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	01/15/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, it was determined the facility failed to make prompt efforts in resolving a resident's grievance for 1 of 7 sampled residents (#23) reviewed for misappropriation. This placed residents at risk for unresolved grievances. Findings include:A revised Resident Rights Grievances Policy and Procedure (revised in 3/2023) indicated the grievance officer with assistance of Social Services, responsibility to oversee the grievance process, receive and track grievance through conclusion, lead any necessary investigations, maintain confidentiality, and issue written grievance decisions. Staff will immediately report to the Grievance Officer any grievance alleging violations related to misappropriation of resident property. The Grievance Officer will make reports available within seven business days of filing. A summary report of the investigation will be available to the resident, and a confidential file will be maintained on grievance decisions and investigations for three years. Resident 23 was admitted to the facility in 2/2025, with a diagnosis including depression. An 8/26/25 Resident Council meeting minutes indicated residents reported missing items from their room. Resident 23 attended the meeting. An 8/31/25 MDS revealed Resident 23 BIMS was 15 (cognitively intact). Review of the Grievance List report for 7/2025 and 8/2025 revealed no grievances submitted for Resident 23. On 1/12/26 at 12:46 PM, Resident 23 stated in 8/2025 she/he was missing jewelry, an oximeter, a set of colored pencils and gel pens. Resident 23 stated she/he reported the missing items to staff and at the resident council meeting. On 1/14/26 at 11:49 AM, Staff 26 (CNA) stated Resident 23 reported in 8/2025 she/he was missing a set of earrings and an oximeter. Staff 26 stated she reported the missing items to the charge nurse. Staff 26 stated Resident 23 had completed a grievance form the day before, so she did not assist with completing one. On 1/15/26 at 9:13 AM and 11:19 AM, Staff 11 (Director of Social Services and Recreation) stated he did not remember any grievances for Resident 23 regarding missing items. Staff 11 stated no grievances were found for Resident 23 for 8/2025. Staff 11 stated there had been confusion due to multiple staff members in 8/2025 and the grievance was possibly submitted but became lost. On 1/15/26 at 11:49 AM, Staff 1 (Administrator) stated he would expect staff to complete a grievance and to be resolved in five days.

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

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 01/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined the facility failed to report an incident of potential neglect for 1 of 9 sampled residents (#28) reviewed for elopement. This placed residents at risk for accidents. Findings included:Resident 28 was admitted to the facility in 2/2025, with diagnoses including anxiety and cognitive communication deficit (difficulty in expressing or understanding language). A 3/7/25 Elopement Investigation Report revealed on 3/6/25 around 4:30 PM, Resident 28 was found approximately a block away from the facility next to a busy street. The investigation stated root cause was Resident 28 was confused and her/his wander guard (electronic monitoring device) was not functioning. There was no documented evidence Resident 28's elopement was reported to the State Survey Agency for the elopement incident on 3/6/25. On 1/14/26 at 9:48 AM, Staff 40 (Former Administrator) stated she could not remember if Resident 28's elopement was reported to the state but stated she would not report an elopement because it was no longer listed on the FRI form. On 1/13/26 at 10:27 AM and 1/15/26 at 11:55 AM, Staff 1 (Administrator) stated to his knowledge no FRI was completed for the resident's 3/6/25 elopement. Staff 22 (Regional RN) stated if there was an alleged violation it would be expected to submit an FRI for an elopement.

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	01/15/2026

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 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. Based on interview and record review, it was determined the facility failed to ensure a resident's environment remained free from accident hazards for 1 of 9 sampled residents (#28) reviewed for accidents. This placed residents at risk for accidents. Findings include:Resident 28 was admitted to the facility in 2/2025, with diagnoses including anxiety, and cognitive communication deficit (difficulty expressing or understanding language). A 2/7/25 admission MDS revealed Resident 28's BIMs score was three (severe cognitive impairment). A 3/4/25 Care Plan indicated Resident 28 had episodes of wandering and had a Wander Guard (electronic monitoring device) placed on her/his wheelchair. Interventions included checking placement of Wander Guard on the wheelchair every shift and distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. A 3/2025 TAR instructed staff to check Resident 28's Wander Guard placement on the left area of her/his wheelchair every shift with a start date of 3/4/25. There was no documented evidence found in Resident 28's clinical record to indicate staff were checking the resident's Wander Guard to ensure it was functioning properly. A 3/7/25 Elopement Investigation Report revealed on 3/6/25 around 4:30 PM, Resident 28 was found approximately one block away from the facility next to a busy street. The investigation indicated the root cause was Resident 28 was confused and her/his wander guard was not functioning. Resident 28 was placed on 15-minute checks, and a 15-minute monitoring sign-up sheet was set up for the staff. There was no documented evidence found in Resident 28's clinical record to indicate staff were conducting 15-minute checks after the resident's elopement. On 1/15/26 at 9:53 AM, Staff 47 (Former Physical Therapist Assistant) stated Resident 28 was very confused. Staff 47 stated he found Resident 28 on 3/6/25 approximately 18 inches from a busy street in a precarious position. Staff 47 stated Staff 24 (CNA) helped him assist Resident 28 back to the facility. Staff 47 stated the Wander Guard became a big thing after the resident returned to the facility. On 1/15/26 at 1:14 PM, Staff 24 stated he assisted Staff 47 with bringing Resident 28 back to the facility when she/he was found next to a busy street. Staff 24 stated Resident 28 did not have a Wander Guard on her/his wheelchair. On 1/14/26 at 8:58 AM and 1/15/26 at 11:55 AM, Staff 1 (Administrator) stated no 15-minute monitoring sheets for Resident 28 were located. Staff 1 stated it would be expected for staff to check Wander Guard placement and functionality.

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 01/15/2026
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)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interview and record review, it was determined the facility failed to staff a registered nurse (RN) for eight consecutive hours per day seven days per week for 21 out of 78 days reviewed for staffing. This placed residents at risk for unmet assessment needs. Findings include:A review of the facility's Direct Care Staff Daily Reports for 8/2025, 9/2025, 10/2025, and 11/2025 indicated there were 21 days without RN coverage for eight consecutive hours. The dates were as follows: -8/3/25-8/8/25-8/10/25-8/11/25-8/16/25-8/17/25-8/18/25-8/19/25-8/24/25-8/25/25-8/29/25-8/31/25-9/1/25-9/7/2 On 1/15/26 at 9:23 AM, Staff 27 (Staffer) and Staff 23 (LPN) stated they were told to start reporting the RN manager on the Direct Care Staff Daily Report on 1/13/25. On 1/15/26 at 11:52 AM, Staff 1 (Administrator) stated it was the expectation for staff to call off work two hours before their shift to give time for additional staff to be found to cover. Payroll documentation of RN working on the above listed days were requested. No additional documentation was provided.