STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385156	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Rehabilitation Health Center	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review it was determined the facility failed to ensure a resident was treated with dignity for 1 of 3 (#1) residents reviewed for dignity. This put residents at risk for a decreased quality of life. Records reveal: Resident 1 was admitted to the facility in 4/2025 with diagnoses including hip fracture and Fibromyalgia (chronic pain illness). An 4/22/25 admission MDS revealed she/he was cognitively intact and required moderate assistance from staff for transfers. On 10/24/25 at 11:54 AM, Resident 1 stated while speaking with Staff 5 (Speech Therapist) about self-transferring for toileting needs she/he was told to only get up with staff assistance and to urinate in the bed when staff were not available. She/He stated the comment was mortifying and caused her/him to feel degraded. On 10/27/25 at 11:45 AM, Staff 5 stated she did not remember Resident 1. She stated she often instructs residents to follow all safety and assistance recommendations to prevent possible injuries. She stated if she was aware a resident was transferring in an unsafe manner to use the toilet, she would instruct them to urinate in the bed rather than get up unassisted. On 10/27/25 at 3:50 PM, Staff 3 (Interim DNS) stated he did not remember Resident 1 or any incidences involving Staff 5. He stated had he been made aware of the incident, he would have coached the staff member and spoken with the resident. He stated the expectation of all staff is for them to treat all residents with dignity and respect.

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 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. (continued on next page)

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	385156	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview it was determined the facility failed to ensure a resident's medications were given according to provider orders and a wound was properly monitored for 1 of 5 residents (#1) reviewed for medications and wound care. This put residents at risk for adverse medication reactions, infections, and death. Records reveal: The facility Wound Treatment Management policy revised 4/1/25 stated the effectiveness of wound care treatments would be monitored with ongoing assessments of the wound until healed.Resident 1 was admitted to the facility in 4/2025 with diagnoses including hip fracture and Fibromyalgia (chronic pain illness). An 4/22/25 admission MDS revealed she/he was cognitively intact, had pain daily, and had a surgical wound. On 10/24/25 at 11:54 AM, Resident 1 stated the facility ran out of her/his pain medications multiple times and the facility staff did not implement wound observations or treatment after her/his wound care needs changed. She/He stated they were constantly in pain while at the facility and was admitted to the hospital with an infection in their wound. On 10/24/25 at 12:05 PM, Witness 2 (Family Member) stated Resident 1 was without pain medication on multiple occasions, and Resident 1's wound became infected due to not having any wound observations or treatments in place after the care needs changed.The 4/16/25 provider orders indicated the following: - Oxycodone (an opioid pain medication) 5 - 10MG was to be given as needed every four hours.- Tramadol (an opioid pain medication) 1,00MG was to be administered in the AM and at bedtime.The 4/16 - 4/26/25 Medication Administration Records showed:- Oxycodone was administered 29 times - Tramadol was not administered on 4/16/25 PM, 4/17/25 AM, 4/21/25 AM and PM, and 4/22/25 AM. An 4/17/25 progress note indicated Tramadol was not given on 4/16/25 and 4/17/25 due to the facility not getting the medication from the pharmacy. An 4/18/25 provider wound care order indicated treatment was changed to a honeycomb dressing (clear honeycomb shape post-surgical dressing designed to protect the wound and manage drainage). The order indicated it was to be removed 4/26/25 and did not have any instructions for monitoring of the wound after placement of the honeycomb dressing. An 4/19/25 progress notes indicated the facility ordered an Oxycodone emergency supply due to running out of the regular shipment. An 4/20/25 progress note indicated Witness 1 spoke to staff regarding Resident 1's Oxycodone supply running out and her/his pain. The note revealed facility staff contacted the pharmacy who stated the cause of the delivery delay was unknown and the Oxycodone would be sent that night. Progress notes from 4/21/25 and 4/22/25 indicated Tramadol was not given because the pharmacy had not delivered the medication.Resident 1's April pain level record indicated pain levels ranging seven out of 10 to 10 out of 10 on days medications were missed. Shower records for 4/2025 revealed all facility offered showers were refused by the resident and no as needed showers were requested. Progress notes from 4/26/25 indicated Resident 1 had complaints of chills, a fever of 103 degrees Fahrenheit, an elevated heart rate, and elevated blood pressure. An assessment of the wound revealed redness, swelling, warmth, and tenderness and Resident 1 was sent to the Emergency Department for treatment. On 10/24/25 at 6:47 PM, Staff 9 (Medication Technician) stated she did not remember Resident 1. She stated when residents had scheduled and as needed pain medications, she checked in with the residents throughout the shift for pain levels and medicated as needed. She stated there were times medications were late or got missed altogether.On 10/24/25 at 4:24 PM, Staff 7 (LPN) stated she did not remember Resident 1. She stated medication refills were monitored by the medication technician and nursing staff, and at times medications did not get re-ordered properly which caused residents to miss medications. She stated all wound care treatments and monitoring were initiated and completed by the wound care nurse. On 10/27/25 at 2:04 PM, Staff 4 (LPN Unit Manager) stated she did not remember Resident 1. She stated staff have been trained to monitor medication amounts and re-order enough to cover all possible administrations. She stated all medications were expected to be re-ordered prior to the current supply running out. She stated wound care assessments were completed by the wound care nurse, and the expectation for all wounds was for them to be monitored until healed. Multiple attempts to reach the wound care nurse were unsuccessful. On 10/27/25 at 3:50 PM, Staff 3 (Interim DNS) stated he did not remember Resident 1. He stated pain levels were monitored by multiple staff members throughout the shift and residents were medicated for pain as needed or ordered by the provider. He stated the expectation was for medication refills to be ordered prior to the current supply running out. He stated honeycomb dressings were not touched by staff, and all wounds were expected to be monitored until healed regardless of the wound care dressing in place.