STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385143	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Umpqua Valley Nursing & Rehabilitation Center	525 W. Umpqua Street Roseburg, OR 97471

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review it was determined the facility failed to ensure narcotic records were maintained accurately, and an account of all controlled substances were kept for 4 of 4 medication carts reviewed for medication administration. This placed residents at risk for drug diversion. Findings include:On 8/20/25 at 2:00 PM, the narcotic logbook for the Skilled Hall medication cart showed 114 instances out of 300 opportunities in which facility staff did not sign to verify the narcotic count.On 8/20/25 at 2:04 PM, the narcotic logbook number 13 for the 200/300 hall medication cart showed 126 instances out of 300 opportunities in which facility staff did not sign to verify the narcotic count.On 8/20/25 at 2:06 PM, the narcotic logbook number 15 for the 200/300 hall medication cart showed 129 instances out of 300 opportunities in which facility staff did not sign to verify the narcotic count.On 8/20/25 at 2:10 PM, the narcotic logbook number 20 for the 100/300 hall medication cart showed 92 instances out of 300 opportunities in which facility staff did not sign to verify the narcotic count.On 8/19/25 at 3:01 PM Staff 15 (CMA) stated two staff members (CMA or Licensed Nurse) are required to reconcile the narcotics at the end of each shift to ensure narcotics are not missing. Staff 15 stated both staff members are required to sign the narcotic logbook which indicated the narcotic reconciliation was correct. Staff 15 stated if the narcotic reconciliation was not accurate Staff 2 (DNS) was to be notified.On 8/20/25 at 9:19 AM Staff 16 (CMA) stated at the end of each shift two staff members (CMA or Licensed Nurse) reconcile the narcotics after each shift to ensure narcotics are not missing. Staff 16 stated both staff sign the narcotic logbook which indicated the reconciliation was accurate. Staff 16 stated if narcotics are missing Staff 2 should be notified.On 8/20/25 at 2:12 PM, the narcotic logbook for the (TCU) Transitional Care Unit hall medication cart showed 110 instances out of 300 opportunities in which facility staff did not sign to verify the narcotic count.On 8/20/25 at 2:28 PM, Staff 2 (DNS) verified the missing signatures in the narcotic logbooks. Staff 2 stated the process for the narcotic logbooks were for two nurses or CMAs to verify the narcotic count was accurate.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary medications and provide rationale for PRN psychoactive medication beyond 14 days for 1 of 5 sampled residents (#75) reviewed for medications. This placed residents at risk for adverse side effects. Findings include: Resident 75 readmitted to the facility in 2024 with diagnoses including depression and dialysis dependence.A 6/5/25 physician order indicated trazodone in the evening for sleep as needed (PRN). No end date was indicated on the order.Review of Resident 75's MARs from 6/2025 through 8/2023 indicated trazodone was administered the following times:- 6/2025: 19 times of out 26 days.- 7/2025: 22 times out of 31 days.- 8/2025: 12 times out of 18 days.A 7/25/25 Pharmacy review indicated the PRN trazodone was requested 19 times in the past 30 days. The pharmacy review indicated the PRN medication was past the 14-day requirement and recommended to discontinue the medication or to provide a clinical rationale and duration for the medication. The pharmacy review directed the provider to use the facility's fax number to respond.A review of Resident 75's medical record revealed no clinical rationale for the continued use of the PRN trazodone past 14 days since the order date on 6/5/24.On 8/21/25 at 11:43 AM Staff 5 (RCM LPN) acknowledged Resident 75 continued to use the PRN trazodone and there was no clinical rationale in the medical record for the continued use of the medication beyond the required 14 days since the order date in 6/2025.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide adequate supervision to prevent accidents for 1 of 4 sampled residents (# 17) reviewed for accidents. This placed residents at risk for increased falls. Findings include: Resident 17 was admitted to the facility in 7/2025 with diagnoses of dementia and a history of falls.A Care assessment dated [DATE] noted increased fall risk due to personal history of falls, wandering behavior, poor memory, frequent self-transfers, and dementia. Staff were directed to anticipate her/his needs and perform frequent safety checks.A Nursing Facility Incident Form dated 7/30/25 indicated resident 17 had an unwitnessed fall during an attempt to reach the bathroom in her/his room.On 8/15/25 Resident 17 tested positive for Covid-19 and had been placed on droplet (tiny liquid particles) isolation. Staff were to keep the bedroom door closed at all times.Random observation from 8/11/25 through 8/15/25 on day and evening shifts revealed Resident 17 was in her/his room the entire time with staff entering when the resident's call light was activated.On 8/21/25 at 10:39 AM Staff 12 (CNA) and at 10:58 AM Staff 14 (CNA) both stated the resident was impulsive and tried attempted to exit the bed unassisted. Staff 12 stated staff were expected to perform frequent checks, but with Resident 17 being on droplet precautions and ensuring the door remained closed made it difficult to monitor the resident appropriately. On 8/21/25 at 10:55 AM Staff 13 (LPN) stated Resident 17 displayed forgetfulness and attempted self-transfers. Staff 13 reported Covid-19 precautions required Resident 17's door to be closed. Staff 13 stated more frequent checks were necessary given the resident's increased fall risk. On 8/22/25 at 8:47 AM Staff 2 (DNS) stated Covid-19-positive residents required the doors to be closed for droplet isolation. Staff 2 stated staff were expected to check high fall-risk residents every 30 minutes even if the residents were on precautions.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review it was determined the facility failed to provide therapy services for 1 of 1 sampled residents (#78) reviewed for rehabilitation. This placed residents at risk for functional decline and immobility. Findings include:Resident 78 was admitted to the facility in 10/2024 with diagnoses including stroke with weakness to the non-dominant side. A 7/10/25 Provider Encounter Note revealed an order for physical therapy evaluation due to reduced mobility. On 8/19/25 at 10:03 AM Resident 78 stated she/he wanted physical therapy in order to walk again and felt frustrated because she/he was promised PT and never received it. On 8/20/2025 at 9:56 AM Staff 13 (LPN) stated when he reviewed the provider notes after a physician visit, he checked for any new orders and input them into the system. Staff 13 stated if there was any therapy order he would print out the order for therapy services. Staff 13 stated he was unaware Resident 78 had PT orders. On 8/21/2025 at 11:44 AM Staff 5 (LPN-Resident Care Manager) stated she was not unaware Resident 78 had PT orders from 7/2025. Staff 5 stated she expected the provider to either tell the floor nurse of therapy orders or to input the therapy orders into the EMR (electronic medical record).On 8/21/25 at 1:25 PM Staff 2 (DNS) she acknowledged Resident 78 had PT orders from 7/2025 and was not evaluated by therapy. Staff 2 stated she expected the provider to inform floor staff of any therapy orders and for the floor staff to review any providers notes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined the facility failed to follow proper infection control precautions for 1 of 1 sampled resident (#60) reviewed for infection control. This placed residents at risk for cross contamination and risk of infection. Findings include:According to the Center for Disease Control and Prevention: Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (2009) III. B.2: -Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Resident 60 admitted to the facility in 8/2025 with diagnoses including a urinary tract infection.On 8/20/25 at 12:38 PM Resident 60's catheter bag and tubing were observed lying on the floor.On 08/20/2025 1:00 PM Staff 18 (CNA) stated the resident's catheter bag was placed on the floor with a towel underneath due to the resident's bed being in the lowest position.On 8/20/25 at 1:08 PM Staff 4 (LPN Resident Care Manager) entered Resident 60's room and confirmed the catheter bag and tubing were placed on the floor with a towel underneath and stated it was not appropriate infection control related to catheter care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure air conditioning units were free from leaks and bathroom doors were operational in resident rooms for 2 of 5 facility hallways reviewed for physical environment. This placed residents at risk for an unsafe, lack of privacy and unsanitary environment that was not homelike. Findings include: 1. On 8/18/25 at 12:07 PM room [ROOM NUMBER]'s air conditioning was observed dripping water along the entire bottom panel onto the bedside table and down the wall causing the wall panel to [NAME]. On 8/19/2025 at 3:04 PM Staff 21 (CNA) stated the air conditioning unit had been leaking for the entire summer and the maintenance department was in the room to look at the unit several times, but the problem was ongoing. On 8/19/25 at 3:13 PM Staff 22 (CNA) stated she noticed the air conditioning leaking about six weeks ago and notified the nurse and maintenance staff of the concern.On 8/20/25 at 11:20 AM Staff 23 (Maintenance Assistant) acknowledged the air conditioning unit in room [ROOM NUMBER] was dripping water along the bottom panel to the dresser and along the wall. Staff 23 stated he unaware the unit was leaking. Staff 23 stated the maintenance department did not complete monthly audits and relied on housekeeping and nursing staff to report concerns regarding room repairs.On 8/21/25 at 10:44 AM Staff 11 (Maintenance Director) stated he was aware the air conditioning unit in room [ROOM NUMBER] was leaking. Staff 11 stated the leak was caused from the coils in the unit forming ice when the temperature was turned down too low and then would melt when the unit was turned off.On 8/21/25 at 2:24 PM Staff 1 (Administrator) stated the facility was in the process of replacing air conditioning units and expected all the units to be functioning properly.a. On 8/20/25 at 2:26 PM during a Resident Council meeting residents reported room [ROOM NUMBER]'s air conditioning was leaking and ruining posters and shelving below the unit.On 8/21/25 at 10:15 AM Staff 27 (CNA) stated she reported the air conditioning leaking in room [ROOM NUMBER] to nursing and maintenance.On 8/21/25 at 10:44 AM Staff 11 (Maintenance Director) stated he was aware the air conditioning unit in room [ROOM NUMBER] was leaking. Staff 11 stated the leak was caused from the coils in the unit forming ice when the temperature was turned down too low and then would melt when the unit was turned off.On 8/21/25 at 2:24 PM Staff 1 (Administrator) stated the facility was in the process of replacing air conditioning units and expected all the units to be functioning properly.2. On 8/20/25 at 2:26 PM during the Resident Council meeting it was revealed the pocket doors for the bathroom in room [ROOM NUMBER] and room [ROOM NUMBER] were broken and were replaced with shower curtains. Residents stated they did not feel they had privacy, odor control and was a potential fire safety concern without an appropriate door.On 8/21/25 at 10:44 AM Staff 11 (Maintenance Director) acknowledged room [ROOM NUMBER] and room [ROOM NUMBER] pocket doors were broken and shower curtains were used as a replacement. Staff 11 stated parts for the pocket doors were no longer available.On 8/21/25 at 2:24 PM Staff 1 (Administrator) acknowledged the pocket doors were broken, and the facility was in the process of repairing the doors.