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	06/01/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review it was determined the facility failed to ensure a safe and orderly discharge for 1 of 3 sampled residents (#8) reviewed for discharge. This placed residents at risk for an unsafe and disorderly discharges. Findings included: Resident 8 was admitted to the facility in 2/2026 with diagnoses including dementia. Review of a Resident 8's Care Plan dated 2/13/26 indicated the resident had an ADL self-care performance deficit and limited physical mobility. Interventions included ambulation with a four-wheeled walker. The care plan also indicated the resident was at risk for elopement due to Alzheimer's, with the goal to ensure the resident did not leave the facility unattended. The resident's care plan also indicated the resident wished to be discharged to her/his home where a family member lived with the resident. Interventions including to discuss the discharge planning process with the family. Review of Resident 8's BIMS Evaluation dated 2/17/26 documented the resident scored a 5 out of 15 (indicating severe cognitive impairment). A Physician Assistant's (PA) Note dated 5/11/26 indicated discharge planning concerns for failure to thrive at home. Resident 8 was being discharged home (65 miles away) despite clinical reservations given past concerns at home. Cognitive status appeared to be at baseline. A Discharge Readiness form dated 5/11/26 at 3:24 PM, indicated the resident was to be discharged to home approximately 65 miles from the facility. The resident was to be transported home via public transportation. A Nurse's Note dated 5/12/26 at 2:51 PM, indicated the resident was discharged from the facility at 2:45 PM. A train ticket dated 5/12/26 indicated Resident 8 was to depart via bus from the local train station to a grocery store in the resident's hometown one mile from the resident's home. The bus was scheduled to leave at 3:45 PM and arrive at 5:26 PM. A Nurse's Note dated 5/12/26 at 7:53 PM, documented the resident arrived back at the facility after missing the bus to her/his hometown. The note indicated the resident's family was informed. A Physician Assistant's Note dated 5/13/26 at 9:21 PM, indicated the resident was seen for readmission to the facility after being sent to the bus stop via taxi to take a bus back home where family were to meet Resident 8. The note indicated the resident did not get on the bus due to a severe cognitive impairment and the inability to find the correct bus on her/his own. In an interview on 5/20/26 at 12:15 PM, Resident 8, who was alert, stated the facility treated her/him well and had no concerns with care. Resident 8 wanted to go home to her/his family on the coast but did not know what city she/he resided. The resident stated she/he was currently at a hospital but did not know which hospital. The resident stated she/he was recently sent home via a car, there was an accident on the way home and the car brought her/him back to the facility. Resident 8 did not remember being at the bus stop. In an interview on 5/20/26 at 12:25 PM, Staff 3 (RCM) stated Staff 4 (RCM) made a suggestion during a pre-discharge meeting the facility should send a staff person with the resident to the bus stop and not be sent alone. Staff 3 stated no staff went with the resident to the bus station. Staff 3 stated an attendant at the bus station called the facility to report the resident missed the bus. In an interview on 5/20/26 at 12:42 PM, Staff 5 (Social Services) stated Staff 4 had concerns regarding the resident's cognition and being dropped off at the bus station to catch a bus to go home. Resident was sent alone by the facility via taxi to the local bus stop. Staff 5 stated Witness 8 (Family Member) member was supposed to meet the resident in their hometown when the resident (continued on next page)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrived and had called the facility to let them know the resident did not get on the bus. In an interview on 5/20/26 at 1:27 PM, Staff 6 (LPN) stated on 5/12/26 he received a call from Witness 8 who stated a bus station attendant had called her to tell her Resident 8 had missed the bus to go home. Staff 6 stated the resident was found by the bus station attendant, confused, and the bus station attendant had called Witness 8 to let them know. Staff 6 immediately called Staff 1 (Administrator) and Staff 2 (DNS) and an ambulance was sent to pick up the resident at the bus station who was taken back to the facility. In an interview on 5/20/26 at 1:40 PM, Staff 1 and Staff 2 stated Resident 8 was sent via taxi to the bus station on 5/12/26 with a prepaid bus ticket to go home. Resident 8 was not accompanied by staff and failed to get on the scheduled bus to go home. Resident 8 was found by a bus attendant who called Witness 8 who then notified the facility. Staff 2 was present at the pre-discharge meeting and was aware of the concerns by Staff 4. The facility did not feel sending the resident to the bus station alone would be a problem. In an interview on 5/21/26 at 7:13 AM, Witness 8 stated she received a call from the local bus station who informed her the resident had missed the bus to go home. Witness 8 called the facility who dispatched EMS to pick up the resident.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to complete a discharge summary, including a recapitulation of the resident's stay and the resident's functional status upon discharge for 3 of 4 sampled residents (#s 2, 3, 5 and 8) reviewed for discharge. This placed residents at risk for an unsafe discharge. Findings include:1. Resident 3 was admitted to the facility in 1/2026 with diagnoses including pneumonia. A Discharge Planning Questionnaire dated 2/23/26 indicated Resident 3 was to be discharged home on 2/24/26. The form did not include a recapitulation of the resident's stay or the resident's functional status upon discharge. In an interview on 5/21/26 at 8:10 AM, Staff 5 (Social Services) stated the facility used the Discharge Planning Questionnaire for all discharges from the facility. Staff 5 acknowledged Resident 3's discharge summary did not include the resident's recapitulation of stay and the resident's functional status. 2. Resident 2 was admitted to the facility in July 2025 with diagnoses including kidney cancer. A Discharge Planning Questionnaire dated 9/12/25 indicated Resident 2 was discharged home on 9/15/25. The form did not include a recapitulation of the resident's stay or the resident's functional status upon discharge. In an interview on 5/21/26 at 8:10 AM, Staff 5 acknowledged Resident 2's discharge summary did not include the resident's recapitulation of stay and the resident's functional status. 3. Resident 8 was admitted to the facility in 2/2026 with diagnoses including dementia. A Discharge Planning Questionnaire dated 5/11/26 indicated Resident 8 was to be discharged home on 5/12/26. The form did not include a recapitulation of the resident's stay or the resident's functional status upon discharge. In an interview on 5/21/26 at 8:10 AM, Staff 5 acknowledged Resident 8's discharge summary did not include the resident's recapitulation of stay and the resident's functional status.