

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Green Valley Rehabilitation Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 Adkins Street Eugene, OR 97401	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41453</p> <p>Based on observation, interview and record review it was determined the facility failed to follow physician's orders related to oxygen administration for 1 of 3 sampled residents (#8) reviewed for respiratory care. This placed residents at risk for respiratory complications. Findings include:</p> <p>Resident 8 was admitted to the facility in 1/2024, with diagnoses including respiratory failure with hypoxia (lack of oxygen) and asthma.</p> <p>Resident 8's 2/2024 Physician's Orders indicated staff was to administer oxygen continuously at 2 liter per minute via nasal cannula. This order was discontinued when Resident 8 was sent out to the hospital.</p> <p>Resident 8 readmitted on ,d+[DATE] without an order for oxygen.</p> <p>On 1/31/25 at 12:20 PM, Staff 3 (SSD) confirmed Resident 8 had an appointment on 12/9/24 at summit surgical. Staff 3 remembered her/him coming back upset about the appointment.</p> <p>On 1/31/25 at 10:38 AM, Staff 44 (CNA) stated Resident 8 should have had oxygen when she/he went out to the appointment on 12/9/24. Resident 8 came back and her/his pulse oxygen reading was at 64%. Staff were supposed to send oxygen tanks with residents, which attach to residents' wheelchairs. Staff 4 stated Resident 8 did not have an oxygen tank with her/him during her/his appointment.</p> <p>On 1/28/25 at 10:32 AM, Resident 8 was observed with a nasal canula in place and an oxygen concentrator running at four liters per minute.</p> <p>On 2/3/25 at 10:36 AM, Resident 8 was observed with a nasal canula in place and an oxygen concentrator running at four liters per minute.</p> <p>On 2/3/25 at 10:40 AM, Staff 9 (CMA) confirmed Resident 8 was on four liters of continuous oxygen.</p> <p>Review of Resident 8's clinical record found no order for the resident's continuous oxygen at four liters.</p> <p>On 2/3/25 at 10:43 AM, Staff 2 (DNS) was informed Resident 8 was on oxygen without an order. Staff 2 stated they would look into it.</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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>33179</p> <p>Based on observation, interview and record review it was determined the facility failed to assure there was sufficient nursing staff available to provide nursing and related services to meet the residents' needs safely and timely for 2 of 2 units reviewed for staffing. This placed residents at risk for missed or delayed care, missed or late meals, an increase safety risk for falls and aspiration, and a decline in health status. Findings include:</p> <p>Intermittent call light and staffing observations conducted on 1/29/25 from 8:15 AM to 5:00 PM revealed call light wait times up to 27 minutes.</p> <p>Intermittent call light and staffing observations conducted on 1/30/25 from 5:00 AM to 2:00 PM revealed call light wait times up to 40 minutes.</p> <p>Review of the facility's grievances found the following:</p> <ul style="list-style-type: none"> - On 11/6/24, staff entered Resident 24's room and found Resident 24 soaked so bad that it was dripping off of [her/his] bed onto the ground and there was a huge puddle of pee underneath. Additionally, the resident was found laying flat in bed with no oxygen, her/his oxygen saturation was 79% (normal is 93-100%) and the resident stated she/he saw yellow spots. - On 11/20/24, Resident 18 indicated she/he experienced long call light wait times and soiled linens. - On 12/16/24, staff did not provide timely incontinent care and Resident 5 sat in a soiled brief for an hour and a half before care was received. - On 1/27/25, Resident 31 indicated she/he had waited over two hours for assistance with her/his lunch meal and expressed via a writing board, I feel sad, no one comes. I'm always last. <p>The facility's 11/2024 and 1/2025 Resident Council Notes revealed concerns related to call lights.</p> <p>The facility's Payroll Based Journal (PBJ) Reports revealed in 11/2024, the facility was short CNA staff for 17 shifts; and in 12/2024 short CNA staff for five shifts.</p> <p>The facility's Direct Care Staff Daily Report from 1/1/25 to 1/26/25 revealed the facility was short eight CNAs for seven shifts.</p> <p>On 1/28/25 at 10:19 AM, Resident 5 stated call light wait times were long and she/he occasionally missed showers because there was not enough staff.</p> <p>On 1/28/25 at 11:58 AM, Resident 4 stated call light wait times were long and she/he did not always get a shower.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/28/25 at 3:58 PM, Resident 11 stated the facility was short staffed, call light wait times could be long and she/he sometimes did not get any incontinent care at night.</p> <p>On 1/29/25 at 10:06 AM, Resident 17 stated she/he frequently waited a long time for call lights to be answered and assistance with her/his care needs. Resident 17 further stated meal trays were often delivered late.</p> <p>On 1/29/25 at 10:07 and 2/3/25 at 9:15 AM, Resident 3 stated staff ignored the call lights and she/he would wait for hours. Resident 3 stated she/he needed incontinence care recently, no staff came to provide care and sometimes her/his friend would help with brief changes. Resident 3 stated showers did not always get done, meals were served late, and the resident smoke breaks were missed.</p> <p>On 1/29/25 at 10:12 AM, Resident 16 stated there was not enough staff and had to wait a long time for her/his call light to be answered and her/his care needs were not met in a timely manner. Resident 16 further stated meal trays were delivered late.</p> <p>On 1/31/25 at 10:02 AM, Resident 15 stated there was not enough staff to meet her/his needs and concerns without having to wait a long time and call light wait times were between 45 minutes to hours long. Resident 15 stated meal trays were delivered late due to staffing and the food was often cold. Resident 15 further stated staffing and call lights were complained about at every Resident Council meeting with no resolution.</p> <p>On 1/31/25 at 10:09 AM, Resident 14 stated there was not enough staff to meet her/his needs in a timely manner, she/he had to wait over an hour for assistance and needed staff to provide incontinent care more often. Resident 14 further stated meal trays were delivered late and the food was sometimes cold.</p> <p>On 1/31/25 at 11:36 AM, Resident 34 stated staff did not respond to her/his call lights, frequently left her/him in soiled briefs and did not ensure she/he had fresh water to drink. Resident 34 stated she/he was care planned to be a two person assist with the Hoyer (mechanical lift) to transfer, but would be transferred with one staff member at times. Resident 34 further stated call lights could take two hours to be answered, and meal trays were passed late.</p> <p>On 2/3/24 at 9:07 AM, Resident 2 stated the facility missed having resident smoke breaks at least twice a week.</p> <p>On 2/3/25 at 12:24 PM, Resident 1 stated smoke breaks would be late or canceled due to staffing issues.</p> <p>On 1/29/25 at 11:20 AM, Witness 23 (Family) stated she visited Resident 35 daily and observed there was not enough staff to meet her/his basic care needs. Witness 23 stated Resident 35 was left in soiled briefs and bed linens for over one and a half hours, would come in to visit and find multiple soiled briefs in the trash can with a full urinal hung from the side of the can. Witness 23 stated she would empty the urinal and take out the trash during her visits. Witness 23 further stated she brought the family dog for a visit and the dog jumped up on the side of the bed and came down with feces all over his fur. Witness 23 stated the nursing staff were overwhelmed, stretched too far, and the care the facility provided was a failure of basic human decency.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/30/25 at 1:18 PM, Witness 25 (Family) stated Resident 18 waited a long time for her/his call light to be answered. Witness 25 stated she visited weekly and another family member visited daily. Witness 25 further stated on many occasions, she would activate the call light and no staff would respond. Witness 25 stated Resident 18 would sit in a soiled brief for 30 - 45 minutes after the call light was activated. Witness 25 further stated on one occasion she activated the call light at 11:25 AM because she wanted Resident 18 up in the wheelchair and taken to the dining room for lunch. After waiting over 25 minutes, she got Resident 18 dressed, into the wheelchair, and took her/him to the dining room herself.</p> <p>On 1/31/25 at 11:46 AM, Witness 26 (Family) stated she visited Resident 24 daily and observed the resident sitting in soiled briefs for an extended length of time due to short staffing. Witness 26 stated staff did not put in Resident 24's hearing aides or assist Resident 24 to brush her/his teeth. Witness 26 stated due to inadequate staffing Resident 24 did not get her/his call lights answered timely, receive timely incontinence care, or get her/his trash taken out of her/his room. Witness 26 stated she now cleaned out Resident 24's drinking cups and took out her/his trash when she visited. Witness 26 stated she had observed staff go in to other resident rooms, shut off the light and not provide care to the residents on multiple occasions. Additionally, Witness 26 stated staff had informed Resident 24 on multiple occasions, they could not provide incontinence care because they were taking other residents out to smoke or they needed to provide eating assistance with meals.</p> <p>On 1/28/25 at 1:33 PM, Staff 44 (LPN) stated staffing could be a nightmare and management had an I don't care attitude. Staff 44 stated showers were haphazard if they got done; many residents did not get showers. Staff 44 stated call lights on the weekend could be 70 - 90 minutes before they were answered; other days the wait time might average up to 30 minutes. Staff 44 further stated smoke breaks could get missed, meal trays were served late, and residents who needed assistance with meals were served last.</p> <p>On 1/29/25 at 1:24 PM, Staff 45 (CMA) stated medications could be passed an hour or more late on some days due to the workload.</p> <p>On 1/28/25 at 2:35 PM, Staff 18 (CNA) stated the facility's staffing ratios were not sufficient for the acuity needs of the residents.</p> <p>On 1/28/25 at 3:00 PM, Staff 20 (CNA) stated the day shift CNAs frequently double briefed (put two incontinence briefs on at the same time) several residents were not provided incontinent care every two hours as appropriate. Staff 20 further stated showers were not always completed on evening shift because it was hard to fit in a shower.</p> <p>On 1/28/25 at 3:31 PM, Staff 21 (CNA) stated resident call light wait times were long and it was difficult to complete resident showers so they were not completed on many occasions.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/29/25 at 9:00 AM, Staff 5 (Unit Manager) stated the majority of the intermediate care facility (ICF) residents were a two person assist with a high acuity level. Staffing was unacceptable, not safe for the acuity level, and an ongoing problem that turned into an every day problem. Staff 5 stated resident showers were missed, residents did not get repositioned, and when she arrived in the morning she often found residents soaked in urine because the night shift did not have enough staff to complete their last rounds. Staff 5 further stated documentation often got missed because there was not enough time to complete it, meals were served late, and the residents who required assistance to eat were assisted last.</p> <p>On 1/29/25 at 9:05 AM, Staff 25 (CNA) stated the facility worked short staffed a lot and some residents did not want to wait for assistance.</p> <p>On 1/29/25 at 9:16 AM, Staff 6 (CNA) stated she was regularly assigned nine or ten residents, was not able to complete the residents care per their individual plans of care, and would let some things go. Staff 6 stated she would not get everyone's teeth brushed, miss resident showers and not able to perform personal hygiene. Staff 6 further stated this occurred almost daily.</p> <p>On 1/29/25 at 9:19 AM, Staff 33 (CNA) stated she was unable to get Resident 10 up in the morning when the facility was short staffed which would cause her/him to get very upset. Staff 33 stated when she was assigned 13 residents to care for she was unable to complete showers or provide care per the residents' care plan.</p> <p>On 1/29/25 at 9:24 AM, Staff 7 (CNA) stated when the facility was short staffed she was responsible for eight to 13 residents on day shift. When this occurred call lights were not answered timely, showers would not get done, and it was hard to meet residents' needs. Staff 6 stated many residents were a two person assist for care and those residents waited a long time for assistance. Staff 6 stated when she arrived for her shift she would find residents soaked in urine, with one time a resident's entire bed was wet. Staff 6 further stated meal trays were passed late and residents who needed supervision with meals were brought to the dining room for meals, however, no staff were available to supervise them. These situations occurred at least once or twice a week.</p> <p>On 1/29/25 at 9:28 AM, Staff 26 (CNA) stated staffing levels were not good and Resident 11 was usually soaked with urine every morning when she arrived on shift. Staff 26 stated showers did not get done and residents complained about it.</p> <p>On 1/29/25 at 10:17 AM, Staff 3 (SSD) stated, staffing is sickening to me, and it's a consistent problem. Staff stated residents complained of staffing and call lights at every Resident Council meeting. Staff 3 stated residents did not receive showers, brief changes or bed linen changes because one CNA to nine residents was not feasible with the high acuity level. Staff 3 stated she had recently received facility Grievance Forms for a resident's bed that was not changed for two weeks, a two hour wait time for the call light to be answered and general call light and staffing concerns. Staff 3 further stated one to two days a week residents who need assistance and supervision in the dining room were not observed by staff, especially on evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/30/25 at 10:26 AM, Staff 11 (CNA) stated due to short staffing she had to rush resident care, omit showers, teeth brushing and personal hygiene, give untimely incontinent care and perform two person Hoyer transfers by herself because no staff was available to help her. Staff 11 stated when she arrived on day shift she would often find residents soaked with urine due to low CNA staffing levels on night shift. Staff 11 stated meal trays were delivered late, residents who required assistance to eat either received late assistance or sometimes not get to eat, and residents who required supervision with meals were left unsupervised. Staff 11 further stated she was told the nurses at the nurses' station would supervise the residents (there was an obstructed view into the dining room from the nurses' station.)</p> <p>On 1/30/25 at 10:52 AM, Staff 10 (CNA) stated it was difficult to provide adequate care due to staffing levels. Staff 10 stated he was unable to provide care per the residents care plan, showers were constantly missed and he was unable to reposition the residents who needed repositioning every two hours. Staff 10 stated the hardest part was when a continent resident would activate the call light for toileting assistance and because he was unable to answer the call light timely they would soil themselves. Staff 10 further stated meal trays were usually passed late and the residents who required assistance were assisted very late. There were multiple occasions when breakfast did not get passed until after 9:00 AM, which then delayed lunch, and because lunch was late he could not get to his last resident round and had to pass off the residents' afternoon care to the next shift.</p> <p>On 1/30/25 at 11:15 AM, Staff 12 (Staffing Coordinator) stated she utilized a matrix to determine staffing levels and looked at both the facility census and number of residents who received the bariatric rate. Staff 12 stated she did not staff to the residents' acuity, needs or diagnoses. Staff 12 verified the facility was short staffed on several shifts in 11/2024, 12/2024 and 1/2025.</p> <p>On 1/30/25 at 11:50 AM Staff 2 (DNS) and Staff 4 (Assistant DNS) stated the facility determined staffing levels off the census based on the regulations and the minimum state staffing levels for the bariatric rate.</p>