9:41 AM Staff 4 (LPN Unit Manager) reviewed Resident 18's clinical record and stated it would have been appropriate to request a PASARR Level II. On 5/23/25 at 10:50 AM Staff 1 (Administrator) stated she would expect a PASARR Level II to have been completed for Resident 18.

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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. 26991 Based on interview and record review it was determined the facility failed to follow physician orders for CBGs and medications for 2 of 8 sampled residents (#s 8 and 218) reviewed for nutrition. This placed residents at risk for ineffective medication regimen. Findings include: 1. Resident 8 was admitted to the facility in 12/2024 with a diagnosis of diabetes. Resident 8's hospital After Visit Summary revealed she/he was on oral diabetic medication and CBGs were to be checked three times a day. Resident 8's 12/17/24 nurse practitioner note revealed Resident 8 reported at home she/he checked her/his CBGs up to five times a day. The nurse practitioner indicated the plan was to initiate CBG monitoring. Resident 8's clinical record did not include staff perform CBG monitoring. On 05/22/25 at 10:49 AM Staff 4 (LPN Unit Manger)stated when a resident was admitted to the facility, medical records staff entered orders into a resident's electronic record, a floor nurse reviewed the orders entered by the medical records staff, and then a second nurse reviewed the orders prior to implementing the orders. The orders were then forwarded to a nurse manager and she reviewed the admission orders one more time for accuracy. Staff 4 verified Resident 8 had orders upon admission to the facility for CBG monitoring but staff did not implement the orders. On 5/22/25 at 2:00 PM Staff 2 (DNS) stated she reviewed Resident 8's record, verified the admission orders for CBG monitoring were not implemented, and indicated after the nurse practitioner visit staff did not implement CBG monitoring. 47001 2. Resident 218 was admitted to the facility in 5/2025 with diagnoses including herpes virus infection. A review of Physician Orders revealed a 5/13/25 order for acyclovir (a medication used to treat viral infections) twice a day as needed for a herpes outbreak. On 5/19/25 at 10:13 AM Resident 218 was observed to have a sore near the left side of her/his mouth. Resident 218 stated the sore was from herpes and she/he was taking acyclovir for it. A review of Resident 218's 5/2025 MAR revealed she/he started taking acyclovir on 5/14/25. Resident 218 was administered acyclovir once daily except on 5/19/25 the acyclovir was given twice. On 5/23/25 at 8:24 AM Staff 4 (LPN Unit Care Coordinator) stated Resident 218 was given the acyclovir when she/he asked for it and acknowledged the acyclovir should be given twice a day per orders for herpes outbreak.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48830 Based on interview and record review it was determined the facility failed to ensure the care plan related to bathing was followed for 1 of 1 sampled resident (#16) reviewed for accidents. This placed residents at risk for injuries. Findings include: Resident 16 was admitted to the facility in 2/2023 with diagnoses including depression and muscle weakness. The 2/19/25 Annual MDS revealed Resident 16 had a BIMs score of 15, which indicated the resident was cognitively intact. A review of the 3/14/25 Care Plan revealed Resident 16 required one person assistance for bathing. A facility reported incident dated 3/29/25 revealed Staff 6 (CNA) was reported to have escorted Resident 16 to the shower room, set the resident up and left the resident to shower independently. On 3/29/25 at 7:30 PM Resident 16 reported the incident to Staff 5 (LPN) and expressed she/he felt it was neglectful to have been left alone, but did not report feeling unsafe. On 5/21/25 at 11:35 AM Resident 16 stated she/he remembered the incident on 3/29/25. Resident 16 stated she/he was taken into the shower room, the CNA set her/him up then left for an unknown reason. Resident 16 stated, it made me feel very unsafe left alone in the shower. The resident reported no other incidents had occurred since. On 5/21/25 at 1:10 PM Staff 7 (CNA) stated on 3/29/25 during her shift the call light in the shower room was turned on so she answered the call light and Resident 16 was in the shower room alone. Staff 7 stated she worked with Resident 16 often and knew the resident required assistance in the shower, so she stayed with the resident and radioed for Resident 16's assigned CNA. On 5/21/25 at 1:17 PM Staff 6 (CNA) stated Resident 16 was assigned to her on 3/29/25 and this was the first time she worked with that resident. Staff 6 stated she read the care plan but never assisted Resident 16 in the shower before and, apparently missed out on some important details. On 5/21/25 at 7:51 PM Staff 5 (LPN) stated Resident 16 spoke with her on 3/29/25 and she/he was left in the shower room earlier that day and Resident 16 was upset. Staff 5 stated the resident had been back in the shower room since the incident and had no further concerns. On 5/23/25 at 11:26 AM and at 12:46 PM Staff 1 verified the incident occurred on 3/29/25 between Resident 16 and Staff 6. Staff 1 acknowledged Staff 6 was to have follow up education on 5/1/25, which did not occur until 5/23/25.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47001 Based on interview and record review it was determined the facility failed to staff a registered nurse (RN) for 8 consecutive hours per day 7 days per week for 4 out of 34 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include: A review of Direct Care Staff Daily Report revealed there were no RNs scheduled on 7/6/24, 7/7/24, 7/20/24, 7/21/24, or 8/3/24. On 5/22/25 at 12:33 PM Staff 1 (Administrator) acknowledged there were no RNs scheduled on on the above dates. The deficient practice was identified as Past Noncompliance based on the following: In 10/2024, the deficient practice was identified by the facility and was corrected when the facility completed a staffing root cause analysis and determined the facility needed to hire an additional RN. The plan of correction included hiring an agency RN on 10/21/24 to ensure seven day a week RN coverage.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 47001 Based on interview and record review it was determined the facility failed to process physician laboratory orders timely for 1 of 5 sampled residents (#35) reviewed for unnecessary medications. This placed residents at risk unmet needs. Findings include: Resident 35 was admitted to the facility in 12/2024 with diagnoses including hypothyroidism (a condition where the thyroid gland is underactive). A review of Physician Orders revealed a 2/19/25 order for TSH (Thyroid Stimulating Hormone)lab. A review of Resident 35's medical record revealed a TSH lab was completed on 3/25/25. On 5/23/25 at 8:41 AM Staff 4 (LPN Unit Care Coordinator) acknowledged the TSH was ordered on 2/19/25 and completed on 3/25/25. Staff 4 stated the TSH lab was not completed timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on observation, interview and record review it was determined the facility failed to follow CDC (Centers for Disease Control and Prevention) Infection Control Guidelines related to Enhanced Barrier Precautions for 13 of 13 sampled resident rooms (#s 3, 7, 8, 12, 13, 14, 17, 21, 22, 23, 24, 29, and 33) reviewed for infection control. This placed residents at risk for exposure to infections and cross contamination. Findings include: The CDC's 4/2/24 implementation of Nursing Home PPE guidelines for prevention of spread of Multidrug-Resistant Organisms (MDROs) included a trash bin was to be placed inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. On 5/19/25 at 10:12 AM room [ROOM NUMBER] was observed to have enhanced barrier precaution signage next to the door. A plastic storage bin with new PPE in the drawers and a garbage bin with used PPE inside was observed outside of the resident's room. On 5/19/25 at 1:20 PM Staff 10 (CNA) performed hand hygiene, donned PPE, entered room [ROOM NUMBER], exited the room at 1:28 PM and doffed PPE in the hallway and placed the soiled PPE in the garbage bin outside of the resident's room. On 5/19/25 at 1:49 PM Staff 10 stated after direct care was provided for the resident, used PPE was placed in the garbage located outside of the resident's room. On 5/20/25 from 1:52 PM to 2:50 PM rooms 7, 8, 12, 13, 14,17, 21, 22, 23, 24, 29, and 33 were observed to have enhanced barrier precaution signage next to the room door. Each room had a plastic storage bin with new PPE in the drawers and a garbage bin that contained used PPE outside of the resident's room. On 5/21/25 at 9:29 AM Staff 7 (CNA) performed hand hygiene, donned PPE, entered room [ROOM NUMBER], then exited the room at 9:31 AM, doffed PPE in the hallway and placed the soiled PPE in the garbage bin outside of the resident's room. On 5/21/25 at 10:00 AM Staff 7 stated staff were provided education from the facility related to enhanced barrier precautions and were directed to discard used PPE in the garbage bin located outside of the resident's room. On 5/21/25 at 3:57 PM Staff 3 (RN Infection Preventionist) stated management discussed enhanced barrier precautions and placement for the garbage bins and she was advised to keep the garbage bins outside of the resident's room in the hallway. Staff 3 acknowledged the facility was not following the CDC guidelines related to enhanced barrier precautions.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48830 Based on interview and record review it was determined the facility failed to ensure residents were offered and received pneumococcal vaccines for 4 of 7 sampled residents (#s 31, 52, 267, and 268) reviewed for vaccines. This places residents at risk for pneumonia. Findings include: A review of the revised 4/8/25 facility Pneumococcal Vaccine policy for residents revealed the following: 1. Each resident should be offered pneumococcal immunizations, unless the immunization is medically contraindicated, or the resident has already been immunized. 2. Consents and declinations should be documented using the Med-Pass form (CP-1900P-25) and placed in the medical record. The facility should re-address the refusal with the resident and/or resident representative each year to ensure they have not changed their decision. These conversations should be captured in the medical record. 1. Resident 31 was admitted to the facility in 2021 with a diagnosis of heart failure. Resident 31's clinical record revealed she/he was eligible for, but was not offered a pneumococcal vaccine. On 5/22/25 at 11:16 AM Staff 3 (RN Infection Preventionist) stated all long-term residents who were eligible for a pneumococcal vaccine were not yet offered. No additional information was provided. 2. Resident 52 was admitted to the facility in 2023 with a diagnosis of diabetes. Resident 52's clinical record revealed she/he was eligible for, but was not offered a pneumococcal vaccine. On 5/22/25 at 11:16 AM Staff 3 (RN Infection Preventionist) stated all long-term residents who were eligible for a pneumococcal vaccine were not yet offered. No additional information was provided. 3. Resident 267 was admitted to the facility in 3/2024 with a diagnosis of kidney failure. Resident 267's clinical record revealed on 3/23/24 the resident was offered and consented to receive a pneumococcal vaccine. The resident's clinical record did not indicate she/he received the vaccine. No additional information was provided. 4. Resident 268 was admitted to the facility in 4/2024 with a diagnosis of heart failure. Resident 268's clinical record revealed on 4/16/24 the resident was offered and consented to receive a pneumococcal vaccine. The resident's clinical record did not indicate she/he received the vaccine. No additional information was provided.